



South West Yorkshire Partnership NHS Foundation
Trust

Mental health crisis services and health-based places of safety

Quality Report

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Date of inspection visit: 07-11 March 2016

Date of publication: 24/06/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXGCC	The Dales	Calderdale Intensive Home Base Treatment Team & Health Base Place of Safety	HX3 0PW
RXG82	Kendray Hospital	Barnsley Intensive Home Base Treatment Team & Health Base Place of Safety	S70 3RD
RXG10	Fieldhead Hospital	Wakefield Intensive Home Base Treatment Team & Health Base Place of Safety	WF1 3SP

Summary of findings

RXG10

Fieldhead Hospital

Kirklees Intensive Home Based
Treatment Team

HD1 3LT

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire 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 South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire 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 South West Yorkshire NHS Partnership Foundation Trust as good because :

- The environment of the health based places of safety (136 Suites) were adequate and in line with Mental Health Act guidance. It optimised patient dignity, safety and comfort.
- The crisis teams had robust monitoring of medication and had rapid access to psychiatry; patients could be seen within the day. We saw examples of the crisis team learning from incidents and implementing changes within their practice. Staff across all the teams were up to date in their adult and child safeguarding training.
- All the teams worked alongside external stakeholders to respond to people in crisis effectively. This was in line with the trust's responsibilities under the crisis concordat.
- All initial assessments are carried out by a band 5 or band 6 nurse. If a band 5 nurse carries out the initial assessment, this is always discussed with a band 6 nurse. We saw initial assessments were comprehensive and detailed. Staff across all the teams had a good understanding of the Mental Health Act and Mental Capacity Act. They understood the guiding principles and were able to give examples of how they could apply it in practice.
- We observed meaningful, compassionate and person centred care delivered by dedicated staff. Patients were positive about their experiences with the crisis teams.
- Staff within the crisis teams met their targets to complete initial assessments within four hours of

referral. We observed flexible working around patients' needs. Staff adjusted their schedules so that patients could attend their appointments. Crisis teams utilised a range of resources which increased the quality of the service they delivered, for example, self-help leaflets and interpreting services.

- We saw effective use of auditing which provided oversight of team performance. These enabled team leaders to plan work and identify gaps. We saw teams shared good practice across the different regions, learning from each other's experiences. Staff had good morale and were happy about how they were managed. Staff felt valued and that their thoughts mattered.

However,

- We saw that the staff on the 136 suites did not always review their ligature risk assessments in a timely manner.
- Monitoring for Mental Health Act and Mental Capacity Act training were not always present.
- Appraisals for staff had not been completed equally across the four crisis teams.
- Not all teams provided crisis team leaflets describing their crisis service other than in English.
- Not all teams were commissioned to have police liaison officers.
- The crisis team in Barnsley had high levels of sickness. The sickness levels year to date was 12%.
- Teams felt less confident with the management structure above the team leaders.

Summary of findings

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

Are services safe?

We rated safe as good because :

- The crisis teams had robust medication monitoring and the correct storage of medicines.
- All the 136 suites had appropriate environments which were in line with the MHA Code of Practice guidelines.
- We saw evidence of team managers embedding outcomes of serious incidents into the agenda of team meetings for future learning.
- Patients across all four crisis teams had access to psychiatrists and could be seen within 24 hours. Urgent access to psychiatry was available during the assessment period.
- Crisis teams were compliant with mandatory training around child and adult safeguarding.
- We saw all the crisis teams had appropriate cover procedures for sickness and leave.

However,

- Staff on the 136 Suites did not always review ligature risk assessments in a timely manner.

Good



Are services effective?

We rated effective as good because :

- The crisis teams were consistent in formulating detailed and comprehensive initial assessments.
- We saw regular use of outcome measures and audits by teams to manage effectiveness and to shape future planning.
- Teams had processes in place to assure staff received regular clinical and management supervision.
- Staff were able to demonstrate a sound understanding and provide examples of application of the MCA and MHA.
- All the teams worked alongside other agencies (police, ambulance, A&E) to respond to patients in crisis in line with their duties under the crisis concordat.
- All the medication cards we reviewed were up to date, clear, legible and provided detail to why medication had been changed or stopped.

However,

- Monitoring for MHA and MCA training were not always present.
- Appraisals for staff had not been completed equally across the four crisis teams.

Good



Summary of findings

Are services caring?

We rated caring as good because :

- We observed warm, caring, and meaningful interaction between patients and staff.
- We saw that staff had built a good rapport with patients even though the patients had been with the team for a short period.
- We received positive feedback from the patients and carers that we spoke to.
- We saw evidence of patient surveys that had been carried out to identify gaps in the service for future improvement.
- Staff we spoke to were passionate and motivated within their roles.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- All the crisis teams were achieving their targets for assessments under four hours.
- We saw evidence of the trust's responsibilities under the crisis concordat by employing police liaison workers to reduce the numbers of patients being assessed under section 136.
- We observed staff change their appointments to suit patients and their timetables.
- All the teams had access to interpreters if and when required.
- We saw support leaflets readily available for patients with a variety of issues such as anxiety, stress, hearing voices and eating disorders.

However,

- Not all teams provided crisis team leaflets describing their crisis service other than in English.
- Not all teams were commissioned to have police liaison officers.

Good



Are services well-led?

We rated well-led as good because :

- All staff felt fully supported by their team leaders and were able to approach them.
- The team leaders had good oversight of their teams, caseloads and the work that was being done. There was regular use of KPI to help inform them of team performance.
- All team managers had admin support which was appropriately utilised.
- We saw teams sharing good practice and it being implemented.

Good



Summary of findings

- Staff felt as though their opinions were valued regardless of their banding or experience.

However,

- The crisis team in Barnsley had high levels of sickness. The sickness levels year to date was 12%.
- Teams felt less confident with the management structure above their team leader.

Summary of findings

Information about the service

South West Yorkshire Partnership Foundation trust have four crisis teams for adults of working age across, Kirklees, Calderdale, Barnsley and Wakefield. The trust have three health based places of safety in the same regions apart from Kirklees.

The crisis service are known as Intensive Home Base Treatment (IHBT) teams. They provide short term work to support people at home when they have a mental health crisis. They see patients under their care on a regular basis, this could be up to three times a day. The IHBT teams aim to facilitate early discharge from acute wards, and prevent patients being admitted by providing intensive support at home.

The trust operates three health based places of safety in Calderdale, Barnsley and Wakefield. The health based places of safety (HBPOS) are units where people are arrested under Section 136 of the Mental Health Act. Police have the powers to detain people under this act and bring them to the 136 suites to have their mental health assessed in a safe environment.

Section 136 sets out the rules for the police to arrest people in a public place where they appear to be suffering from mental disorder and are in immediate need of care or control in the interests of that person or to

protect other people. The arrest enables the police to remove the person to a place of safety to receive an assessment by mental health professionals. This would usually be a health based place of safety unless there are clear risks, for example, risks of violence which would require the person being taken to a police cell instead. People could be detained for a period of up to 72 hours so they can be examined by doctors and assessed by an approved mental health practitioner to consider whether compulsory admission to hospital is necessary. The HBPOS offers a 24 hour, 7 day a week service, open 365 days per year.

A responsive inspection was undertaken in 2012 after information was received relating to an unexpected death of a patient from post-natal depression who was using the service. A compliance action was found against the trust under Regulation 23 of the regulated activities in the Health and Social Care Act. During this inspection we found that staff members across the crisis team had undertaken specialised training in caring for patients suffering from post-natal depression. This meant that they were better prepared to care for patients suffering post-natal depression. No repeat incidents had occurred since this breach of regulation.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leaders: Chris Watson, Inspection Manager, mental health services, CQC

Berry Rose, Inspection Manager, community health services, CQC

The team that inspected the mental health crisis services and health-based places of safety included one CQC inspector, one consultant doctor specialist advisor and a Mental Health Act reviewer.

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

Summary of findings

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?

During the inspection visit, the inspection team:

- Visited all four crisis teams and three health based places of safety.
- Spoke with 15 patients that had used or are currently using the service, and three carers.
- Spoke to a total of 26 staff ranging a variety of disciplines, these included doctors, nurses, health care assistants, social workers and police liaison officers.

- Reviewed a total of 39 prescription cards.
- Observed five patient reviews, and one initial assessment.
- Reviewed 14 care records, this included initial assessments, risk assessments, care planning and crisis planning.
- Spoke to all the managers/team leaders in the crisis teams and persons in charge of the health based places of safety.
- Looked at medication management and storage across all the crisis teams.
- Looked at a range of policies and procedures for the crisis teams and health based places of safety.
- Reviewed clinical audits and team meeting minutes across all the teams.
- Observed two MDTs and one handover meeting.

What people who use the provider's services say

During the inspection, people had an opportunity to comment on the services they received on comment cards prior to the inspection. We received no comment cards from patients receiving support from the crisis services or about their experiences in the health based place of safety.

We spoke to 16 patients who had used or were currently using the crisis service. We also looked at patient satisfaction questionnaires provided by the trust. Overall we found patients were happy with the service they received. Many patients complimented the team on their responsiveness and flexibility in care.

Most of the carers we spoke to said that they were always involved in the care their family received, however we saw on some feedback from the questionnaires that this was not always the case.

We were able to observe staff in the community and saw really positive interactions with patients. It was clear that staff knew their patients well and were quickly able to develop a rapport.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure risk assessments are reviewed in a timely manner.
- The provider should have processes in place which enables all teams monitor training around the Mental Health Act and Mental Capacity Act.
- The provider should ensure that appraisals are completed equally across the teams.
- The provider should provide easy read leaflets about its services in ways that meets the needs of different people, i.e. a different language.

South West Yorkshire 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
IHBT Calderdale	The Dales
HBPoS Calderdale	The Dales
IHBT Kirklees	Folly Hall
IHBT Wakefield	Fieldhead Hospital
HBPoS Wakefield	Fieldhead Hospital
IHBT Barnsley	Kendray Hospital
HBPoS Barnsley	Kendray Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Training in the use of the Mental Health Act was not mandatory, however, we found that staff had a good

understanding of it and its guiding principles. We were assured by talking to staff that they understood how patients should be assessed, treated and cared under the statutory requirements of the Mental Health Act.

Detailed findings

Support was made available to staff through via the Mental Health Act Office where staff could clarify any issues or concerns.

Most of the mental health crisis teams had an approved mental health practitioner (AMHP) within their team. This meant that mental health act assessments could be carried out effectively and in a timely manner.

Patients had access to Independent Mental Health Advocacy (IMHA) services, they were provided with easy read flyers which had all the relevant contact details. Details could also be found in the patient areas of the hospital. They were available to patients for crisis teams and patients under s136 also had access to advocacy services.

Staff in the health based places of safety understood their roles in relation to s136 of the mental health act and had a good overall understanding of the legislation. When patients were admitted via s136 they had their rights read to them upon arrival. If staff felt that patients did not fully understand, they would read their rights periodically over the duration of their stay.

There was regular interagency meetings in relation to crisis care and s136 admissions. This was as part of the trust's involvement with the crisis concordat and involved external agencies such as the police and ambulance service. There were systems in place where by police understood their roles and procedures in adhering to detaining patients under s136, this was outlined in the trusts policy.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity act training was not mandatory therefore we did not have a clear sense of training levels within the trust. When speaking to staff we found they had a fair understanding of the Mental Capacity Act. Staff understood that patients should always be deemed to have capacity unless proven otherwise and that capacity could fluctuate. Staff understood their responsibility in undertaking capacity assessments and continuously monitoring patients to see if they understood what was being asked. Staff knew that if any decisions had to be made must be done so in the best interests of the patient.

We saw little evidence of patients having been being asked to make advance decisions in relation to their care. We did not see any advanced decisions in the crisis plans or care

plans that we looked at. However, the trust had upgraded its electronic record keeping system and staff were regularly encountering problems, this may have had an impact on where information around advanced decision being stored.

We saw that staff assessed capacity at every initial assessment they undertook. This was evidenced in the 'initial assessment' template where staff had to identify whether they deemed the patient to have capacity.

Patients had access to Independent Mental Capacity Advocates (IMCA) to support them. Information about IMCAs was provided to patients via leaflets and on notice boards.

Are services safe?

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

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

Our findings

Intensive Home Based Treatment Team (IHBT) :

Calderdale – The Dales

Kirklees – Folly Hall

Barnsley – Kendray Hospital

Wakefield – Fieldhead Hospital

Safe and clean environment

The crisis team saw patients within the community. This was primarily in their own homes. Patients would only be seen at the hospital site if there were any issues around risk, preference or if the crisis team were assessing the patient in Accident and Emergency.

Staff had access to clinic rooms within hospitals which were all well maintained and clean. All Patient-Led Assessments of the Care Environment (PLACE) programme results from 2015 showed the trust scored 100% across all four sites in 'cleanliness' and 'condition appearance and maintenance', the national average for these areas were 98% and 91% respectively.

In the event of patients having appointments at the hospital, sufficient measures were in place in order to protect staff. Staff carried personal alarms on their person which when set off allowed staff from the surrounding wards to attend and provide support. This was different at the crisis team in Kirklees, where rooms had alarm buttons which identified which room staff needed to attend.

Safe staffing

Crisis teams had sufficient number of staff to meet the needs of patients. Nurses were the main qualified staff within the teams. However, there were other disciplines within the teams such as social workers, psychology and health care assistants. Vacancies across all the teams were low at 2.5% from November 2014 to October 2015. Team leaders informed us that they struggled to recruit appropriately qualified staff at times and that it was paramount in their view to recruit quality over quantity. We found that the vacancy levels varied across teams. For example, the crisis team in Kendray hospital were at full

complement and had not had vacancies for over 12 months. However, the crisis team in Calderdale had just recruited an additional four band six nurses and an additional psychologist in order to expand the service

The nursing staff worked 12 hour shifts, with administrative staff and doctors working regular day shifts. The crisis teams were in operation 24 hours a day, seven days a week. Two members of staff were on duty during the night hours. Most teams had two qualified members on duty, but one team had one qualified and one unqualified member on duty.

All the teams had very good access to psychiatry and appointments in most cases could be arranged on the same day. Emergency appointments could be made available if a patient was undergoing an initial assessment. We observed a telephone consultation with a doctor during a home visit, the patient felt this flexibility made the patient feel safe. During weekends and evenings the crisis teams had a duty doctor in place. Staff and management felt as though this provision was sufficient. We were not given any figures as to response for times out of hours doctors.

Staff did not have individual caseloads, instead they managed the caseloads as a team. We saw that this was effective as they were able to meet performance targets. For example, all teams met the target to assess patients within four hours of referral. This meant patients would have quicker access to see a member of staff during an emergency.

Sickness levels for three of the crisis teams were in line with trust and national average of around 5%. The IHBT team at Barnsley had an average sickness rate at 12% over the last 12 months. This included long term sickness for some staff members. We were informed that staff were due to return to work within the coming weeks. We did not find any impact on patient care due to the cover arrangements that had been made. All the teams used regular bank staff, or current staff undertaking overtime hours. This enabled continuity in care. We identified a team ethic within the service where team managers and deputy managers would support clinical staff by carrying out assessments and reviews. Positive team work also reflected within feedback from staff. No agency staff were used in the teams.

Are services safe?

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

Assessing and managing risk to patients and staff

Staff used a recognised risk assessment tool when assessing patients, this was the Sainsbury's risk assessment. Crisis teams completed risk assessments during every initial assessment. If the patient was known to services then historical risk assessments were sought to inform their current risk profile. We saw that when the patients risk profile had been changed it was reflected in the care records. This was an on-going process.

We saw 14 patients' records during our inspection. This was a cross section of all the teams. We found the initial assessments showed a comprehensive understanding of patient risk. However, the detail of the risk in the initial assessments was not always reflected on the risk assessment template. The Sainsbury's risk assessment template was a separate document on the trusts electronic system this focused solely on patient risk. This meant staff would not always get a clear understanding of patient risk unless they looked at the initial assessment.

We found many examples of crisis and care planning being updated on the progress notes. For example, if a patient's risk profile had changed, it was often updated on the live notes, opposed to the template. We found this had little impact on the patient care as most of the staff in the crisis teams primarily worked from the live notes. This meant they were always up to date with patient care. The nature of a crisis team and the short term basis they upon which they care for patients has an impact the on how records are updated, which will be different to other teams within the trust. We saw the teams were able to balance these limitations and still provide the important information on case records.

The risk assessments had a section in place to identify whether the patient had any contact with children and prompted staff to provide full details. All of the records we saw captured these details accurately however; we found one example of a child's details not recorded accurately within the record. This meant it was difficult for staff to ascertain the correct age and identity of the child. The team leader acknowledged this error and stated it would be rectified.

All the crisis teams had lone working procedures in place. All staff that worked night shifts had to attend visits in pairs. In addition, they had to inform a staff on duty of their whereabouts. After every appointment staff would call back into the office. The Calderdale, Kirklees and Barnsley IHBT

provided staff with badges that could be tracked via GPS. We observed the lone working procedure when we attended a home visit and it had over run. The nurse received a call from the duty person to see if everything was ok.

Track record on safety

The combined number of serious incidents from June 2014 to September 2015 was eight. Kirklees IHBT had one serious incident within this period, Wakfield had three incidents, Barnsley had two and Calderdale had one. At the time of the inspection Kirklees had a case load approximately three times of the other teams.

We found evidence that practice had changed as a result of serious incidents. These changes had been embedded into practice and serious incidents were reviewed during the weekly team meetings.

Reporting incidents and learning from when things go wrong

The trust uses the Datix system to record incidents. All of the staff we interviewed understood what a notifiable incident was and how to report it. Staff had a fair understanding on how the reporting system worked. They were also able to tell us what processes would take place after they had submitted an incident. Managers held debriefs for staff after serious incidents, this took format in ways that suited staff. For example, group debriefs or individual one to ones.

We saw evidence of learning after serious incidents had taken place. A patient had committed suicide whilst waiting for their care to be transferred from the crisis team into a community team. As a result of this incident, the crisis teams now keep patients within their service until a formal joint handover is completed. This means there are no gaps in care between services and patients are cared for through transitions.

We also saw learning from incidents on a local level, where teams had improved their practice from incidents occurring within their teams. An example of this was in the crisis team in Barnsley where there had been issues around medication administration. As a result of this staff now had to go into appropriate detail when documenting medication care plans for patients. This learning was fed back through the team in their weekly operational team meetings.

Are services safe?

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

The Datix system the trust uses to report incidents also provides a prompt to managers in relation to their actions under the duty of candour. Majority of staff we spoke to understood the Duty of Candour and their responsibilities as health professionals. We did not see any evidence of letters of apology to patients. However; we saw one record where the patient had declined receiving a letter but was happy to accept a verbal apology.

Health Based Places of Safety :

Calderdale – The Dales

Wakefield – Fieldhead Hospital

Barnsley – Kendray Hospital

Safe and clean environment

All of the 136 suites were commissioned to run 24 hours a day, seven days a week.

We found all three health base places of safety (HBPoS) to be clean, well maintained and appropriate for their function. Where there were blind spots, risk was mitigated by CCTV. We found this in two of the suites. All suites were under continuous supervision with a member of staff whilst patients were detained under s136. The units were in line with the Mental Health Act 1983 Code of Practice and guidance from the Royal College of Psychiatry.

The furnishings in the suites were suitable for the rooms and did not put the patients or staff at any risk. We saw the hospital had implemented heavy furnishings so patients could not move, pick up, or throw them. En suite facilities were also available in all three suites. The suites had equipment available to staff to monitor physical health, including examination couches and resuscitation apparatus.

All of the staff in the health based places of safety carried personal alarms which when activated sought support from the neighbouring acute wards. Staff felt that adequate support would be provided in a timely manner if the alarm was activated.

There was no unsupervised contact with patients in rooms that had ligature points. We saw evidence of ligature risk assessment for the environment, but staff did not always review it in a timely manner. We saw staff had carried out a ligature risk assessment on the 136 suite at Fieldhead Hospital in November 2014. We found no evidence to show this was reviewed in November 2015, but found evidence

that the wards had been reviewed during this period. Even though the trust had mitigated these risks, best practice would be to review the audits in a timely manner as they did on the wards.

Safe Staffing

Nurses on the acute wards staffed all health based places of safety. As s136 admissions were low, there was no identifiable impact on staffing on the wards. Patients were brought in by emergency services. We found there to be a good working relationship between the staff looking after the 136 suites and the crisis teams. In Calderdale and Kirklees, the crisis teams had police liaison officers who often supported patients in the 136 suites. A police liaison officer is a mental health professional who works alongside emergency services supporting people in mental health crisis to avoid s136 admissions. Barnsley and Wakefield did not have access to this street triage initiative as it was not commissioned in those areas.

Assessing and managing risk to patients and staff

A member of the nursing team alongside an approved mental health practitioner would assess patients admitted to the 136 suites. Part of the assessment process would look at the risk posed by the patient to themselves and the public. This assessment would determine what the correct course of action should be.

Patients in the 136 suites would not be left unattended for the duration of their stay; at least one member of staff would remain with the patient. We were informed that more than one member of staff could be called upon if required. Police would also remain on site if the levels of risk were very high. Nurses that worked on the suites had attended a five day management of violence and aggression training. Staff informed us that physical restraint was avoided and rarely used, where possible verbal de-escalation was utilised.

Staff were aware of safeguarding protocols and understood how to make a safeguarding referral. They were able to talk us through the process. The health based places of safety had no safeguarding referrals made in the last 12 months.

Track record on safety

There were no serious incidents in the 136 suites for the last 12 months.

The trust had signed up to the crisis concordat and had submitted an action plan. The crisis concordat is a nationwide scheme which looks to support people in crisis.

Are services safe?

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

It provides a multi-agency approach including all emergency services working together to support people in crisis. One of its aims is to avoid inappropriate admissions, and to prevent people being admitted via s136.

Reporting incidents and learning from when things go wrong

Staff we spoke to knew how to recognise and report incidents through the trust Datix online system. Managers

reviewed incidents and carried out further investigations if needed. These incidents could be escalated if formal investigations needed to take place. The online system provided the trust an oversight of incidents enabling them to establish themes and trends.

Staff in all three health base places of safety understood their obligations under the Duty of Candour.

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

Intensive Home Based Treatment Team (IHBT) :

Calderdale – The Dales

Kirklees – Folly Hall

Barnsley – Kendray Hospital

Wakefield – Fieldhead Hospital

Assessment of needs and planning of care

We looked at 15 records of patients. Records were stored electronically on the trusts RIO system and access was protected.

The crisis teams within this trust had different functions which included;

- Gate keeping hospital admissions.
- Reducing the lengths patient stay on the wards by facilitated early discharges.
- Assessing and supporting patients who are in a crisis providing short term interventions.
- Referring patients into secondary care or discharging them back to their GP.
- Reduce s136 admissions through its work around the crisis concordat.
- Triaging telephone calls for people in crisis to ascertain if they need an assessment.

The initial assessment carried out provided the basic formulation of the care patients would receive. It would feed into further care planning if patients were referred into primary or secondary care.

We found all the assessments were detailed, holistic, patient centred and meaningful. They included areas of risk, safeguarding, carer input and capacity to consent. Staff had completed the assessments in a timely manner and in most cases were available within the same day of the assessment. This was important due to the nature of the crisis team. Unlike other teams within the trust, caseloads were managed as a team and not individually. This meant different staff may see the same patient throughout the week. We found the information within the assessments to be detailed enough for a new member of staff to begin work with that patient.

We reviewed 39 medication cards and found they were all up to date, legible and in line with the National Institute of Clinical Excellence (NICE) guidance. The teams had demonstrated good practice by adding clear evidence as to why medication had been stopped or changed.

Each team had a dedicated member of staff who attended discharge meetings on the hospital wards to facilitate a more timely discharge. If the crisis team could care for the patients within the community it supported wards in creating bed spaces for admissions.

Best practice in treatment and care

Staff were using NICE guidelines in their practice. We saw the teams were using a range of recognised tools in enabling staff to formulate more detailed assessments. Staff used the 'Becks' assessment tool to understand levels of depression patients may be suffering. They also used the Hospital Anxiety and Depression Scale (HADS). The 'Lunsers' self-assessment tool was given to patients to enable practitioners to understand side effects of antipsychotic medication patients may be experiencing. The Clinical Institute Withdrawal Assessment for Alcohol (CIWA) were utilised for patients suffering from alcohol abuse. Practitioners used memory tests such as the Mini Memory State Examination (MMSE) to understand issues around memory and mental abilities patients are suffering. This is most commonly associated with people suffering dementia. These recognised tools and best practice guidance enabled comprehensive assessments of patients.

All teams had access to psychology, however the Calderdale IHBT had a psychologist in post and the Kirklees team had a psychologist due to start April 2016. The other teams had access and support from psychology services readily available. Teams also had staff trained in Dialectal Behavioural Therapy (DBT) and Cognitive Behavioural Therapy (CBT). This meant that staff members within the teams could use low level psychological interventions as part of recovery work with patients.

We saw effective auditing used which provided team leaders with oversight of the quality of the care being provided. The most common audits that took place were on care records which were completed by the team leader or their deputy. A member of the pharmacy team completed audits on medication management and storage. The teams also used the Health of the Nation Outcome Scales (HONOS) as one of their outcome measuring tools. We saw that these had been undertaken.

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.

We found excellent examples of auditing from the IHBT team in Barnsley which had not been implemented in all teams. Audits had been carried out in areas which enabled the team to understand their patients, trends and themes. For example, we saw an audit which monitored all the referrals into the crisis team. This showed where the highest referral rates were coming from and which care pathways patients followed after the initial assessment by the crisis team.

We saw examples of patient questionnaires and service user feedback which was reviewed and compared against other teams. The questionnaires enabled teams to see what was working well and areas patients thought they could improve.

The teams considered physical health in their care planning. They had good links with the pharmacy teams who had regular contact with the teams to review patient medication. The teams did not have any clinic rooms to for physical health observations, however they had access to these facilities if needed. Staff told us they often supported their patients to go to the GP to address any physical health needs.

Skilled staff to deliver care

The teams were primarily made up of band 6 nurses, which reflected the experience needed for this service. The teams included social workers, doctors and health care assistants. They also had input from psychology and pharmacy. Most teams had Approved Mental Health Practitioners (AMHP) within their teams which provided them with expertise in the Mental Health Act and Mental Capacity Act. An AMHP is traditionally a social worker. They carry out Mental Health Act assessments which determine whether a patient may need a hospital admission.

87% of non-medical staff had an appraisal in the last twelve months. We saw staff had regular supervision, both clinical and management. Clinical supervision was facilitated in formats that suited staff. We saw examples of clinical supervision done in groups, one to ones and in team meetings. Management supervision was on a one to one basis and we saw most band 6 nurses had received this regularly. The team leaders had planned that band 6 nurses would facilitate supervision to band 5 nurses and below. This had not yet been implemented except in Barnsley.

We saw the trust supported staff to undertake specialist training for personal development and to enhance the skills within the team. For example some staff members were trained in psychological therapies, and others were trained to take physical health checks such as phlebotomy. This meant they were qualified to take blood samples from patients.

Staff performance was monitored and addressed. We saw a record of meetings held between management and a member of staff addressing issues around performance. We saw the approach was holistic and consideration had been taken as to why the member of staff may have been underperforming. We found this to be an effective process and clearly documented. It addressed the issue but supported the member of staff at the same time.

Multi-disciplinary and inter-agency team work

All teams had weekly team meetings which included all members of the multi-disciplinary team (MDT) such as admin, consultants and in some cases pharmacy. We observed two of these meetings and found it to be well organised. We saw the team used the traffic light RAG system (Red, Amber Green) to identify risk and areas of concern. The meeting was comprehensive covering areas such as, crisis planning, clustering, medication management, physical health and discharge. We saw that everyone was encouraged to reflect and voice their thoughts regardless of their role in the team. The admin staff member wrote up the notes for the meeting and the consultant signed them off as accurate. This meant that any information missed out or not included could be rectified.

The mental health crisis services had established positive working relationships with other service providers. This included the acute admission wards, GPs, community services and voluntary groups. The teams worked with the acute wards and community teams to plan patients' transitions between services in an holistic way. Staff in the crisis team attended discharge meetings on the acute wards to support early discharges into the community. They also referred onto other organisations within the community that could support patients and carers. The crisis team endeavoured to work alongside community teams in avoiding admissions. They did this by working more intensively with patients who were unwell but could still be supported in the community.

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.

As part of their duties under the crisis concordat the teams had good working relationships with outside agencies, in particular emergency services. The Calderdale and Kirklees IHBT were commissioned to have police liaison officers who were clinical staff that worked with emergency services as part of a street triage. The primary purpose of this community initiative was to reduce s136 admissions. In addition it enabled appropriate and timely assessments directly from the crisis team bypassing intervention from emergency services. The police liaison officers bridged a gap between mental health services and emergency services and enabled a better working relationship.

We found that not all crisis teams had this service. Wakefield and Barnsley IHBT were not commissioned to have police liaison officers. The team leaders felt if they had this service in their teams would be more effective in supporting people in crisis. To mitigate not having this service, the crisis teams worked alongside the emergency services. They attended the agency meetings to look at ways in which they could support each other.

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

Training in use of the Mental Health Act 1983 was not mandatory for staff. Therefore, it was difficult to establish what training staff had undertaken as it was not consistently monitored. We reviewed a sample of 10 staff training records across Kirklees and Calderdale. We found that none of the staff had received any Mental Health Act training in the last twelve months. We found monitoring of Mental Health Act training for the crisis team in Barnsley, which showed majority were up to date with the training. It was unclear to see whether it had been done in the last 12 months. However, it was flagged as 'green' on their Red Amber Green (RAG) system.

Mental health crisis services had approved mental health practitioners (AMHP) integrated within all the teams. This meant that when a patient required a MHA assessment, an AMHP was available to arrange assessments within reasonable timescales.

We found staff in the crisis teams had good knowledge of the Mental Health Act during interviews. They felt comfortable in its application and were confident to seek support if required. Most commonly staff said they would speak to the trust Mental Health Act Office, or an Approved Mental Health Act Practitioner.

The teams supported patients who were on Community Treatment Orders (CTO), however this documentation was managed by their responsible clinician in the community. A CTO a form of detention whilst retaining legal powers of supervision within the community.

Patients had access to independent mental health advocacy services (IMHAs). IMHAs are independent of mental health services and can help patients get their opinions heard and make sure they know their rights under the law. The crisis team had easy to read leaflets and contact details available for IMHA services.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training is not mandatory within the trust. We found staff had more up to date training in Mental Capacity Act than they did in Mental Health Act Training. A sample of ten staff records across two teams showed that seven had some form of Mental Capacity Act training.

We found that staff assessed capacity during every initial assessment that the crisis team undertook. We saw this was clearly reflected on the assessment template. Staff had a good understanding of the Mental Capacity Act and felt confident in application.

Staff felt they could get support on the Mental Capacity act through their peers, and through the trust Mental Health Act office. Staff felt supported enough to ask for help when they needed it.

Patients had access to IMCA (independent mental capacity advocacy) services. IMCAs are a legal safeguard for people who lack the capacity. They support patients to make important decisions. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member.

Health Based Places of Safety :

Calderdale – The Dales

Wakefield – Fieldhead Hospital

Barnsley – Kendray Hospital

Assessments of needs and planning care

We found patients underwent a comprehensive assessment process when admitted under 136. The nurse in charge undertook the assessments alongside an AMHP. Physical health observations were completed as part of the assessment process.

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 carried out observations on patients in line with the trust observation policy. Observation levels were based on current risk and risk history. Staff had to contact the local safeguarding authority to see if there were any safeguarding issues in relation to the detained patient, this was in line with the trusts safeguarding policy. The Approved Mental Health Act Practitioner undertook mental Health Act assessments and arranged for the doctors to give their recommendations.

Rapid tranquilisation was not given across any of the 136 Suites. Rapid tranquilisation is the use of medication for patients who are agitated or displaying aggressive behaviour, it helps to quickly calm them.

Staff had electronic records of patients on the trusts RIO system. This meant if patients were previously known to the trust their information would be easily accessible. The staff also had access to the ICE online system which GP's use. This enabled staff to see the patients' GP medical records.

Best practice in treatment and care

Patients detained under s136 were brought to one of the three suites in the trust. If the most local suite was occupied then the patient would be taken to the nearest alternative. The trust had four crisis teams over four localities, but only had three health based places of safety. Patients detained in the Kirklees area were taken to the Calderdale health based place of safety or nearest alternative. We did not find any evidence that this had caused any delays in assessment or patients being taken to unsuitable places, for example, police cells. Patients who were severely intoxicated or high risk could be taken into police custody, this was in line with the Mental Health Act Code of Practice and the trust Section 136 policy. Staff told us if patients were high risk, police were happy to stay with them at the health based place of safety until the risk reduced.

Patients were given their rights under s136 and staff read their rights again if they felt as though patients did not fully understand. Some teams had police liaison officers who worked with the trust to co-ordinate care and treatment of people who made contact with the police and the trust. This service aimed to reduce s136 admissions. We saw evidence of this in Calderdale, where the number of admissions in the last month was three. However, prior to police liaison officers being available they averaged 20 admissions a month.

Patients had a range of information leaflets made available to them. This was to support them in understanding processes, treatments and self-help.

Skilled staff to deliver care

All the health based places of safety were situated next to an acute ward or a psychiatric intensive care unit. Staff on these wards managed the 136 suites when required. This set up enabled a timely and rapid response when needed.

Teams with police liaison officers had close links to the ward staff and clinical managers of the health based places of safety. The consultants from the crisis teams and AMHPs carried out mental health act assessments in the 136 suites where possible. This provided more timely assessments and continuity of care.

The staff that we spoke to understood their roles and responsibilities under s136.

Multi-disciplinary and inter-agency team working

The trust were part of the crisis concordat which meant there were agreements in place for joint working protocols. This was between emergency services and other external agencies to support people in mental health crisis. We saw adherence to this protocol by the employment of police liaison officers who acted as a bridge between emergency services and the crisis team. Not all teams were commissioned to have police liaison officers, they instead attended regular multi-agency meetings under the crisis concordat with services such as the police and ambulance. The aim was to develop least restrictive methods in assessing patients in mental health crisis.

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

Staff demonstrated good working knowledge of the Mental Health Act and its guiding principles. They understood their responsibilities under s136 when the police brought patients to the suite.

Patients were read their rights when detained under Section 136. If staff felt that the patients did not understand their rights, every effort was made support patients in understanding it, for example going over the rights again until they better understood. Patients had access to advocates.

One of the guiding principles in the Mental Health Act states that care and treatment should be provided in the least restrictive way possible. We saw evidence of this by

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 crisis team, police liaison officers and ward staff on health based places of safety working together to reduce admissions. Barnsley IHBT gate kept 100% of admissions and attended mental health act assessments. They were able to offer their services, if appropriate, to patients in mental health crisis to support them in the community instead of being cared for on the wards. Other teams had police liaison officers who prevented s136 admissions with street triage by directing care of people in crisis to their local IHBT where appropriate.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was not mandatory for this trust. Therefore, we could not identify which staff were up to date with training. Staff did however demonstrate good knowledge of the Mental Capacity Act during interviews. They understood their responsibilities in considering patients' capacity continuous monitoring of capacity and best interests decisions.

Patients had access to support from Independent Mental Capacity Advocates.

Are services caring?

Good 

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

Our findings

Intensive Home Based Treatment Team (IHBT) :

Calderdale – The Dales

Kirklees – Folly Hall

Barnsley – Kendray Hospital

Wakefield – Fieldhead Hospital

Kindness, dignity, respect and support

We observed kind, compassionate and respectful interactions between staff and patients. We saw staff had built a rapport with patients in the short time they had been working with them. The patients and carers that we spoke to were overall complementary about the crisis teams. There was a clear theme regarding the responsiveness of the team's and their ability to support patients in a crisis.

During our observations we saw flexibility in care and working in a way that suited patients. An example of this was during a routine visit where the patient wanted to speak to a doctor but could not attend the clinic. He was happy to speak to the doctor over the phone, and the member of staff facilitated this to during the visit. The patient commented that this service was, "worth its weight in gold."

The teams undertook patient feedback surveys and the results were overall very positive. However the number of patients that took part in the survey was not representative of all the patients, the sample was small. Only 10% of participants across Barnsley and Wakefield said they would not recommend this service to their friends or family. No teams scored 'poor' or 'very poor' when patients were asked how they found the assessment, majority scored it as 'good' followed by 'excellent' as the second highest score. When the IHBT teams were asked if they were 'on time' to appointments the results were more variable. In Barnsley, 60% of patients said they were on time and 47% of patients in Wakefield said the crisis team were on time. Patients from Calderdale were not represented in the survey as they did not receive any completed questionnaires.

The involvement of people in the care that they receive

We found patients were not always provided with a copy of their care plans after their initial assessment had taken

place. The teams had issues around the practical aspects of being able to do this. New ways to address this issue were in the process of being rolled out. For example, staff completing a hand written care plan on carbonated paper and leaving a copy with the patients. This was not yet in place. Patients we spoke to did not identify this as an issue, or that it had an impact on their care. Patients felt as though the crisis team were readily accessible in their time of need and that was identified as most important to them.

One carer stated that they were not always involved in the care that their family member received. However, the majority of feedback showed us that carers were involved in care.

Health Based Places of Safety :

Calderdale – The Dales

Wakefield – Fieldhead Hospital

Barnsley – Kendray Hospital

Kindness, dignity, respect and support

Staff on the wards were enthusiastic about the care they provided. They understood anxieties patients may experience whilst detained under s136, and told us about how they would try to support patients through this.

Managers and other teams understood each others roles and work together to achieve a caring service. This was evidenced by work completed with the police liaison officers, crisis teams and ward staff.

Food and drinks were available to patients detained under s136.

The involvement of people in the care that they receive

The wards provided patients with information in an easy read format. Staff could utilise interpreters for better communication if required. Staff explain patients' rights to them upon admission, but this was repeated if they were unable to understand. Patients had access to advocacy services if they wanted.

We found no evidence of patient feedback being collected by the trust in these areas.

Are services responsive to people's needs?

Good 

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

Our findings

Intensive Home Based Treatment Team (IHBT) :

Calderdale – The Dales

Kirklees – Folly Hall

Barnsley – Kendray Hospital

Wakefield – Fieldhead Hospital

Access and discharge

The national target for someone in crisis to be assessed is four hours after a referral has been made. All four teams achieved higher than the national average. Calderdale, Kirklees and Wakefield met this target in 93% of cases during January to December 2015. In the same period Barnsley IHBT achieved 98%. The national target was 90%. Teams met this target through strong interagency working and the ability to work cohesively as a team.

The referral system enabled anyone in crisis to contact the services, 24 hours a day, seven days a week. As well as people in crisis, carers, family members and services could make a referral. There was little delay in referral as the crisis team worked alongside other teams. For example, liaison nurses in A&E ensured patients were safe and supported until a member from the crisis team could arrive.

Referrals were primarily taken through the trusts 'single point of access' and then triaged by a member of duty staff in the crisis team who would screen the call and make an assessment. The teams were flexible in their approach and prioritised the patients that were in most distress. Band 5 or 6 nurses carried out all initial assessments; if a band 5 nurse carried out the initial assessment they would always discuss it with a band 6 nurse. This meant an experienced member of staff supported less experienced staff in making the initial assessment and taking matters further if needed.

The IHBT managed patients being admitted onto the wards and supported patients with timely discharges. The IBHT bridged the gap between community teams and inpatient wards. We saw that all the teams gate kept over 90% of admissions, however Barnsley IHBT gate kept 100% of admissions in the last year. We saw that gatekeeping was a regular agenda item on the team meeting minutes.

Staff told us the teams were proactive in supporting patients who were difficult to engage. This was done through having experienced staff, flexibility within seeing

patients and having a risk based approach. We were given examples of the teams supporting family and carers in supporting patient in crisis because the patient did not want to engage.

We observed flexibility of the teams. We saw staff attended a patient's house for a routine visit but needed to have that patient's medication reviewed and changed. A telephone call was facilitated with the consultant during the home visit and arrangements made for the nurse to come back later in the evening to drop off medication. This showed the teams worked flexibly to meet the patient's needs.

The facilities promote recovery, comfort, dignity and confidentiality

The crisis teams across the trust endeavoured to see their patients within the community, most commonly at their home. This was a part of their recovery model, to support patients in crisis within their home environments. Staff only saw patients within a hospital setting if the level of risk was too high, or if they were being assessed in A&E in the general hospital. There were facilities for patients to be seen at the IHBT base. We saw these, felt that they were adequate, and were able to meet the patients' needs. However, found some of the therapy rooms at Fieldhead hospital to be too small, and not appropriate. Staff informed us that if larger rooms were available then they would be utilised first.

Meeting the needs of all people who use the service

Staff had access to interpreters if and when needed. The demographic of the population the trust covered was a diverse and staff felt this was an important resource to have. Easy read leaflets were available. We saw teams have a range of self-support leaflets provided to patients. Some examples we saw were around eating disorders, anxiety, stress and hearing voices.

Calderdale, Kirklees and Wakefield IHBT staff said that leaflets were available in a different language if requested, however we did not see any which were readily available. The Barnsley IHBT said they did not have leaflets in any other languages but the team leader advised us they were looking at having these available in the future.

Are services responsive to people's needs?

Good 

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

Listening to and learning from concerns and complaints

The crisis teams received a total number of 12 complaints from February 2015 to January 2016. Wakefield IHBT received the most number of complaints with five.

We saw the teams were comparing performance figures with each other utilising feedback received from patients. This provided the reader with at a glance information on experiences patients were undergoing and how it compared to other teams.

We found that Barnsley IHBT had actively sought for patient feedback. We looked at 11 examples of the most recent feedback forms filled in and found most were positive. This feedback was integrated into the team meetings as an agenda item to see how the team could learn from complaints and compliments.

Health Based Places of Safety :

Calderdale – The Dales

Wakefield – Fieldhead Hospital

Barnsley – Kendray Hospital

Access and discharge

There was a joint agreement as part of the crisis concordat which enabled the trust and partner organisations (such as the police) to aim to reduce admission. There had been a reduction in s136 admissions for the teams that had police liaison officers. The teams which were not commissioned to have police liaison officers, still worked closely with the acute wards and AMHP's to reduce admissions into hospitals. They also attended the regular interagency meetings to discuss on-going development around supporting patients in crisis.

The trust policy for the 136 Suite indicated clear flow chart to support police liaison workers and the police in making decisions for appropriate admissions to the 136 Suite.

The IHBT teams had to source beds for anyone within the health based place of safety who had been assessed as needing admission as an inpatient. . We found bed occupancy levels to be high and the teams spoke about the difficulties in finding appropriate spaces. There were bed flow managers in place to support the IHBT teams in allocating beds.

The facilities promote recovery, comfort, dignity and confidentiality

We found the health based places of safety provided a dignified environment for patients whilst being able to protect them from causing harm. There were separate entrances for patients being detained under s136. Parking bays were made available near the suite so that patients would not have to travel a great distance. This helped reduce stress and anxiety for the patients. Patients had en-suite facilities made available to them in the suites. Food and drinks were available for patients all day. Clocks were visible to patients detained in the suites which meant patients were able to have a sense of time and were as comfortable as possible.

In the circumstance of the s136 suite having to be utilised by another patient, the trust were able to transfer them to another health based place of safety within the locality. If all the suites were occupied then the trust policy allows for patients to be taken to police custody, however this was done as a last resort. We found no instances of this happening.

The revised policy for the s136 suites states that patients being transferred to another suite should be transported in an ambulance which is the preferred method of travel. This is to maintain the dignity and privacy of the patient.

Meeting the needs of all people who use the service

The health based places of safety did accept young people under the age of 18. The trust operates a 24 hour service which would support any child coming into the s136 suite from the Child and Adolescent Mental Health Service. Any patients suffering from a learning disability or needing specialist help would be accommodated. Staff said they would be able to get advice or support from specialists within the trust.

Easy read leaflets were available for patients detained in the health based places of safety. These briefed patients about their rights and what they should expect.

Listening to and learning from concerns and complaints

Staff said patients were provided with information to make complaints. We saw that staff were being encouraged in the

Are services responsive to people's needs?

Good 

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

trust's 136 meetings to promote the friends and family test for patients who had used the 136 suites. The minutes of the meeting discussed the difficulty in getting feedback from patients.

We were informed of one complaint made by a carer in regards to how their family member was treated on the 136 Suite. However, this was against a member of the police and not a trust employee.

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

Intensive Home Based Treatment Team (IHBT) :

Calderdale – The Dales

Kirklees – Folly Hall

Barnsley – Kendray Hospital

Wakefield – Fieldhead Hospital

Vision and values

The trust had the following vision,

Enabling people to achieve their full potential and live well in their communities.

The trust's values were,

- Honest, open and transparent.
- Respectful.
- Person first and in the centre.
- Improve and be outstanding
- Relevant today, ready for tomorrow.
- Families and carers matter.

During our observations and interviews staff were able to demonstrate the trusts values and vision. It was embedded into their practice.

Staff in the crisis teams were aware of local management structures up to the trusts 'trio' level, and they knew who the chief executive was, however, were unfamiliar in recognising the management levels in-between. The trio level was a set of three senior managers which included a clinician who worked together above team leaders. The team leaders we spoke to felt supported by the trio level of management.

Good governance

We found the crisis teams to be well managed locally. Staff told us they were happy with how the teams were being operated and understood their roles within the teams.

We saw staff were up to date with mandatory training. Any training that was due to be refreshed or not been done was clearly identified on the dashboard. This enabled managers to plan training for staff. We found that staff were booked onto training however; they had a prolonged wait due to availability. As Mental Capacity Act and Mental Health Act training was not mandatory it was not routinely monitored. It was difficult for us to establish figures for the current training levels.

We found that staff had received regular supervision, and most appraisals were up to date. We saw clinical supervision was utilised more effectively. The teams provided staff with a range of options that suited their needs, for example clinical supervision in a group setting or one to one. Management supervision happened less frequently, every 6 to 8 weeks. Staff felt supported in approaching their managers whenever they needed to.

All the staff we spoke to were aware of the trust's safeguarding procedures and were confident in being able to use it. Staff were up to date in their adult and child safeguarding. Staff had access to posters which directed them on processes around raising safeguarding alerts, they were easy to follow and staff said they found them helpful.

All the teams had admin support. We found they were well utilised and played an important role within the team. We spoke to some of the admin staff, who said they felt supported within their role. One member of the admin team said they were being supported to pursue a career in obtaining a nursing degree. They said this was due to the positive experiences they had in the team they worked in.

Staff could not submit items directly onto the trust's risk register. This had to be done through the team leader. This did not cause any issues between staff or management. They preferred this method as it enabled staff to be able to reflect on the risk with the team leaders before submitting it.

All the teams carried out regular audits which gave them better oversight on team performance. They also had regular team meetings with a comprehensive agenda items. These team meetings provided a safe space for staff to address concerns, development in trust wide issues, reflect on practice and learn from incidents.

Leadership, morale and staff engagement

We found staff morale to be positive throughout the teams. They attributed this to the local leadership within the teams. Staff felt less confident in the trusts wider leadership structures.

We saw a very supportive team approach across all the crisis teams. This was reflected within staff interviews and feedback from management. The teams were also trying to better relationships with other teams such as the acute wards and community teams. They felt this was important, as they were the link between the two.

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.

Most of the staff we spoke to understood their responsibilities under the Duty of Candour. Staff had access to a flow diagram which described to them in an easy read format on processes they must follow. The online DATIX system also directed team leaders to act under the Duty of Candour when required. We did not see any examples of letters of apology. It appeared that staff were unclear how the apology had to be provided to patients.

Commitment to quality improvement and innovation

We saw that feedback from patients was being sought, this was then feedback into the team meetings and compared to the other teams. This enabled the crisis teams as a collective to see any emerging trends or themes of change that needed to be identified.

The crisis teams were continuously developing relationships with external partnerships to enable clearer and safer pathways for patients using these services. An example of this is all of the crisis teams working closely with the local accident and emergency departments at the general hospitals. This worked to improve services A&E could deliver for people suffering physical health issues, and protected patients in mental health crisis by enabling them to be seen by the right people.

Some teams invited guest speakers to attend team training sessions to provide valuable training around areas of interest or development.

Health Based Places of Safety :

Calderdale – The Dales

Wakefield – Fieldhead Hospital

Barnsley – Kendray Hospital

Vision and values

The trust's visions and values were visible to staff across all the areas of the hospital. When we spoke to the staff at the HBPOS, they were able to identify how the trust's visions and values were aligned to their practice.

There were local joint protocols with agencies such as the police to protect people in mental health crisis. Staff were aware of these and understood their roles and

responsibilities as part of this. They were aware of the responsibilities of other agencies in relation to their practice. For example, the importance of patients being transported in an ambulance as opposed to a police vehicle.

Good governance

Regular s136 audits were carried out by staff, which included risk assessments and ligature audits. There were regular s136 clinical meetings conducted to discuss areas of development and concern. We found the audits were not always reviewed in a timely manner. For example, a ligature assessment carried out in November 2014 identified a ligature risk, however the trust had mitigated risks surrounding the issue. The trust policy states that this should be reviewed yearly, we found in this case the risk was not reviewed a year. The environment of the health based places of safety provided patients with dignified care.

We saw in the meeting minutes that the teams addressed their wider responsibilities under the crisis concordat.

Leadership, morale and staff engagement

There were no regular based staff at the health based places of safety. Staffing was provided by experienced individuals who worked on the acute wards. The units were managed by the clinical managers of the ward. Staff understood their roles and responsibilities when working in the 136 Suites and felt supported by management. Staff understood their responsibilities under the Duty of Candour.

Commitment to quality improvement and innovation

We found that the IHBT and police liaison workers had good links with partner agencies with an aim to reduce s136 admissions. The police liaison service had reduced admissions via s136 in the Calderdale and Kirklees locality. We saw Barnsley IHBT had formulated good relationships with ambulance and police services which enabled them to contact the crisis team directly. This had a reduction in 136 admissions as the crisis team could visit the patients within the community after a referral had been made by the police.