Outstanding ☆

2gether 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)
RTQX1	Stonebow Unit	Herefordshire Crisis and Home Treatment Team	HR1 2BN
RTQXX	Trust HQ	Gloucester and Forest Crisis Resolution and Home Treatment Team	GL1 3HZ
RTQXX	Trust HQ	Cheltenham, Tewkesbury and North Cotswolds Crisis Resolution and Home Treatment Team	GL53 8AG

Summary of findings

RTQXX	Trust HQ	Stroud and Cotswolds Crisis Resolution and Home Treatment Team	GL5 2JG
RTQ02	Wooton Lawn	The Maxwell Centre 136 Suite	GL1 3WL

This report describes our judgement of the quality of care provided within this core service by 2gether 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 2gether NHS Foundation Trust and these are brought together to inform our overall judgement of 2gether 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
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 outstanding because:

- The heath-based place of safety was well managed and was purpose built to provide a safe and effective service. Systems and procedures were in place which supported staff to keep themselves and patients safe from harm.
- Patients were seen quickly and there were no waiting lists. Patients had thorough, up-to-date risk assessments and care plans, which looked at both their physical and mental health needs. Care plans were holistic, person-centred and recovery focused. Care plans were effective in supporting patients through their mental health crisis. Carers were identified and supported in their role.
- Staff supported patients to take positive risks as part of their recovery. Patients could access shorter-term, psychological therapies as part of their crisis resolution and patients waited no longer than around four weeks for this. Staff referred patients to other teams for longer-term psychological interventions. Patients were supported to work toward a safe discharge from the team and were referred to other services for longer term help to manage their longer term goals and mental health.
- Staff worked well together to provide a safe and effective crisis service to their patients. They shared important information with each other quickly and effectively. Handover and multidisciplinary meetings were well managed and were effective in managing patient risk and progress. The teams had good multidisciplinary, cross service and interagency joint working arrangements.
- The service had developed strong links with community groups who could offer additional support to their patients. Staff worked well with the police and ambulance service to deliver an effective and responsive 136 service to patients. Where issues were identified these were proactively dealt with.
- Staff listened to their patients. The trust had an effective and embedded system for collecting patient feedback. The service was making changes based upon feedback from patients, carers and stakeholders. Patients were extremely positive about the service they received and the staff who supported them.

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:

- Patients had effective and up to date risk assessments.
- There were sufficient staff to operate the service safely and effectively.
- Policies and procedures were in place to manage the service safely.
- There were good lone working policies in place and staff used these effectively.
- Staff had a good understanding of incident reporting and learning from incidents was effectively shared.
- Staff understood and managed safeguarding issues well.
- Doctors were part of the team and could be accessed quickly for advice and support
- Mandatory training compliance rates for staff were good.
- The Maxwell Centre section 136 suite met the Royal College of Psychiatrists'standards for health-based places of safety.
- Systems and procedures were in place to ensure the safe and effective operation of the section 136 suite.

However;

- One the Cheltenham, Tewkesbury and North Cotswolds team did not effectively monitor medication management and there was the potential for errors.

Are services effective?

Good

We rated effective as good because:

- Teams worked effectively together and with other services to ensure patients received an effective crisis intervention service.
- Patients were assessed in a timely manner.
- Patients were supported to address their physical health needs along with their mental health needs in line with national guidelines.
- Patients could access short-term psychological therapies and were referred to other specialist teams for longer-term therapies.
- Staff had a thorough understanding of the Mental Health Act and how it applied to their professional practice.
- The understanding and practice of assessing mental capacity was embedded within the teams.
- Effective recording and storage of information meant that patient information was easily accessible to staff in a safe and timely manner.

Summary of findings

However

- Staff routinely recorded information about patients' physical health needs in different places of the electronic database which meant that there was the potential for important information to be missed.
- Staff routinely recorded information about mental capacity assessments in different places of the electronic database which meant that there was a risk that important information could be missed.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients and carers consistently told us that they were very impressed with the service and with the staff who supported them.
- Patients felt that staff cared about them.
- Staff treated patients and carers with dignity, compassion and respect.
- There was a strong person centred culture within the teams where staff supported patients with wider needs including physical health, emotional wellbeing and social needs.
- Staff were interested in their patients and committed to supporting them effectively through their mental health crisis.
- Patients and carers were treated as full partners in their care and were empowered to manage their own health.
- Care plans were routinely given to patients and patients were involved in developing them.
- Staff supported patients to understand their condition and their treatment.
- Seeking feedback from patients was routine and embedded within the service. Staff actively sought the views of patients so they could make improvements to the service.
- The health-based place of safety (HBPoS) at the Maxwell Centre was designed to promote patients' dignity and privacy and to be a comfortable place during the assessment period.
- Significant thought had been placed upon the things that might promote choice, comfort, dignity and recovery in the HBPoS, such as the availability of snacks and drinks as well as bedding and washing facilities.
- We saw timely and compassionate staff responses to patients experiencing emotional distress.
- Staff demonstrated a thorough understanding of their patients both in terms of their strengths, goals and risks.

However;

Summary of findings

- Whilst patients and carers reported that they received their care plans, staff did not always record that they had been given.

Are services responsive to people's needs?

Outstanding 

We rated responsive as outstanding because:

- Patients told us that they felt listened to and were confident that if they had a complaint it would be acted upon.
- Patients were given information about how to complain and how to access an advocate.
- Complaints were dealt with effectively and used as a way of improving the service.
- The service actively collected patient feedback and made changes to reflect this.
- Contacting the teams was straightforward and patients could get support when they needed it - 24 hours a day, seven days a week. There was a freephone telephone number for people living in Gloucestershire
- Patients were assessed and treated in a timely manner and were effectively supported to move on from the service when it was appropriate for them to do so.
- People with urgent needs were prioritised.
- The service was provided in a way which was flexible and offered choices to patients.
- Information packs were routinely given to patients. These included important information to support their recovery and independence within the community.
- The purpose-built facilities at the Maxwell Centre 136 health-based place of safety had been designed with safety and comfort in mind. It was well appointed and appropriate for the service that was being delivered.
- The needs of different people were taken into account when planning and delivering the service, including gender, age, other disabilities, and those living in vulnerable circumstances.
- The service worked with partner agencies and community organisations to support patients.

Are services well-led?

Good 

We rated well-led as good because:

- Staff were familiar with the trust's vision and values.
- Robust systems were in place to effectively measure the quality and safety of the service.
- The trust consistently captured data on performance and used this to enhance the service.

Summary of findings

- Staff knew who their senior managers were and told us that some had occasionally visited their teams.
- Local managers were strong leaders and supported their staff well. Local managers were accessible and available to their staff who valued and respected them.
- Staff had access to developmental opportunities and could progress with their careers.
- There was an open culture that welcomed feedback from staff.
- Staff morale was mostly very good.
- Innovation and development was embedded within the service.

Summary of findings

Information about the service

2gether NHS Foundation Trust operated four crisis teams across the region. Three were based in Gloucestershire and one in Herefordshire. Crisis services support patients who are experiencing an acute mental health episode which has culminated in a crisis for which the person's normal coping strategies have been unsuccessful. The crisis service is designed to be short term and provide intensive support to patients to enable them to live as independently as possible throughout their mental health crisis. Crisis teams support patients to leave hospital more quickly and to prevent unnecessary hospital admissions. Patients who require ongoing support to manage their mental health are referred on to other teams for additional and longer term therapies. The 2gether service was amongst the first to sign up to the mental health crisis care concordat (a national agreement between services and agencies involved in the care and support of people who are in crisis).

When a person experiences a mental health crisis, it is important they are kept safe while an assessment of their needs is made. Section 136 of the Mental Health Act provides emergency powers for the police to detain and deprive a person of their liberty temporarily, if they appear to be suffering from a mental disorder and are in immediate need of care or control whilst in a public place. In these circumstances, a person can be removed to a place of safety under section 136 of the Mental Health Act. The purpose of section 136 is to allow the person to be assessed by a registered medical practitioner and an approved mental health professional. 2gether NHS Foundation Trust have a purpose built section 136 suite called the Maxwell Centre. The suite is situated in the grounds of the Wotton Lawn mental health hospital and is approximately 100 yards from the Gloucester and Forest crisis team office. It is staffed by a rota of crisis team staff from across the county. There is a facility at the Herefordshire Stonebow unit which can be used as a section 136 assessment suite. However, the facility is not operated or staffed by the the trust as it is not commissioned to provide section 136 services in Herefordshire. The facility is used by the police as an alternative to holding a patient in a police cell whilst carrying out Mental Health Act assessment. At the time of the inspection the trust were in negotiation with Herefordshire clinical commissioning group and the multi-agency monitoring group in Herefordshire to agree whether it should operate the facility as a health based place of safety. We did not inspect the facility as part of this inspection.

There is a facility at the Hereford Stonebow Unit which could act as a section 136 assessment suite. However, this is not owned, operated or staffed by the 2gether Foundation NHS Trust and is used by the police as an alternative to a police cell for carrying out Mental Health Act assessments. At the time of the inspection, 2gether NHS Foundation Trust were in negotiation with the police to operate the facility as a section 136 health-based place of safety. In view of the fact that the trust did not provide any staff for the unit, we did not inspect the facility as part of this inspection.

2gether NHS Foundation trust were in the process of developing a new mental health acute response service in Gloucestershire (MHARS). MHARS would bring about significant changes to the way the service was operated. More patients would be able to access crisis support, including children and young people, there would be a single urgent response team (URT) for the county and locality crisis teams would be increased in size to become rapid assessment and home treatment teams, working alongside the URT. The changes were planned to take place during 2015-16. As the changes had not been fully implemented, we inspected the mental health crisis and health-based place of safety as we found them at the point of inspection.

This was the first inspection of 2gether Foundation NHS Trust mental health crisis and health-based place of safety services.

Summary of findings

Our inspection team

Chair: Vanessa Ford, Director of nursing standards and governance, West London Mental Health NHS Trust

Team Leader: Karen Bennett-Wilson, head of inspection, Care Quality Commission

The team that inspected this core service comprised three CQC inspectors, five nurses and nurse managers, a Mental Health Act reviewer, an approved mental health professional and an assistant CQC inspector.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about crisis services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited all four crisis resolution and home treatment teams
- visited the health-based place of safety (the Maxwell Centre section 136 suite)
- observed how staff were caring for patients during two home visits and two assessment appointments
- spoke with 17 patients who were using the service and one patient who had recently used the service
- spoke with 13 carers of patients who were either using the service or had recently used it
- spoke with the managers or acting managers for each of the teams
- spoke with 36 other staff members including; doctors, nurses, support workers, occupational therapists, administrators, pharmacists and social workers
- interviewed a divisional service manager with responsibility for most of the services
- attended and observed two hand-over meetings and a multi-disciplinary patient meeting.
- looked at 29 patient care and treatment records
- carried out a specific check of medication management in the four teams
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with 17 patients who were using the service, one patient who had used the service in the recent past and 13 carers of people using the service.

- Patients and carers told us that they were very satisfied with the care and treatment they received from the service.
- They told us that staff treated them with kindness, dignity and respect.
- Patients and carers said they knew how to contact with the service and almost always received a quick response from staff.
- All but two patients remember being given the 24 hour crisis telephone number and many had used it to speak to staff outside of normal working hours. Those that had used the 24 hour telephone number said it was useful to them.

Summary of findings

- All but one patient told us they had been involved in developing their care plan and had received a copy of it.
- Patients and their carers knew how to make a complaint about the service and were confident they would be taken seriously if they made a complaint.
- Patients and carers were very complimentary about the service and told us that staff had effectively supported them through a difficult time. All but two patient comments were highly positive. Most said how brilliant the service was, how great the staff were and what a really great service the teams provided.
- Most patients had been involved in providing feedback about the service by competing satisfaction questionnaires.

Good practice

- The service used the National Early Warning Score (NEWS) for assessing patients' physical wellbeing. The Royal College of Physicians advocates the use of NEWS for assessment and response in acute illness. Some staff in the teams were trained to take blood samples from patients. This ensured that patients benefited from physical health tests, even if their mental health crisis meant they did not feel well enough to leave their home and go to their local general practitioner or hospital for the tests.
- Staff did not wear uniforms and discretely wore their identification badges when visiting patients. Staff were conscious that they wished to protect their patients' confidentiality from neighbours and the general public.
- Staff went over and above their remit by supporting patients before a formal referral had been received. While referrals were being taken, we saw staff busy gathering as much information as possible to ensure that they were as prepared as they could be to support the patient without delay.
- Staff ensured that each patient was followed up after they had been discharged or transferred to another team. They made contact with the patient and new team to ensure that care and treatment was progressing. This meant that patients were provided with a seamless service as they moved on from the crisis teams. This also meant that the risks of a patient not receiving a follow-up service were significantly reduced
- Gathering feedback was embedded within teams. Staff gathered information verbally and by using formal questionnaires. Staff used the information to improve their services and demonstrated the value they placed on listening to patients.

Areas for improvement

Action the provider SHOULD take to improve

The trust should ensure that:

- Mental capacity assessments are consistently recorded in the same place, so that staff can easily reference and find them.
- Physical health screening checks and updates are consistently recorded in the same place, so staff can easily reference and find them.
- Staff supervision is effectively recorded and stored by local managers.

2gether 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
Herefordshire Crisis and Home Treatment Team	Stonebow Unit
Gloucester and Forest Crisis Resolution and Home Treatment Team	Trust Head Quarters
Cheltenham, Tewkesbury and North Cotswolds Crisis Resolution and Home Treatment Team	Trust Head Quarters
Stroud and Cotswolds Crisis Resolution and Home Treatment Team	Trust Head Quarters
The Maxwell Centre 136 Suite	Wooton Lawn

Mental Health Act responsibilities

- Staff demonstrated a good understanding of the Mental Health Act 1983 (MHA) and how it related to their professional practice.
- At the time of our inspection, there were no patients subject to Community Treatment Orders (CTOs) under the MHA.
- Consent to treatment and capacity forms were completed.
- Staff knew how to get advice about the MHA if they needed it and said they could also speak with approved mental health professionals in their teams for information and guidance if needed.
- Information about independent mental health advocacy services was readily available to support patients and was displayed in patient areas. Staff knew how to access advocacy support for their patients.

Detailed findings

- Staff had a good understanding of their responsibilities and duties when people were admitted under section 136 of the MHA. They ensured they worked within the Act, the Code of Practice and the guiding principles. Patients had their rights under the MHA explained to them on admission to the Maxwell Centre health-based place of safety (HBPoS) and these were repeated until patients could understand them. Patients were also given printed copies of their rights under the MHA.
- Information about advocacy and independent mental health advocacy (IMHA) services were available to patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good awareness of the Mental Capacity Act 2005 (MCA) and the implications this had for their clinical and professional practice. MCA training was not mandatory for staff. They had received training on the MCA and could update their knowledge using e-learning resources if they needed to. Staff were clear about their ability to assess mental capacity and able to demonstrate examples of when to use the MHA and the MCA.
- Records showed that staff routinely assessed mental capacity for their patients. However, this was not always recorded in the specific section of the electronic database and was sometimes recorded in the daily record of contact / activity. This meant that there was the potential that assessments and decisions relating to mental capacity could be missed by staff. Mental capacity was also discussed in multidisciplinary meetings and daily handover meetings.
- Staff routinely assessed mental capacity before admission to hospital and before assessment under the MHA. This was to determine if the patient had capacity to consent to admission to hospital informally, or whether powers for detention under the MHA were required.
- Understanding of the MCA was embedded within the teams.

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

Our findings

Safe and clean ward environment

- Clinic rooms were mostly shared with other teams or wards depending upon the site where the teams were based. We inspected all of them and found them to be clean, appropriately stocked and audited for correct fridge and room temperatures. Where there was emergency equipment, it was checked regularly to ensure it was in good working order and showed service dates. Logs for reporting maintenance issues were effectively used.
- The environment was visibly clean, well maintained and regularly cleaned. Staff practiced appropriate infection control procedures such as hand hygiene to reduce the risks of infection.
- Portable appliance tests were carried out for any equipment used. It was checked regularly to ensure it continued to be safe to use and clearly labelled indicating when it was next due for service.
- Formalised ligature risk assessments were carried out for areas that were used by patients and improvements were made to reflect risks that had been identified.

Safe staffing

- The whole time equivalent (WTE) staffing establishment in the Hereford team was 14.9 nurses, a half time nurse manager and an admin post. The team had the lowest vacancy rate at 14% (2 nurses and 0.1 admin). The Stroud and Cotswolds team WTE was 12 plus a full time manager, an administrator, a social worker and 2.8 WTE support workers. The vacancy rate was 24% (3.9 nurses and 0.2 social workers). However, the manager told us that in preparation for the new mental health acute response service developments, additional roles had been created within the team and these vacancies were actively being recruited to. We met an additional social worker and an occupational therapist who had very recently joined the team. The Cheltenham, Tewkesbury and North Cotswolds team WTE was 11 nurses, two social workers, an administrator and 4.6 WTE support workers plus a full time manager. The vacancy rate was 23% (1.8 wte nurses, 0.4 admin and two social workers). The WTE staffing establishment in the Gloucester and Forest team was 14 nurses, 5.8 support workers, 1.9 admin and two social workers. The vacancy rate was 23% (3.6 WTE nurses and 0.9 admin). Vacancies in all teams were being actively recruited to, but one manager said this took up a lot of their time and effort and was pleased that the trust recognised this and had made arrangements the human resources team to provide a greater level of recruitment support to managers. Vacancy levels across the service averaged 21% for non-medical roles and included administrators. This represents a high vacancy level, but the service was in a transition and had created additional new roles in readiness for the planned changes, so the level of vacancies did not appear to be having a negative impact upon staff and patients.
- Sickness levels in the 12 month period leading up to the inspection were 5.1% for the service. The team with the lowest rate was Stroud and Cotswolds with 2.4% and the highest was the Herefordshire crisis team at 7.6%.
- In the 12 months leading up to the inspection, staff turnover stood at an average of 14.7% across the service. The team with the lowest turnover was Stroud and Cotswolds, at 6.3% (1 member of staff) and the highest was Cheltenham, Tewkesbury and North Cotswold, at 23.5% (four staff). Managers told us that some staff had retired, which accounted for the largest portion of the turnover figures and one left for personal reasons.
- The trust was not able to tell us how many shifts had been worked by bank or agency staff. Staff said that agency staff were almost never used. Bank staff were routinely used in the service and many were existing part-time staff or people who had previously worked in the service. Most bank staff were regular and knew the teams well. The Herefordshire team reported that not all their bank staff knew their team or the processes well and did not have access to the electronic recording system. Notes taken by temporary staff had to be typed and entered into the database by administrators. There were times when this was delayed due to administrative staff sickness or leave. This meant that there was the potential that patient notes were not up-to-date. If staff did not have the most up-to-date information, this could affect their decision making which could potentially put either staff or patients at risk.

Good

Are services safe?

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

- The service had reviewed the number and grade of staff required for each team and planned increases in the staffing numbers had been agreed.
- Staff were not allocated individual patients and all patients were managed and supported by the shift of staff on duty. Between April – September 2015, the average number of patients supported by the service was 93 a month. The teams aimed to be as consistent as possible but in line with crisis teams nationally (where a 24/7 service is provided) it was not possible for patients to be seen by the same workers at each home visit because staff worked shifts. We asked patients about this and patients told us this was not a problem for them. Many patients said they liked the variety of staff and most commented that staff who visited them understood their needs well and they did not have to repeat themselves unnecessarily. Some patients commented positively on the shift handover process and felt that this made sure the staff who visited them were fully prepared and knowledgeable about their situation.
- All staff told us that they could easily and quickly speak with a psychiatrist when they needed to.
- Records showed that the overall average for completion of mandatory staff training in the Herefordshire crisis team was 78%. There was 100% compliance in areas such as equality and diversity, non-clinical infection control, multiagency child protection and conflict resolution. However, the rate fell to 46% for infection control and clinical risk assessment. Staff in the Stroud and Cotswolds crisis team had completed 83% of their mandatory training. Rates in the Cheltenham, Tewkesbury and North Cotswolds crisis team were 87% and the Gloucester and Forest team were 95% compliant with their mandatory training. Two out of the three Gloucestershire crisis team managers had completed all of their mandatory training and the third manager had completed 81%.

Assessing and managing risk to patients and staff

- We looked at 29 sets of care and treatment records across the service. A risk assessment had been completed for all patients at the initial assessment and a copy was present in each of the records we inspected. Risk assessments were updated regularly and discussed in the twice daily handover meetings and weekly multidisciplinary meetings.
- There were clear arrangements in place to respond to a sudden deterioration in patients' mental state. The teams provided a service 24 hours a day, 7 days a week. There was access to an out-of-hours on-call system for managers and psychiatrists. Patients told us that they were able to get assistance out hours and the teams responded quickly, almost all of the time.
- Longer term advance decisions were not routinely developed by the crisis teams. These were carried out by teams who would have longer term involvement after the crisis had been resolved.
- There were no waiting lists and patients were seen quickly, based upon risk.
- All staff had undertaken safeguarding training and staff demonstrated a good understanding of safeguarding issues. There was good reporting and joint interagency working arrangements in place. Safeguarding issues were shared with the teams via handover and multidisciplinary team meetings. Information on safeguarding was readily available to support staff and they knew where to get advice if they needed it. We saw that staff made referrals to the trust safeguarding team. There were 13 adult and eight children safeguarding enquires made to the trust safeguarding team between October 2014-15 which showed that the teams were routinely considering and acting upon safeguarding concerns for their patients. The new manager in the Herefordshire team had appointed a team champion for safeguarding.
- All staff were aware of the lone working policy and told us that they followed it. We observed good and safe lone working practices. Staff had mobile phones and used "safe words", a code staff used if they needed to alert their colleagues that they were in a position of risk and required assistance. All but one member of staff were aware of the safe word to be used in an emergency. There were established systems for signing in and out, with expected time of return so that the staff whereabouts were known at all times. Staff were contacted if they exceeded their expected return time. Risk assessments were carried out to establish worker safety in patients' homes and any areas where patients were to be seen. Staff were trained in breakaway techniques. Staff saw patients in pairs.
- Teams had nurse prescribers and doctors who prescribed medication for patients. The teams did not store controlled drugs. Procedures for safe medication collection, storage and distribution were in place. Staff

recorded medication in and out. Medicines management was audited by a specialist mental health pharmacist. We saw that this was safe and effective. However, we noted that two of the medication charts we inspected had the potential to miss reviews of "as required" medication but there was no evidence that any reviews had actually been missed. The Cheltenham, Tewkesbury and North Cotswolds team did not use prescription and medicines administration records to monitor what medication they delivered to people in their own homes. They recorded medication "in and out" on the patients' electronic notes, using the daily recording section. This meant that it was more difficult for staff to check that medication had been given to patients as prescribed. This was pointed out during the inspection and the manager acknowledged that the system could be clearer.

Track record on safety

- No serious incidents were reported for the crisis teams during the last 12 months. There had been one incident where a member of staff had been threatened by a patient while their co-worker was not in the room. This had been effectively reported and the lessons learned had been shared amongst other staff, to prevent a similar incident occurring. Staff changed their practice after the incident.

Reporting incidents and learning from when things go wrong

- All teams had an effective way of recording incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to recognise and report incidents through the reporting system. Examples of incidents reported included when staff had needed to spend longer than planned supporting a patient which impacted upon their ability to see the next patient. In January and October 2015 there were two incidents relating to the malfunctioning of the Gloucestershire crisis team freephone telephone number and the pager used by the police to contact the teams. These were reported and dealt with effectively and quickly.
- The teams had a clear reporting system and managers analysed incidents. Incidents were investigated, clear action plans were developed and learning was identified.
- Systems for sharing learning from incidents were embedded within teams. The trust produced regular incident reports which were effectively cascaded to staff in handover meetings, multidisciplinary meetings, in team meetings and via email. They were available on the trust internal website for staff to read independently.
- Staff were offered debrief and support sessions if they were involved in or affected by an incident.

Health-based Places of Safety

Safe and clean environment

- The interview rooms at the Maxwell Centre 136 suite were fitted with alarms and closed circuit television cameras.
- Staff using the unit followed security procedures which included joint working arrangements with the police for violence risk assessments.
- The environment was visibly clean, well maintained and regularly cleaned. Staff practiced appropriate infection control procedures such as hand hygiene to reduce the risks of infection.
- Emergency equipment and testing equipment was in place. Portable appliance tests were carried out for any equipment used. It was checked regularly to ensure it was safe to use and clearly labelled indicating when it was next due for service
- The Maxwell Centre 136 suite facilities met the safety standards recommended by the Royal College of Psychiatrists. It was separate from the main hospital area, suitably furnished, clean and with toilet facilities.
- Deep cleaning of the facility took place when required and daily cleaning was carried out and logged for audit purposes.
- The suite was visibly free of ligature points and contained collapsible curtains and ligature free taps. Supervision was provided for any patients using the 136 suite and there was no history of a patient having ligatured whilst being assessed there.
- Kitchen facilities were protected behind a metal roll-down shutter. These were visibly clean and well maintained.
- Fridge temperature checks were carried out and logged but the thermometer was found to be defective. The service manager dealt with this immediately and the maintenance department responded on the day of the inspection to rectify the matter.

Safe staffing

Good

Are services safe?

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

- The health-based place of safety was staffed on a rota basis by the crisis teams in Gloucestershire which we saw worked effectively.

Assessing and managing risk to patients and staff

- A member of the team was identified as section 136 co-ordinator for each shift. The Gloucestershire crisis team was based in the Maxwell Centre 136 suite at night and at weekends. Staff worked in pairs and never alone.
- Risk assessments were carried out for each patient admitted to the 136 suite. Violence risk assessments were carried out by the police. If staff were not satisfied with the potential level of risk established for the patient, the police would remain on site and / or colleagues from the main hospital could attend in order to deliver effective and safe management of violence and aggression support. Crisis team staff were trained in breakaway techniques.

Track record on safety

- There were no recorded incidents for the Maxwell Centre 136 suite for the 12 months leading up to the inspection.

Reporting incidents and learning from when things go wrong

- Staff used the same procedures for the 136 suite as they did for other aspects of their roles.

Are services effective?

Good

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

Our findings

Mental Health Crisis Services

Assessment of needs and planning of care

- We inspected 29 care and treatment records for patients using the crisis service. Assessments were completed in a timely manner and within timescales.
- Physical health checks were mostly carried out on the second visit when staff formed a baseline physical health assessment which they revisited at regular intervals with the patient. However, the recording of physical health information was not always stored in the correct section of the electronic database, which meant that information could be duplicated or missed by staff.
- Information and patient records were stored safely and securely on the trust electronic database. Teams used white wipe boards which displayed patient details such as risk levels and treatment information but these were not visible to members of the public or other patients. The management and storage of information enabled staff to deliver effective care in a timely manner, whilst protecting patient confidentiality
- Assessments were completed quickly with urgent referrals being prioritised.All the teams held twice daily handover meetings where staff discussed patients' care, risks, progress and the support they required.
- Care plans were developed with the patient and carers if appropriate. In the sample we inspected, all but one care plan was up to date. Care plans were holistic, personalised for the individual patient and recovery focused in 100% of the sample inspected. Care plans were regularly reviewed to take account of the patients' risks and progress.

Best practice in treatment and care

- Staff referred patients for longer term psychological therapies, as recommended by National Institute for Health and Care Excellence (NICE). The "Let's Talk" service, provided by the Improving Access to Psychological Therapies service (IAPT), routinely took referrals form the crisis teams.
- Teams used the HoNOS (Health of the Nation Outcome Scales). The use of HoNOS is recommended by the **English National Service Framework for Mental Health** and by the working group to the Department of Health on outcome indicators for severe mental illnesses. They also form part of the English minimum data set for mental health.
- The teams offered practical support for patients with employment, housing and welfare benefits. They had developed links with local employment, voluntary and housing providers in order to support their patients.
- Physical healthcare needs were routinely assessed, monitored and supported. The service used the National Early Warning Score (NEWS) for assessing patients' physical wellbeing. The Royal College of Physicians advocates use of NEWS for assessment and response in acute illness. Some staff in the teams were trained to take blood samples from patients. This ensured patients benefited from physical health tests, even if their mental health crisis meant they did not feel well enough to leave their home and go to their local general practitioner or hospital for the tests. Local managers told us that they had carried out an audit of recording physical health monitoring but the trust said they did not collect the information so we could not verify the results. There were monitoring arrangements in place for prescribed antipsychotic medication. However, we found that staff did not always record physical health care assessments and monitoring in the relevant section of the electronic database. This meant that staff could duplicate tasks or miss important information.

Skilled staff to deliver care

- The teams contained a mix of experienced support workers and qualified staff. They included occupational therapists, nurses, social workers, support workers, doctors, approved mental health professionals and administrators. There was a psychologist attached to the Herefordshire crisis team who was able to support and direct patients to group therapies at the Stonebow unit. Pharmacy was provided via a service level agreement for specialist mental health pharmacists. They were available for consultation and advice but could not extend to attending multi-disciplinary meetings. Staff and the pharmacy reported good working relationships. The pharmacy team operated an on call system for out-of-hours enquiries.

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.

- Newly appointed staff received appropriate inductions which involved shadowing experienced staff. Newly qualified staff were supported with their professional development.
- Staff told us that they received regular supervision but we found that records were not always available to corroborate this. There had been a gap in provision of management supervision in the Herefordshire crisis team due to a manager vacancy. We saw that this was being rectified by the recently appointed manager. Staff in the Stroud and Cotswolds team received regular supervision as did those in the Gloucester and Forest team. Staff in the Cheltenham, Tewkesbury and North Cotswold team said they had regular supervision but not all records were available to corroborate this at the time of inspection. All staff told us they could have formal and informal supervision with their managers or with peers when they required it. However, not all managers effectively stored information about staff supervision, so it was not clear if all staff were receiving regular supervision in line with trust policy.
- The percentage of non-medical staff that received an appraisal in the last 12 months was 82% across the service. All staff in the Stroud and Cotswold team had received their appraisal by the time the inspection was carried out.
- Staff told us they had undertaken training relevant to their role and training was available to them.

Multi-disciplinary and inter-agency team work

- There were effective handovers and multidisciplinary meetings within the teams. We observed some of these patient focused meetings, and saw that staff discussed the progress and risks of each patient in detail. Changes in treatment plans, risks, presentation and carer issues were discussed effectively. Staff demonstrated a thorough understanding of their patients' needs and how they were to be supported effectively.
- Staff worked well together and showed respect for each other. There was opportunity for discussion and the meetings were effective and ran to time.
- The teams had developed strong working relationships with other mental health teams and effectively shared information about patients about to move between services. Staff from receiving teams, such as the recovery teams, were present at meetings to ensure a thorough sharing of information and smooth transition. Crisis team staff followed up patients after they had been discharged from the team to ensure that the transfer had been effective and risks were monitored.
- The teams worked well with others in the trust to ensure a seamless service for patients. Contact was maintained with acute wards, general practitioners, the police, housing and voluntary agencies. There was effective contact with the local authority if patients had social care needs, if there were safeguarding concerns or if there were children involved with the patient.

Adherence to the MHA and the MHA Code of Practice

- Staff demonstrated a good understanding of the Mental Health Act (MHA) and how it related to their professional practice.
- At the time of our inspection, there were no patients subject to Community Treatment Orders (CTOs).
- Consent to treatment and capacity forms were completed.
- Staff knew how to get advice about the MHA and said they could also speak with approved mental health professionals in their teams for information and guidance if needed.
- Information about independent mental health advocacy services was readily available to support patients and was displayed in patient areas. Staff knew how to access advocacy support for their patients.

Good practice in applying the MCA

- Staff demonstrated a good awareness of the Mental Capacity Act 2005 (MCA) and the implications this had for their clinical and professional practice. MCA training was not mandatory for staff. They had received training on the MCA and had access to e-learning so they could update their knowledge. Staff were clear about their ability to assess mental capacity and were able to demonstrate examples of when to use the MHA and the MCA.
- Records showed that staff routinely assessed mental capacity for their patients. However, this was not always recorded in the specific section of the electronic database and was sometimes recorded in the daily record of contact / activity. This meant there was the potential that assessments and decisions relating to mental capacity could be missed by staff. Mental capacity was also discussed in multidisciplinary meetings and daily handover meetings.

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.

- Staff routinely assessed mental capacity before admission to hospital and before assessment under the MHA in order to determine if the patient had capacity to consent to admission to hospital informally or whether powers for detention under the MHA were required.
- Understanding of the MCA was embedded within the teams. New recruits to the teams received training as part of their induction programme and e-learning was available for all staff.

Health-based Place of Safety

Assessment of needs and planning of care

- A comprehensive assessment was undertaken by crisis staff when patients were brought to the Maxwell Centre health-based place of safety (HBPoS) by the police for assessment under section 136 of the Mental Health Act.
- Records relating to assessments in the HBPoS were maintained on the trust wide electronic database. The information could be accessed by staff from any of their base locations. Staff had access to packs of pre-prepared paper documents in case there was ever a situation where the database was not available. The pre-packed forms meant that there was no delay in recording important information.

Best practice in treatment and care

- Patients assessed in the HBPoS were given an information pack explaining their rights. Staff also explained this verbally. This ensured that people understood where they were, why they were there, the assessment process and what their rights were.
- The HBPoS was available to young people.

Skilled staff to deliver care

- Qualified staff from the Gloucestershire crisis teams co-ordinated admissions to the Maxwell Centre health-based place of safety. A member of staff was identified on each shift to be the 136 co-ordinator. They arranged admission and received the detained patient.
- The HBPoS was located on the site of an acute mental health hospital. Staff told us that, in the event of an emergency, colleagues trained in safe management of violence and aggression could be called upon if required.
- Staff completed a routine checklist of actions to be undertaken for each patient detained in the HBPoS. These were audited on a regular basis.

Multi-disciplinary and inter-agency team work

- There was a joint inter-agency policy in place for implementation of section 136 of the Mental Health Act (MHA). This had been agreed by the trust, the local authority, the police and the ambulance service. Staff and managers told us they had a strong commitment to multi-agency working and when difficulties occurred, they worked proactively to resolve them. Team meeting minutes showed when issues were identified and who was responsible for dealing with them.
- There were strong links with the police for the operation of section 136. Staff were supportive of each other and worked well together for the patient and for the safety of staff. The police undertook a violence risk assessment prior to attending the HBPoS at the Maxwell Centre. This protected staff and ensured effective use of the service. The police did not leave patients at the Maxwell Centre until full agreement with the crisis team had been reached. The police could get into the Maxwell Centre without having to wait for crisis team. These ensured minimal delays for the patient and the police could settle the patient, if possible, while they waited for the crisis staff to attend.

Adherence to the MHA and the MHA Code of Practice

- Staff had a good understanding of their responsibilities and duties when people were admitted under section 136 of the MHA. They ensured they worked within the Act, the Code of Practice and the guiding principles.
- Patients had their rights under the MHA explained to them on admission to the HBPoS and these were repeated until patients could understand them. Patients were also given printed copies of their rights under the MHA.
- Information about advocacy and independent mental health advocacy services (IMHA) were available to patients.

Good practice in applying the MCA

- Staff demonstrated a good awareness of the Mental Capacity Act 2005 (MCA) and the implications this had for their clinical and professional practice. They had received training on the MCA and had access to e-learning so they could update their knowledge. Staff were clear in their ability to assess mental capacity and were able to give examples of when to use the MHA and the MCA.

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.

- Staff routinely assessed mental capacity before admission to hospital and before assessment under the MHA in order to determine if the patient had capacity to consent to admission to hospital informally or whether powers for detention under the MHA were required.

Outstanding ☆

Are services caring?

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

Our findings

Mental Health Crisis Services

Kindness, dignity, respect and support

- Patients we spoke with told us that they were very satisfied with the care and treatment they received from the service. We received many highly complementary comments about both the staff and the service they provided. All but two patient comments were extremely positive. Most said how brilliant the service was, how great the staff were and what a really great service the teams provided.
- Patients told us staff treated them with kindness, dignity and respect. When they carried out home visits, telephone calls and clinic appointments, we heard and observed staff discussing their patients with respect, compassion and kindness. All but one patient told us they felt staff were respectful, kind and genuinely interested in their well-being. Data from the trust's "Friends and Family" survey showed that 72 out of 77 patients felt trust staff helped them to feel hopeful about things that were important to them.
- Staff held patients' information securely and their confidentiality was respected. Staff did not wear uniforms and discretely wore their identification badges when visiting patients. Staff were conscious that they wished to protect their patients' confidentiality from neighbours and the general public. Staff recorded when they had received a patient's consent to share information with family and carers and they respected this. Consent was discussed in staff handover meetings so the team were clear about who they could and could not share information with.

The involvement of people in the care they receive

- Prior to the inspection, CQC received two negative comments about the crisis teams, suggesting that patients were not routinely given copies of their care plans. However, when we asked patients if they had received a copy of their care plan we found that 17 out of 18 said they had. We inspected 29 records across the service and found that 69% of patients were recorded as having been given a copy of their care plan. The sample size in Herefordshire was only three, due to trust problems allowing us access to the records. None of the three were recorded as having been given a copy of their care plan. However, all of the Herefordshire patients told us they had received their care plan. Records showed that 100% of patients using the Gloucester and Forest crisis team had been given a copy of their care plan. Care plans were holistic and took account of patients' strengths. Positive risk taking was accepted and encouraged in order for patients to reach their full potential with their recovery.
- Patients were given information about treatment options and medication prescribed to them.
- Packs containing useful information were given to patients at the first or second appointment visit. This helped patients to know about the service and about other useful local services such as advocacy and voluntary groups.
- Patients and carers said they knew how to contact the service and always received a quick response from staff, even outside of normal office hours.
- Feedback was routinely sought from patients and their carers. Staff gathered information verbally and by using formal questionnaires. Staff used the information to improve their services and demonstrated the value they placed on listening to patients.
- There was a strong person-centred culture within the service. Staff saw the importance of supporting patients to deal with their immediate mental health crisis but also to support them with their recovery by referring them to longer term interventions such as psychological therapies and mental health recovery teams.
- Staff respected the totality of patients' needs and sought specialist advice to deal with their housing or welfare benefits if this is what the patient needed. Staff could also get help and advice for patients about longer term therapies or employment opportunities that would be suitable once the immediate mental health crisis was resolved.
- We saw strong and positive relationships between staff and their patients which was encouraged by local team leaders.
- All but two patients remembered being given the 24-hour crisis telephone number and many had used it to speak to staff outside of normal working hours. Those that had used the 24 hour telephone number said it was useful to them and they valued it.
- Carers were routinely involved in the provision of care and treatment to patients. Consent to share information with carers was clearly documented and staff ensured

Are services caring?

Outstanding ☆

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

that patients were given the opportunity to change their consent if they wanted to. Carers told us they felt supported and informed about the care and treatment provided by the crisis teams.

- The service had signed up to the "Triangle of Care" which is a national programme advocating a therapeutic alliance between patients, staff and carers to promote safety, support recovery and sustain wellbeing. Signing up to the Triangle of Care was one way the service showed its commitment to positively engaging with carers.

Health-based Place of Safety

We were not able to talk to any patients using the health-based place of safety at the Maxwell Centre 136 suite. However, we inspected the premises and looked at record keeping and audits carried out by the service. We found that:

- Patient information leaflets were readily available. Information was provided in other languages which could be printed when required. The internal internet system was regularly updated so that information leaflets in other languages were as up to date as those written in English. This system was easy for staff to navigate so patients would not be kept waiting.
- Information was available for patients about advocacy services and it was shown on posters and in leaflets for patients.
- If a leaflet in particular language was not freely available, staff could get it translated via the translation service.
- The service had a research proposal agreed to specifically gather patient feedback regarding the HBPoS.

Are services responsive to people's needs?

Outstanding ☆

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

Our findings

Mental Health Crisis Services

Access and discharge

- Target times for patients to receive an initial assessment following referral were 4 hours in Gloucestershire. In Herefordshire the teams were commissioned to respond with a triage service within one hour and emergency referrals seen within four hours. Staff told us that most patients across the service were seen more quickly than 4 hours but we were not able to verify this. Referrals to the crisis teams had been via mental health professional or general practitioner (GP). At the time of this inspection the service was undergoing a transformation and referrals could be accepted from anyone who was concerned about a person's mental health crisis. This meant that patients, their carers, friends, family, GP, social care professional or any other interested party could make a referral to the crisis team. The referral process was simple and easy to follow.
- Crisis team staff went over and above their remit by supporting patients before a formal referral had been received. While referrals were being taken, we saw staff busy gathering as much information as possible to ensure that they were as prepared as they could be to support the patient when they received the referral. This meant that delays were minimised and patients could receive the care and treatment they needed very quickly.
- The crisis teams provided a 24 hour support service to their patients. After 10pm at night, home visits were not routinely carried out but patients could speak to dedicated crisis team staff using the free phone telephone number. Home visits would be carried out based upon risk and need. Patients told us they had used the phone line and had valued the support they received. All but one patient recalled having been given the number.
- The crisis teams mostly visited patients in their homes. Not all teams had access to see patients in their team offices, but all could give examples of how they had adopted a flexible approach to accommodate their patients, taking into account their choice and risk factors. If a patient preferred it, they could be seen in a clinic room or at another facility such as a community team office.
- Patients who presented themselves at a general hospital emergency department (ED) were seen there. Specific rooms were provided in the ED for patients so they could be seen in a way which maximised their privacy and dignity. The crisis teams provided this service at night and at weekends or if their colleagues in the psychiatric liaison service were unable to perform the role.
- The crisis teams acted as "gatekeepers" of inpatient mental health beds. The proportion of admissions to acute wards that were gate kept by the crisis teams was higher than the England average for the whole of the year leading up to the inspection and reached 100% in quarters three and four. This ensured that patients only had to go into hospital if it was absolutely necessary and every effort was made to support them at home in their own environment. The crisis team as were able to prevent unnecessary admissions to acute hospital beds by effectively supporting patients in their own homes. Patients could be treated and supported at home by the crisis teams so they could continue to lead as independent a life as possible during their mental health crisis. This also meant that patients could be supported to leave hospital early because the crisis team could provide intensive support and treatment for them, enabling them to return to home and family life as quickly as possible. The teams provided intensive support to patients which reduced the likelihood of relapse and managed risks effectively.
- Discharge arrangements from the crisis teams were discussed at the earliest opportunity so patients were clear that the service was a short term crisis support measure. This meant that patients and their families were clear about the discharge process from the early stages of the intervention. Only one patient told us that they had not been clear about the discharge process.
- Discharge planning was clear and evident in the recording we inspected. The crisis teams worked well with colleagues in other teams and services to ensure a smooth transition for their patients.
- Crisis team staff went above their remit by ensuring that each patient was followed up after they had been discharged to another team. They made contact with the patient and new team to ensure that care and treatment was progressing. This meant that patients

Are services responsive to people's needs?

Outstanding ☆

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

were provided with a seamless service as they moved on from the crisis teams. This also meant that the risks of a patient not receiving a follow-up service were significantly reduced.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients were seen in their own homes and not in office bases. Patients using the Hereford crisis team could come to the hospital site where the team was based if they preferred to. There were suitable rooms available for them to be seen in and for them to participate in therapeutic group work.
- Patients who were assessed in the emergency departments
- Confidentiality was embedded within the service. Records were stored securely, white boards containing patient names could not be seen by passers-by or members of the public and staff discretely wore their identification badges when visiting patients in the community.

Meeting the needs of all people who use the service

- The crisis teams had access to information in many languages and formats. This information was held on an internal internet system and was printed as patients needed it. This meant that information was always up to date.
- Staff could access interpreting services and did not need the authorisation of managers for the extra cost incurred.
- Staff were able to give examples of how they met the needs of a wide variety of patients in a variety of circumstances.
- Care plans were holistic and ensured that patients' individual, cultural and religious beliefs were taken into account and respected.
- Buildings that were used by patients could be accessed by people with restricted mobility needs.
- The Gloucestershire crisis teams had developed a service referral and pathway for patients from black and ethnic minority backgrounds. This offered patients an opportunity to engage back into in their communities by being involved as volunteers in community led projects. The teams also aimed to deliver cultural competency training to 80 staff members in the crisis teams.

Listening to and learning from concerns and complaints

- Six complaints had been made in the 12 months leading up to the inspection, four of which were upheld by the trust. None were referred to the Parliamentary and Health Service Ombudsman.
- Staff provided patients and carers with information about the complaints procedures and were open to receiving both positive and negative comments. Complaints information was easy to read and the process was straightforward. The complaints leaflet contained a postage paid facility so there was no cost involved for those patients wanting to make a complaint. One patient had previously made a complaint and was satisfied that the issue was in the process of being resolved. All but one patient remembered receiving information about how to complain and all but two felt that if they did complain, their views would be taken seriously. The trust formally investigated complaints but local managers welcomed the opportunity to put things right if they could. Managers and staff looked at complaints to identify themes and to see what they could learn from them. Managers and staff were open to receiving complaints and saw them as a vehicle for learning and improving. Complaints and concerns were routinely discussed at handover meetings, team meetings and in supervision when staff considered how they could improve their practice to improve patient experience. We spoke with one patient who had made a formal complaint and was satisfied that the matter was being resolved. A complaint in October 2014 had identified it was difficult to get a response from the crisis team when staff were in the handover meeting. As handovers were an essential forum for ensuring patients and staff were kept safe, following the complaint, it was agreed that an admin worker would answer the telephone. They either took a message for routine calls or passed the caller to a member of the clinical team for support. This meant that as a result of learning from a complaint, all calls that came into the Gloucestershire teams received a timely response.
- The service was proactive in their approach for gaining feedback from patients. Staff encouraged verbal and written feedback. Satisfaction questionnaires were routinely given out and over 70% of patients told us they recalled giving feedback. The trust collated feedback

Are services responsive to people's needs?

Outstanding ☆

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

using the "Friends and Family" test. Between October 2014 and August 2015 the data showed that 93% of patients would be likely or extremely likely to recommend the crisis teams to their friends and family. We saw some very positive compliments made by patients and families. However, the trust said they did not keep a record of the number of compliments they received because many were received both centrally and in the individual crisis teams, so we could not report a total figure.

Health-based Place of Safety

Access and discharge

- The trust had developed strong working relationships with the Police and the Ambulance Service. This was beneficial to patients because it meant that they could be taken directly to the Maxwell Centre health-based place of safety (HBPoS) without experiencing delays. The police could register the patient and enter the HBPoS without waiting for the crisis team to arrive. Once there, the patient could be made comfortable while waiting for the crisis team to arrive. The close working relationships between the crisis service, the Police and the Ambulance Service had reduced the numbers of patients who were assessed in police cells. Trust data showed that between October-December 2014, 84% of people were taken to the Maxwell Centre as opposed to being taken to a police cell to be assessed. The figure was 86% between January-March 2015 and 95% for April–June 2015. During the same period, South West Ambulance Service conveyed 9% of the patients.
- The working arrangements and availability of crisis team staff meant that the police were able to safely and effectively hand over patients to crisis team staff.
- There were rarely delays in crisis staff attending the HBPoS. Patients could experience a delay while a Mental Health Act assessment was arranged but this was because a section 12 doctor or an approved mental health professional (AMHP) was not available to carry out the assessment. When these delays occurred, they were beyond the control of crisis team staff. The service had noted an increase in delays when obtaining an out-of-hours AMHPs from the local authority. They were trying to resolve this, by taking the matter to the joint working arrangements forum.
- Patients were seen quickly, within the 72 hours required by the Mental Health Act. In 92% of cases, Mental Health Act (MHA) assessments began within the trust target time of three hours. The HBPoS was used 377 times between October 2014 and September 2015. There were no reported incidents of patients not being able to access the HBPoS because it was already in use. Thirteen percent of patients waited in the HBPoS for longer than the trust target time of six hours for their MHA assessment to be completed. From the time of arrival of the approved mental health act professional, only 6% of MHA assessments took longer than the trust target time of six hours to be completed within the HBPoS. Where there were delays, they usually related to the availability of appropriately trained section 12 doctors or AMHPs, which were beyond the control of the crisis team. The crisis team had identified deterioration in the effective working relationship between themselves and the local authority emergency duty team. They were actively working to address and resolve this to ensure a better service for patients and they were taking the issue to the next joint working protocol meeting.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff explained patients' rights quickly and in whatever format was suitable for them.
- The facilities in the Maxwell Centre were modern and comfortable. Patients could sit, walk, rest or sleep comfortably while they were being assessed. The décor was neutral and of a high standard. Patient rooms were not overlooked because the building stood alone from the main hospital at Wooton Lawn and had a private entrance. There was nothing of note to draw attention to the function of the building.
- Information was available for patients about advocacy services.
- Staff said they gave patients a tour of the building. These meant patients could find their way around and knew what facilities were available for them.
- There was a safe external smoking area for patients who wanted to use it.
- A kitchen area was stocked with fresh snacks on a daily basis so patients would not be hungry. Staff had accounted for many tastes with the drinks and snacks provided. They had given thought to providing comfort foods such as bread, jams, yeast spreads and breakfast cereals. A toaster and a microwave were available for patients and staff to use.

Are services responsive to people's needs?

Outstanding ☆

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

- Staff ordered hot meals from the adjoining hospital for any patients who wanted them. Staff could also order meals to suit special dietary requirements or religious needs for patients.
- The service provided clean bedding and towels for patients.
- Toilet and washing facilities protected patients' dignity.
- There was a large television / radio in the lounge area and a clock so patients could orient themselves.
- There was a selection of books and DVDs for patients to use.
- The building housed a separate office area where staff could hold confidential discussions. Staff could monitor the unit, the grounds and the smoking area by looking at the CCTV screens which were located in the office.

Meeting the needs of all people who use the service

- Patient information leaflets were readily available. Information was provided in other languages, which staff could print quickly. The internal internet system was regularly updated so information leaflets in other languages were as up-to-date as those written in English. This system was easy for staff to navigate so patients would not be kept waiting.
- Details of advocacy and interpreting services were readily available in the HBPoS. Staff did not require managerial approval to book an interpreter. Translation services were also available if required.
- Staff could order meals for patients which were culturally appropriate. These could be delivered quickly and easily from the adjoining hospital at Wooton Lawn.
- Private interviewing rooms were available so that more than one patient could be assessed at a time. There was good sound proofing between the rooms to promote dignity and confidentiality. The facility enabled two patients to be safely assessed at the same time.

Listening to and learning from concerns and complaints

- No specific mechanism was employed to gather feedback about the HBPoS. However, there was a research proposal to carry out an audit of patient experience. The service had received no complaints within the last 12 months. Complaints leaflets were available in the HBPoS.

Are services well-led?

Good

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

Our findings

Mental Health Crisis Services and health-based places of safety

Vision and values

- Staff knew the trust values and were able to relate them to their work within the team.
- Managers and staff were aware of the team objectives. All were aware of the planned changes that would be gradually introduced to the service, such as a single point of access and opening the service to include children and young people. The new mental health acute response service for Gloucestershire was due to be gradually introduced in 2016 but measures such as increasing staffing to address increased work load, were already in the taking place.
- Staff were clear about their roles and responsibilities in preventing patients' hospital admission or facilitating early discharge from hospital.
- Almost all staff knew who the senior managers in the organisation were and some were able to give examples of when these managers had visited the teams.

Good governance

- Staff told us they were receiving regular clinical and managerial supervision as well as ad-hoc supervision when required. Previously, there had been gaps in supervision to the Herefordshire team as a result of the team manager vacancy but this had recently been filled and the manager showed us supervision plans for the team. New staff in the teams were undergoing induction programmes and said they were well supported by managers and peers. Newly qualified staff were appropriately supported to develop effectively. There were no ongoing disciplinary actions involving staff within the service. Eighty two percent of staff had received an appraisal within the last 12 months.
- The trust had governance processes in place to manage quality and safety within the service. Managers attended local meetings where trust wide incidents were reviewed, service quality and risk was discussed and audit results were considered. The information was then discussed with staff at team meetings and in supervision sessions to ensure consistency and make improvements to the service.
- Regular audits were undertaken throughout the service, including audits of infection prevention and control, buildings condition, ligature risks, and the quality of care and treatment records. Patient records were randomly and routinely audited by each team every month. It was not possible to determine how effective these audits were but we were able to see that all patients had records that were updated following each contact with the team, which suggested that the audits were effective.
- The Herefordshire crisis team had recently appointed champions within the team for areas such as safeguarding and mental capacity.
- All managers felt supported within their line management structure to affect change and believed that their feedback was listened to by their manager. Managers were respected by their teams and valued by the service manager.
- Clear policies and procedures were in place to protect both staff and patients. Staff demonstrated a clear understanding of the key policies such as safeguarding, lone working and medication management.
- Staff received mandatory training and were appraised and supervised, incidents were reported and investigated, and safeguarding and Mental Health Act procedures were followed.
- Staff could submit items to be included on the trust risk register. The Herefordshire crisis team had placed staffing costs on the risk register due to the usage of bank staff to cover vacancies and sickness.
- The trust had a good governance structure in place to oversee the operation of the crisis teams. There were effective policies and procedures in place to support staff and ensure the safe and effective running of the service. Crisis team managers had good access to their manager and also met at regular monthly performance meetings. If they were unable to attend, we saw that minutes were quickly distributed to be shared amongst their teams.

Leadership, morale and staff engagement

- Staff in the Gloucestershire crisis teams reported good morale and job satisfaction. Although also reported feeling very busy with the team caseload numbers and expressed some anxiety about the forthcoming planned changes to the service. Some staff in the Herefordshire crisis team reported low morale and feelings of stress

Are services well-led?

Good

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related to workloads and staffing numbers. Staff were proud of their ability to support patients through the most difficult of times and to play a positive role in patient transition through crisis.

- Local managers and service mangers were visible and staff reported they could access them quickly and without issue. Staff in one Gloucestershire team gave examples of their manager working late and then coming back for the next shift to support to staff when needed. A new manager had been appointed in the Herefordshire crisis team after they had been without a manager for some time. The new manager role was part-time, with the other part-time hours spent managing the psychiatric liaison service. However, the manager had already implemented positive support systems for staff such as regular supervision.
- All staff spoke very highly of their local managers and felt supported by them. A number of staff were concerned that their managers had been "acting up" into their management roles for around 18 months and were fearful of the impact this job insecurity might have on them. Some staff told us they felt their managers were being taken for granted.
- Staff believed that their local managers were receptive to feedback and paid attention to their ideas. However, a number of staff felt that managers at the most senior level within the trust were disconnected from them and did not fully appreciate the impact that changes had upon staff working at patient level.

Commitment to quality improvement and innovation

- Each of the Gloucestershire crisis teams were accredited through the Royal College of Psychiatrists' Home Treatment Accreditation Scheme (HTAS) until April 2016. This meant that they were subject to rigorous peer review and assessment which encouraged quality improvement. At the time of the inspection, the Herefordshire crisis team had deferred their accreditation.
- The service had signed up to the mental health crisis care concordat at the very beginning in February 2014. The concordat focuses on; making sure patients can get help when they need it, 24 hours a day and when they ask for help they are taken seriously; making sure that a mental health crisis is treated with the same urgency as a physical health emergency; making sure patients are treated with respect and dignity in a therapeutic environment; and preventing future crisis by referring patients to appropriate sources of support.
- The Herefordshire service was working with Police colleagues to formulate a staffing system so that they could also offer a full health-based place of safety service to their patients.
- In developing the planned mental health acute response service, staff had visited similar services and studied the effects of change upon other teams in terms of referral rates and potential challenges. Managers had considered the benefits and challenges to mental health services across the trust and not solely the impact upon crisis teams.
- The service produced detailed reports on the use of the Maxwell Centre health-based place of safety and used this information for analysis in order to inform the way the service was delivered. Information collected included the apparent mental health condition of detainees, presence of alcohol as a contributing factor, ethnicity, length of stay in the centre and conveyance method. We reviewed detailed data that had been captured and used in reports for over five years. This was a rich source of identifying trends for the service.