

Requires improvement 

Derbyshire Healthcare NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Date of inspection visit: 6-10 June 2016
Date of publication: 29/09/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXM02	Hartington Unit	Chesterfield crisis resolution and home treatment team	S44 5BL
RXM02	Hartington Unit	Health-based place of Safety	S44 5BL
RXM02	Hartington Unit	High Peak and Dales crisis resolution and home treatment team	SK23 0RG
RXM03	Radbourne Unit	Derby City and County South crisis resolution and home treatment team	DE22 3WQ

Summary of findings

RXM03

Radbourne Unit

Health-based place of Safety

DE22 3WQ

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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



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 crisis mental health crisis services and health-based places of safety as requires improvement because:

- The health-based place of safety located in the Hartington Unit had multiple ligature points and other risks, including blind spots. It lacked emergency equipment and ligature cutters.
- The door to the health-based place of safety at the Hartington Unit had an uncovered clear glass panel that people in the reception area could see through.
- All the crisis resolution and home treatment (CHRT) teams had low training rates for medicines management and the Derby City and County South team had low rates for basic life support training.
- Patients' medication records for the Derby City and County South team showed gaps for medicine reconciliation and the recording of patients' allergies.
- Care plans in the Derby City and County South team lacked detail and were not always up-to-date.
- Although staff had recognised and reported safeguarding issues internally, the Derby City and County South team had not made any referrals to the local authority.
- The lone working arrangements for staff in the High Peak team were not robust or safe.
- Staff in the Derby City and County South team did not receive regular one-to-one supervision and appraisals.
- The Derby City and County South CRHT experienced difficulties transferring patients to community mental health teams because of long waiting lists.
- Staff in the Derby City and County South team did not feel assured that their service would remain safe during the transition to integrated community services.
- The trust did not routinely measure performance on key activities such as four-hour response times to referrals.
- Governance systems and processes to help ensure effective practice were inconsistent across the teams.
- The health-based places of safety did not contain clocks. The health-based place of safety at the Hartington Unit did not have anything for patients to lie down on

However:

- All CRHT teams had safe staffing levels for their respective caseloads at the time of our inspection.
- The CRHT teams had good risk assessment and management systems and processes.
- Staff undertook comprehensive assessments of patients' needs taking into account social, psychological and physical needs.
- Patients and relatives gave positive feedback about the CRHT service and described the staff as kind and helpful.
- The CRHT teams had local systems in place to help provide continuity of care, wherever possible.
- The CRHT teams fully involved patients (and relatives, where appropriate) in care planning.
- Staff ensured that assessments of patients detained in the health-based places of safety started as soon as possible after their admission.
- All CRHT teams had good access arrangements covering 24 hours a day, seven days a week, and had no exclusion criteria as long as the presenting issue was mental ill health.
- The CRHT teams prevented hospital admissions by providing intensive short-term support to patients in their own home.
- Patients received timely support, tailored to their needs, in their own home. Staff negotiated the type and frequency of contact with patients.
- All CRHT teams had a clinical leadership model to team and service management, which helped ensure that clinical and managerial needs informed practice and service development.
- The new local leadership team for the Derby City and County South team had made significant improvements to the service following a prolonged period of crisis.
- Staff in the Chesterfield and High Peak teams described good team working, and staff in the Derby City and County South team reported improvements in team morale, and trust and confidence in the team's new managers.
- The trust participated in a multi-agency group concerned with the operation of section 136 of the Mental Health Act.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- The health-based place of safety at the Hartington Unit had a number of ligature points and other risks.
- The staffing arrangements for the health-based places of safety were not sufficient to cover them effectively.
- The health-based place of safety at Hartington Unit did not hold emergency equipment and ligature cutters, and there were no signs to inform staff where to find them.
- There were blind spots in the health-based place of safety at the Hartington Unit even though it had CCTV (close circuit television) and a viewing window for staff.
- Although staff had recognised and reported safeguarding issues internally, the Derby City and County South team had not made any referrals to the local authority.
- The lone working arrangements for staff in the High Peak team were not robust or safe.
- Although CRHT staff received mandatory and role-specific training, the rates for medicines management training and clinical risk management for all CRHT teams were low and there was low compliance with basic life support training in the Derby City and County South CRHT.
- The Derby City and County South CRHT team did not always complete medicine reconciliation and record patients' allergies on prescription charts.

However:

- All CRHT team offices were clean, tidy and well maintained. Staff complied with infection control practices and antibacterial hand gel was widely available.
- All CRHT teams had safe staffing levels for their respective caseloads at the time of our inspection.
- The CRHT teams had good risk assessment and management systems and processes, and the teams reviewed risks frequently.
- The CRHT teams had some good medicines management practices, for example, safe storage of drugs, medication records in good order and daily stock checks.
- Following incidents, all staff received debriefs, feedback and lessons learnt from managers at local level.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

Requires improvement



Summary of findings

- Care plans for the Derby City and County South team lacked detail and were not always up-to-date.
- Although Derby City and County South staff supported patients' physical health needs, the care records did not always reflect this.
- Staff in the Derby City and County South team did not receive regular appraisals and one-to-one supervision.
- Staff supporting the health-based places of safety did not record when they gave patients their rights under section 132 of the Mental Health Act.

However:

- CRHT staff undertook comprehensive assessments of patients' needs, taking into account social, psychological and physical needs.
- Staff from the Chesterfield and High Peaks CRHT teams drew up recovery-focused care plans with patients that covered their full range of needs.
- The CRHT teams followed national institute for health and care excellence (NICE) guidance relevant to their practice, for example, guidance on prescribing, depression, psychosis and borderline personality disorder.
- The CRHT teams worked in line with the Department of Health's mental health crisis care concordat 2014.
- The trust, managers and staff completed specific audits and reviews to help identify issues and make changes.
- All CRHT teams were multidisciplinary and met daily to discuss new referrals, assessments, care plans and review risks. CRHT teams worked closely with inpatient and community services.
- The bleep holder for the health-based place of safety arranged for the appropriate professionals to undertake a MHA assessment of the detained patient as soon as possible after their admission.
- The trust participated in a multi-agency group with other agencies involved in the operation of section 136 of the Mental Health Act.

Are services caring?

We rated caring as good because:

- Patients and relatives gave positive feedback about the CRHT staff and service. They described staff as kind and helpful, and the service as a 'safety net'.
- Patients expressed satisfaction at receiving timely and consistent care in their own homes, which addressed their specific needs.

Good



Summary of findings

- We observed good patient and staff interactions. Staff listened, and showed respect, to their patients.
- Staff involved patients, and relatives, where appropriate, in assessments and care planning. They provided support and advice on a range of issues that affected a patient's mental health.

However:

- In the past, patients had expressed dissatisfaction with the continuity of care because of the number of workers they saw. This remained a challenge for CRHT teams although they had local systems in place to help address this.

Are services responsive to people's needs?

We rated responsive as good because:

- The CRHT teams prevented hospital admissions by providing intensive short-term support to patients in their own home.
- The CRHT teams operated 24 hours a day, seven days a week and had no clinical exclusion criteria as long as the primary presenting issue was mental ill health.
- The CRHT teams followed up all patients discharged from inpatient wards who were not in the care of the community mental health teams.
- The CRHT teams tried to ensure that patients received consistent and continuous service from the same small group of staff. Staff negotiated the type and frequency of contact with patients.
- Patients received support tailored to their individual needs, which took into account the full range of equality characteristics such as gender, disability and ethnicity.
- Patients and relatives knew how to complain about the service, and staff knew how to handle and report complaints and compliments.
- Staff detained patients in the health-based places of safety for the shortest time possible, and always for less than 72 hours.

However:

- The CRHT teams did not accept referrals directly from patients although some teams had plans to change this.
- The CRHT teams did not routinely accept referrals for people aged over 65 years because they were commissioned to provide services for people aged 18-65 years only.
- The Derby City and County South CRHT experienced difficulties safely discharging patients to community mental health teams because of long waiting lists.

Good



Summary of findings

- The health-based places of safety did not contain clocks. The health-based place of safety at the Hartington Unit did not have anything for patients to lie down on although staff could bring a mattress from a storeroom.

Are services well-led?

We rated well led as good because:

- All CRHT teams adopted a clinical leadership model to team management. This helped ensure both managerial and clinical priorities informed practice and influenced improvements.
- The Derby City and County South team had a new leadership team who had made significant improvements to the team. The team had plans for the further improvements it knew it needed.
- Staff in the Chesterfield and High Peak CRHT teams described good team working, support and morale. Staff in the Derby City and County South team reported improvements in team morale and trust and confidence in the team's leaders.
- All CRHT teams had held team away days to consult and engage with staff on the review of their service specification.
- The teams worked in line with the Department of Health's mental health crisis care concordat 2014, which aimed to improve outcomes for people experiencing mental health crisis.
- The trust participated in a multi-agency group concerned with the operation of section 136 of the Mental Health Act.

However:

- Staff felt detached from the trust on a day-to day basis, and some staff in the Derby City and County South team expressed disappointment with senior managers' responses to issues in their service.
- Governance systems and processes to help ensure effective practice were inconsistent across the teams.
- Although CRHT staff had reported incidents and safeguarding concerns internally, the Derby City and County South team had not made safeguarding referrals to the local authority.
- The trust did not routinely measure performance on key activities such as four-hour response times to referrals.
- Staff in the Derby City and County South team expressed anxiety about the plans to integrate community services. Staff did not feel assured that the service would remain safe during transition.

Good



Summary of findings

Information about the service

There are three crisis resolution and home treatment (CRHT) teams and two health-based places of safety provided by Derbyshire Healthcare NHS Foundation Trust.

The three crisis resolution and home treatment (CRHT) teams are Chesterfield, High Peak and Dales, and Derby City and County South. They are located in Chesterfield, Chapel-en-le-Frith and Derby respectively. The High Peak and Dales team is a small 'satellite' team closely linked to the larger Chesterfield team, and has the same clinical management team. The teams offer crisis resolution and home treatment services to patients who would otherwise need hospital admission. The CRHT services run for 24 hours a day, seven days a week.

The two health-based places of safety, also known as section 136 suites, are located in the Hartington Unit in Chesterfield Royal Hospital, and the Radbourne Unit in Royal Derby Hospital.

The Hartington Unit and the Radbourne Unit are registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

This was the first CQC inspection of mental health crisis services and health-based places of safety.

Our inspection team

Our inspection team was led by:

Chair: Vanessa Ford, Director of Nursing and Quality, South West London and St George's Mental Health NHS Trust

Head of Hospital Inspections, CQC: James Mullins

The team that inspected the core service comprised one CQC inspector, one Mental Health Act reviewer, and two specialist advisors. The specialist advisors included a psychiatrist and a mental health nurse.

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 these services and asked a range of other

organisations for information. We also looked at the initial data review from the first phase of the CQC's thematic review of mental health crisis care, published on the CQC website.

During the inspection visit, the inspection team:

- visited all three crisis resolution and home treatment teams, and two health-based places of safety

Summary of findings

- spoke with each of the managers for the three crisis and home resolution teams (CRHT), and the clinical managers (bleep holders) responsible for the health-based places of safety
- spoke with 19 other staff members including doctors, nurses, social workers, team administrators, support workers, domestic staff, and a mental health act administrator
- attended and observed one handover meeting and two multidisciplinary meetings
- spoke with four patients and three relatives
- looked at care records for 10 patients
- looked at 41 prescription charts
- carried out a specific check of the medicines management practices in the three CRHT teams
- looked at health-based place of safety assessment records for 11 patients
- 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 four patients and two relatives. We also reviewed the patient feedback that was available, for example, complaints, compliments, incident reports and service reviews.

Patients gave positive views about the CRHT services and said staff were kind and helpful, and services were easy to access and responsive. Patients described the CRHT service as a safety net that helped them feel less alone. They said staff were always available when needed, and liked that doctors and staff visited them in their homes. Patients felt involved in the assessment and care planning processes.

The concerns patients expressed were about the poor quality of care received from the Derby City and County South team in the past, and included poor continuity of care, poor access to the service and cancelled visits. However, patients said this had improved recently.

Complaints from patients and relatives were mostly about the Derby City and County South team, made in the early months of 2015. They had reduced since then, which reflected the increased stability in the team that we saw during our inspection. For example, in the 12 months to 31 January 2016, the CRHT teams received 90 compliments, of which 51 were about the Derby City and County South team.

Good practice

The CRHT teams encourage staff to act as champions for specific areas of practice based on their special interests. For example, staff acted as champions for medicines management, dual diagnosis (learning disability and mental health), physical health, and housing. The CRHT teams aimed to develop champions for a range of issues such as transgender, domestic violence, and drugs and alcohol. The teams benefited from this local expertise, which enhanced practice and improved outcomes for

patients. For example, the champion for housing offered patients timely help with housing-related issues. The champion for medicines management ensured that the Chesterfield and High Peak teams had safe medicines management practice as they received limited pharmacy support. The team's special interests also extended to charitable practices, for example, staff had started a food bank.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that the health-based place of safety at the Hartington Unit in Royal Chesterfield Hospital is anti-ligature and adequately mitigate the risks present.
- The provider must ensure that emergency equipment is available in health-based places of safety.
- The provider must ensure that staff complete medicines reconciliation and record the allergy status for their patients.
- The provider must ensure that staff receive regular supervision and the appropriate training for their roles.

Action the provider **SHOULD** take to improve

- The provider should ensure the privacy and dignity of patients using the health-based place of safety at the Hartington Unit in Royal Chesterfield Hospital.

- The provider should ensure there is a robust and safe system for lone working for staff in the High Peak and Dales CRHT team.
- The provider should ensure sufficient and effective staffing arrangements for the health-based places of safety.
- The provider should ensure that staff record that patients detained under section 136 of the Mental Health Act (MHA) have received their section 132 MHA rights.
- The provider should ensure that safeguarding incidents are referred to the local authority, in line with local reporting protocols and legal requirements.
- The provider should ensure there are mechanisms in place to measure performance against targets, for example, response times for CRHT services.

Derbyshire Healthcare 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
Chesterfield crisis resolution and home treatment team	Hartington Unit
Health-based Place of Safety	Hartington Unit
High Peak and Dales crisis resolution and home treatment team	Hartington Unit
Derby City and County South crisis resolution and home treatment team	Radbourne Unit
Health-based Place of Safety	Radbourne Unit

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings to help reach an overall judgement about the provider.

Most staff received training in the Mental Health Act. As of May 2016, training compliance rates were 100% for the Chesterfield team and 87% for the Derby City and County South team. However, the compliance rate for the High Peak team was 71%, below the trust's target of 85%.

We reviewed assessments records for 10 patients who had used the health-based places of safety in the past six months. We found that in nearly all cases, appropriate, accurately completed documentation was in place. The documentation contained the required details, for example, time of arrival, length of stay, and outcomes of

Detailed findings

assessment. However, one record showed an incorrect outcome of assessment. None of the records noted that patients had received their rights under section 132 of the Mental Health Act.

Staff at both health-based places of safety reported few delays in accessing medical professionals and approved mental health practitioners. The assessment records we reviewed showed that patients stayed in the health-based places of safety for between four to 22 hours.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. As of May 2016, training compliance rates were 100% for the Chesterfield team and 87% for the Derby City and County South team. However, the compliance rate for the High Peak team was 71%, below the trust's target of 85%.

Staff had a good understanding of, and applied, the principles of the MCA, in particular, the presumption of capacity and its decision-specific application. Medical staff completed capacity to consent or refuse treatment assessments appropriately.

Patients signed consent forms to give permission for information to be shared with family members.

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 environment

- The Chesterfield and Derby City and County South crisis resolution and home treatment (CRHT) teams had offices based within acute hospital settings; the High Peak and Dales team had an office in a local community health centre.
- We completed tours of the CRHT teams' offices. All three sites had reception areas that received all visitors. The offices contained appropriate facilities, for example, toilets, kitchens, and lockable medicine cupboards. They were clean, tidy and well maintained. The teams rarely saw patients at their bases but all teams could access clinic rooms on their sites, if required.
- Staff complied with infection control practices, and anti-bacterial hand gel was widely available throughout the offices.
- The trust had undertaken safety checks on most electrical equipment and appliances although the systems for completing these checks varied. For example, on some appliances, there were clear stickers showing the test date and next test date. On other appliances, there were clear stickers showing safety tests had been completed but with bar codes rather than dates. This meant we could not tell straightaway the date that the appliance was tested.
- We inspected the health-based place of safety (also known as the section 136 suite) located in the Hartington Unit at Chesterfield Royal Hospital. The health-based place of safety was located on one side of the unit's reception area making it easy for police and ambulance staff to find. The suite contained a small corridor that led to the staff office and viewing room, the patient's area and a small clinic room. The patient's area comprised a room with six weighted (strong, heavy and durable) chairs and an ensuite shower room.
- The suite at Hartington unit presented a number of risks to patients and staff. Although the showerhead and taps were anti-ligature, the shower area contained other ligature points associated with the wall panelling, ceiling panels and fixtures. For example, the emergency pull alarm in the shower room and the shower panel key lock were load bearing and the sink and shower casings did not have anti-pick sealant. The ceiling had square panels that could be removed by force. We saw two panels that looked tampered with and there were electrical wires visible behind them. We informed the managers of our concerns during our inspection and they subsequently recorded the ligature risks on the trust's risk register.
- The door to the suite had an uncovered clear glass panel that people in the reception area could see through. There was no privacy screen to obscure the view into the suite. The door to the patient's area lacked a viewing panel. This meant that staff approaching the door could not see the patient. There was a large viewing window between the nursing and patient areas. However, there were a number of blind spots, which meant that staff could not see all of the patient area and although the suite had close circuit television (CCTV), this did not address all of the blind spots. Furthermore, there were no signs to inform patients that CCTV was in use.
- We could see no evidence of ligature cutters and staff told us that there was no emergency equipment kept in the suite although we saw a defibrillator in the clinic room. The nearest location that these items could be located was on the inpatient wards within the same building but there were no signs to indicate this.
- We also inspected the health-based place of safety located in the Radbourne Unit at Royal Derby Hospital. This was based in a discreet and quiet area and was clearly signposted for easy access by the police and ambulance services.
- The suite was purpose-built and well designed with anti-ligature fittings. The suite had CCTV, with signs to indicate that it was in use. There was a large observation screen between the nursing station and patient area and viewing panels in the doors. There were no blind spots and staff could observe all of the patient area. The suite was clean and suitably furnished. It contained a single mattress, a weighted settee and three weighted chairs. There was emergency equipment available in the health-based place of safety, including a resuscitation bag and ligature cutters.

Safe staffing

Are services safe?

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

- The staffing arrangements varied between the CRHT teams. The High Peak and Dales team was a small satellite service closely linked to the Chesterfield team. Although each team had dedicated staff, the two teams shared team management and clinical leadership. The teams had the following whole time equivalent (WTE) staffing levels (excluding managers and clinical leads):
 - Chesterfield: 20.9 WTE qualified nurses, 3 WTE support workers
 - High Peak and Dales: 5.8 WTE qualified nurses, 0.8 WTE support workers
 - Derby City and County South: 26.4 WTE qualified staff (including nurses, occupational therapists and social workers), 2 WTE support workers.
- The Chesterfield and High Peak teams shared team leadership staff equivalent to 2 WTE, and the Derby City and County South had 2.4 WTE staff dedicated to team management and clinical leadership. Each team had administrative staff who were the first point of contact for any referrals. The Derby City and County South team regularly used temporary administrative support to meet the demands on their busy team.
- We reviewed recent staffing rotas for each of the CRHT teams and found that they met the minimum staffing levels for each team. Staffing rotas for the High Peak team showed that each shift met the minimum of two qualified staff. There were occasional exceptions where a low caseload meant staff could take time off in lieu, or take annual leave, without affecting the service. Rotas for the Chesterfield team showed that each day shift had a minimum of three qualified nurses in addition to support workers, in-reach workers and team leaders. There was one qualified worker on night shifts. Rotas for the Derby City and County South team showed that each day shift had a minimum of three qualified nurses in addition to social workers, occupational therapists, support workers and team leaders. Owing to the high demand and caseload in the Derby City and County South team, the total staffing complement reached 13 staff each day.
- At the time of our inspection, the Chesterfield and High Peak teams held no vacancies. The Derby City and County South team had three vacancies for qualified nurses. Recruitment was underway with interviews scheduled for the week following our inspection. In the meantime, staff from the CRHT team acted up to fill the vacant positions.
- For the 12-month period to 31 January 2016, the Chesterfield and High Peak teams experienced no staff turnover. In the same period, the Derby City and County South team had staff turnover rates of 17%, in comparison to the trust average of 10%. At our inspection, the Derby City and County South team managers explained that no staff had left in the past 12 months; the high turnover rate applied to the first half of the period.
- For the 12-month period to 31 January 2016, the staff sickness rate was 3% for the Chesterfield team, 2% for the High Peak team and 7% for the Derby team. The Derby team's sickness rate was above the national average of 4.4% and the trust's level of 5%.
- All teams used regular bank staff to cover gaps in shifts. These were generally CRHT staff or staff from other teams who worked closely with CRHT teams, for example, the A & E liaison team or the community mental health teams. The teams occasionally used agency staff as a last resort. The team managers could adjust staffing levels to take account of caseloads and other demands placed upon the teams. Team managers reported any unfilled shifts that resulted in unsafe staffing levels as incidents. We saw one example of a staffing gap caused by confusion over shift times. The incident record showed that the manager took immediate action to cover the shift, and subsequently made some changes to rota systems to prevent similar incidents.
- The teams had access to out-of-hours on-call arrangements for the Hartington Unit and the Radbourne Unit. The High Peak team could ask the Chesterfield team for additional support during the day if needed.
- Teams rather than individual staff held caseloads. At the time of our inspection, the Derby City and County South team had a caseload of 60 patients in receipt of home treatment services. The team was very busy and previously had a caseload of 100 patients, which proved to be unmanageable and unsafe. The Chesterfield team had a caseload of 25 patients. Staff and managers said that the team had the capacity to manage no more than 30 patients safely. The average caseload for the High Peak team was eight patients. On the day of our inspection, the team had a caseload of six patients, two

Are services safe?

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of whom were ready for discharge. The team managers and clinical leads reviewed the teams' caseloads sizes continually, and escalated any concerns to senior managers.

- Staff received the trust's compulsory training, which included equality and diversity, fire safety, health and safety, information governance, moving and handling, safeguarding adults, safeguarding children, and promoting safer and therapeutic services. The trust's target compliance rate for compulsory training was 85%. In May 2016, the average compliance rate was 93% for the Chesterfield and High Peak teams, and 89% for the Derby City and County South team. However, the compliance rate for fire safety training for the Chesterfield and High Peak teams was 79%.
- Staff also received role-specific mandatory training. Data for the Chesterfield and High Peak CRHT teams showed an overall training compliance rate of 79% for role-specific training, which was below the trust's target rate of 85%. In particular, compliance rates were low for clinical risk management (69%) and the four medicines management courses (20-60%). Data for the Derby City and County South team showed an overall compliance rate of 64% for role-specific training. Compliance rates were low for basic life support (63%), clinical risk management (37%), four medicines management courses (0%), and safeguarding children level three (52%). Following feedback from a number of serious incidents linked to the CRHT service, the trust had introduced specific suicide awareness and response training for which it had already achieved a compliance rate of 71%.
- The trust had introduced an induction passport for new staff, which comprised a mandatory learning package. Some staff experienced difficulties accessing training delivered electronically, such as medicines management courses. Team managers had reported the issues to the trust and awaited action.
- We found there were insufficient staffing arrangements to cover the health-based places of safety effectively. There was no dedicated staffing in either of the health-based places of safety although both health-based places of safety had clearly identified managers - 'bleep holders' - in charge of the facilities at all times. The bleep holder roles were supernumerary posts drawn from staff who worked in services within the same unit. The role included dealing with clinical emergencies, absent without leave incidents and managerial issues for the whole unit. For example, on the Hartington Unit, three ward managers covered the daytime shifts, on a rota basis. Day shifts comprised one manager, and ran from 7am to 2.30pm, and 2.30pm to 9pm. In a typical week, each manager acted as bleep holder two to three times a week. Night shifts ran from 9pm to 7am but the two units had different arrangements for staffing the health-based place of safety at night. The Chesterfield CRHT provided staffing cover at night for the health-based place of safety at the Hartington Unit. At the Radbourne Unit, three ward staff carried out night cover for the health-based place of safety, on a rota basis.
- There was a clear process for contacting the bleep holder, through either reception or the switchboard. The bleep holder managed the handover from the police, and called upon nursing staff to assist. However, attending to the patient in the health-based place of safety meant that the bleep holder left their substantive post.
- During our inspection, we observed a bleep holder trying to manage a number of priorities at the same time. These included incidents on the wards, the admission of a patient to the health-based place of safety, and searching for an available inpatient bed for a patient needing admission.
- The trust recognised the staffing gap for the health-based places of safety. It had submitted a bid to commissioners for funding for a dedicated staff team, but had been unsuccessful. The police were legally obliged to remain at the health-based place of safety if their presence was required to prevent crime caused by violent behaviour. However, a police report for the section 136 inter-agency group suggested that staff often wished to retain police officers because there were not enough staff to manage the patient, and not because of the risk of aggression and violence. The report looked at section 136 detentions during a 12-month period between 2015 and 2016. It found that in 49% of cases, the reason listed for police officers kept for over 30 minutes was a lack of staffing at the health-based place of safety. It further stated that only 17% of cases required police presence due to the risks presented.
- All staff who carried out the bleep holder and assessment roles received specific induction and training. However, not all staff allocated to the health-based places of safety had all the appropriate training.

Are services safe?

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

For example, although staff working in inpatient services received training in control and restraint, staff in the Chesterfield CRHT, who supported the Hartington Unit's health-based place of safety during the night, received only basic personal safety training. No agency staff managed the health-based places of safety.

Assessing and managing risk to patients and staff

- All teams used a RAG (red, amber, green) risk rating system for all patients accepted by their service. A trust policy underpinned the RAG system. Staff usually rated all new patients as red risk and reviewed them daily before re-categorising as required. Patients moved to amber or green as they made progress, but could move back to red if their risks increased. Staff saw patients rated red risk at least once a day; patients rated amber risk were visited at least every other day and patients rated green risk were seen every few days or once a week. The Derby City and County South team aspired to undertake daily visits for high (red) risk patients but struggled to do this consistently when caseloads were high. All CRHT teams used white boards in their offices to record patients in receipt of home treatment, their level of risk and other key information such as the patient's electronic file reference for ease of access to care records. The patient information on the white boards was up-to-date and accurate. The Chesterfield and High Peak team staff also made a record of patients open to community mental health teams who may need their services in the near future.
- The CRHT service used the functional analysis of care environments (FACE) risk assessment tool to assess patients' risks and inform care plans. Risk assessments and reviews featured strongly in the day-to-day business of the CRHT teams. All teams reviewed the patients' risks on each contact, and the Chesterfield and High Peak and Dales CRHT teams recorded the outcomes on a brief form. Each team held daily meetings to discuss new and high-risk patients.
- Staff discussed risks with patients and agreed crisis response plans that took into account patients' wishes for their treatment, including responses to crises (advance decisions).
- Staff negotiated the frequency and type of contact with patients, for example, a home visit or a telephone call, according to the risks and behaviours they presented.
- Staff received training in safeguarding and could demonstrate that they knew how to recognise and

report safeguarding concerns. Data for 1 May 2015 to 31 May 2016 showed that staff in the Chesterfield CRHT team made 11 safeguarding referrals to the local authority and staff in the High Peak and Dales team had made three referrals. The lack of any data for the Derby City and County South team indicated that staff made no referrals to the local authority. This meant that either the team did not have any concerns that needed referring to the local authority or if they did, they did not refer them. Our interviews with staff and observations of multidisciplinary team meetings showed that staff understood safeguarding and identified concerns appropriately. Records showed that the team had logged safeguarding incidents onto their internal system but had made no safeguarding referrals to the local authority. We discussed this with the Derby City and County South team managers who acknowledged that the team had a number of improvements to make, including reporting incidents generally.

- CRHT staff complied with the trust's lone working policy although the High Peak and Dales CRHT team had less robust arrangements than the other teams. For example, the Chesterfield CRHT team used a tracker (known as the 'flight plan') to note staff's scheduled visits, which the duty worker checked regularly. The Derby City and County South CRHT team used an in/out board. However, being a small team, the High Peak and Dales CRHT team staff knew about each other's plans for the day, and noticed when staff did not return to the office when expected. In all the teams, two staff members undertook assessments of newly referred patients or, where appropriate, they arranged to visit with community mental health team staff. If staff failed to return to the office at their expected time, in the first instance, a colleague or the duty worker attempted to contact them by telephone. One staff member in the Derby City and County South CRHT team gave an example of a time when he had received a call from a colleague to check on him when he had not returned to the office at the designated time. All staff we spoke with said they felt safe in their work and could call upon colleagues to help them if needed. The Chesterfield and the Derby City and County South teams had clear protocols for lone working in their offices, for example, staff could use personal mobile ('blick') alarms. However, there were less robust arrangements for the High Peak and Dales team based in a local health centre. The clinic rooms did not contain alarm call

Are services safe?

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systems, and staff did not have access to personal mobile alarms. The health centre opened during normal office hours only, which meant that after these hours, and until the shift ended at 10pm, CRHT staff worked alone in the building. There were usually two staff members working until 10pm during the weekdays but only one staff member at weekends. The High Peak and Dales CRHT team manager had added the risks associated with lone working to the team's risk register.

- Medicines management practices varied between the CRHT teams. There were some good medicines management arrangements in all teams. For example, medicines were stored securely and within safe temperature ranges. Medicine records were easy to read, signed, dated and contained no gaps or errors. Staff completed daily stock checks and regular medicine storage audits. However, in the Derby City and County South CRHT team, staff did not complete medicine reconciliation and record patients' allergies on all prescription charts. We found nine charts that did not show the patient's allergy status and a further one that did not state the source used for identifying the allergy. We also found 16 charts where staff had not completed medicine reconciliation, or completed it using only the patient as the source of information. We informed the team manager who agreed to look into this immediately. The manager advised us that the team had recruited a pharmacist who was due to start work the day following our inspection. Some of the CRHT teams used patient group directions (PGD) to help deliver safe and timely patient care. This meant that staff could administer specified medicines without individual patient prescriptions. The Chesterfield and High Peak CRHT teams had PGDs for diazepam, procyclidine and risperidone, which staff mainly used out-of-hours, if required. The Derby City and County South team did not have access to PGDs, which meant staff had to contact a psychiatrist out-of-hours for any prescriptions. However, the team planned to adopt them as part of their continuing service improvement strategy. Staff had access to locked briefcases for the safe storage and transport of medicines.
- For patients attending the health-based place of safety at the Hartington Unit, the police conducted personal searches before the patient entered the facility. Staff completed further searches, if needed, in line with the trust's policy. For patients attending the health-based

place of safety at the Radbourne Unit, staff conducted searches with police assistance on the patient's arrival. A section 136 admission checklist helped staff comply with the relevant protocols such as seeking consent to search, giving patients their section 132 rights, and completing the relevant paperwork.

- Staff at the Radbourne Unit described difficulties in obtaining police support for aggressive or disturbed patients. They reported these as incidents on the electronic incident-reporting system, and escalated their concerns to their managers. Staff gave examples of occasions where the police had left the unit even though the patient was violent and aggressive; occasions where the police refused to attend when called later for help; and occasions where custody sergeants pressured staff to release their officers.
- The inter-agency section 136 protocol stated that the bleep holder and police officers should agree when the police officers could leave without risk to the individual or staff. However, a police report for the section 136 inter-agency group suggested that staff often wished to retain police officers because there were not enough staff to manage the patient, and not because of the risk of aggression and violence. The report looked at section 136 detentions during a 12-month period between 2015 and 2016. It found that in 49% of cases, the reason listed for police officers kept for over 30 minutes was a lack of staffing at the health-based place of safety. It further stated that only 17% of cases required police presence due to the risks presented.
- Staff who worked in the health-based places of safety followed the trust's protocols for rapid tranquillisation and medicines management.

Track record on safety

- The trust reported eight serious incidents in the period 1 January 2015 to 31 December 2015 for the CRHT service. These were related to unexpected or avoidable death or severe harm. All patients were in receipt of care from the crisis teams.
- Following feedback from a number of serious incidents linked to the CRHT service, the trust had introduced specific suicide awareness and response training.
- The Derby City and County South team had experienced significant challenges in the three years prior to the inspection. The trust undertook a review of CRHT services in July 2014 following the increasing pressure on the team to respond to the high number of referrals.

Are services safe?

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

The review identified a number of issues including inconsistency in the team's responses to referrals, over-reliance on the FACE assessment tool for risk assessment and management, a lack of continuity of care for patients, and delays in transferring patients to community mental health teams. The review made a number of recommendations and the team made some changes, for example, agreed shared care arrangements with the community mental health teams. However, in January 2015, a further review identified concerns about staff and patient safety following a four-week observation exercise, and a SIRI (serious incident requiring investigation) report in February 2015. The concerns exceeded those identified in the July 2014 review and the trust targeted the Derby City and County South CRHT service for an emergency response. The concerns identified included:

- high caseloads, in excess of 100 patients
- insufficient staffing to provide a safe service
- regularly cancelled or re-arranged visits
- an absence of robust systems for decision-making and communication.
- The trust's emergency response to the Derby City and County South CRHT involved strategic management support to the team, new team leaders, and increased staffing levels, including administrative support. There was a change from a managerial leadership approach to a clinical leadership approach. The service established a multidisciplinary team that included occupational therapists and social workers. There were changes implemented to the team's referral and triage processes, and two staff covered 'duty' every day to respond to new referrals to the service. The changes helped reduce caseloads to between 45 and 60 patients, which made the service safer. More recently, in March 2016, an evaluation of CRHT service commenced involving a full review of the service specification and operational policy. At the time of our inspection, the Derby City and County South team showed signs of improvement and stability. They had benefited from dedicated support and new leadership. The team had worked hard to achieve a safe service and acknowledged they now needed to improve their effectiveness and governance.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents. All staff had access to an electronic incident-reporting system, which they used to record all complaints, concerns, incidents and safeguarding issues. We reviewed incident records for the Chesterfield team and found that staff reported a wide range of issues appropriately. Staff reported serious incidents onto the electronic system, and other staff in the trust reported them on to the national serious incident system, where required.
- We reviewed a summary of incident data for all CRHT teams for the period 1 May 2015 to 31 May 2016. The data showed that the Chesterfield team reported 95 incidents, the Derby City and County South team reported 62 incidents, and the High Peak and Dales team reported 12 incidents during this period. The high number for the Chesterfield team reflected good reporting practices by staff and managers. The most frequently occurring issue was self-harm by patients, which amounted to 44% of all incidents. The CRHT teams reported 13 incidents of shortages in staffing. The Derby City and County South team reported eight incidents related to medication.
- Staff were open and transparent with patients and relatives when things went wrong.
- Staff received debriefs following incidents from their local managers and benefited from other opportunities to discuss incidents and any lessons learnt, for example, one-to-one supervision, team meetings, and handovers. However, staff and managers reported delays in receiving feedback from the trust on any investigations undertaken outside the local team. In one case, a staff member felt excluded from a serious incident investigation despite knowing the patient well. The staff member received no feedback and said they had to find their own support.
- In exceptional circumstances, staff in the Hartington Unit and the Radbourne Unit used the health-based places of safety for secluding patients. Staff recorded these as incidents on an electronic system. Records showed that during three weeks in February and March 2016, staff used the suite at the Radbourne Unit on four occasions because the seclusion room on their ward was occupied or under repair. Records showed one use of the suite at the Hartington Unit for seclusion in March 2015.

Are services effective?

Requires improvement 

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

Assessment of needs and planning of care

- We reviewed care records for 10 patients. The CRHT teams completed comprehensive assessments were for all patients in a timely manner. The teams took a holistic approach to assessment and care planning, taking into account patients' mental and physical health, as well as social needs.
- Staff drew up care plans for new patients or added to existing care plans for patients receiving care from the community mental health teams. The standard of care plans was inconsistent across the CRHT teams. Patients' records in the Chesterfield and High Peak and Dales teams showed accurate, fully completed and up-to-date care plans. However, we saw incomplete care plans for two patients in the Derby City and County South team. One care plan had the action plan and signature missing, and staff last updated it in January 2016. Another care plan was very brief and there was no action plan. The care plan lacked important details, for example, it stated the treatment was 'medication' but did not show what this was. The Derby City and County South team managers acknowledged that care plans needed improvement, and planned to address this as part of the team's improvement programme.
- Staff assessed patients' physical health needs but this was not always evident in patients' care records. Patients' records in the Chesterfield and High Peaks teams held assessments and care plans relating to physical health but these were less obvious in the Derby City and County South team. However, we saw that in practice, staff consistently considered and supported physical health needs even though patients' care records did not always reflect this.
- The teams applied a recovery-focused approach to all patients, and planned discharge from the outset. We observed a multidisciplinary team meeting in which the team discussed recovery, pathways and discharge for each patient. We attended a home visit in which staff discussed the patient's personalised wellness recovery action plans (WRAP) with them.
- Where possible, the team tried to ensure consistency and continuity of care for patients. For example, the Derby City and County South team had recently allocated specific workers to each of their neighbourhoods. This aimed to minimise the number of workers patients saw. This helped staff plan care and visits, and build effective working relationships with patients. In the Chesterfield CRHT, wherever possible, staff ensured continuity and consistency by allocating the staff member involved in the initial assessment visit to the patient.
- The CRHT teams kept all patients' notes on the trust's electronic care records system. This made records consistent and easy to access, for example, staff accessed patients' records from different sites within the trust. Staff could view patients' records held by other services within the same trust. This helped staff check patients' needs and risks factors, and provide safe and consistent care.
- Staff ensured patients detained in health-based places of safety (HBPoS) received assessment as soon as possible after their admission. The police or ambulance staff contacted the bleep holder for the HBPoS in advance to tell them a patient was on their way. The bleep holder immediately arranged for the appropriate professionals to undertake an assessment of the patient, in line with the Mental Health Act. Generally, staff at both units reported few delays in accessing medical professionals and approved mental health practitioners. During our inspection, we observed one admission to the health-based place of safety at the Hartington Unit. Staff received the patient on arrival at the suite, undertook a handover with the police and ambulance staff, and completed the relevant paperwork.
- Staff detained patients for the shortest possible time and always less than 72 hours. We reviewed assessment records for four patients who had used the health-based place of safety at the Hartington Unit between January and March 2016. These showed durations of detentions of between four to five hours for three patients and a duration of nine hours for one patient. One patient, who was under 18 years old (17 years, six months), was detained for four hours. We reviewed records for six patients who had used the health-based place of safety at the Radbourne Unit in the past six months. These showed durations of detentions of four to 22 hours. At the Radbourne Unit, staff sometimes experienced delays in accessing inpatient beds for patients who required admission following assessment.
- We reviewed assessment records for ten patients who had used one of the health-based places of safety in the

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past six months. Staff had completed records appropriately with the exception of one record that showed contradictory outcomes for the patient; it was unclear whether the patient was discharged or admitted to hospital. We checked and found the patient was detained in hospital and the ward had the appropriate detention documentation. Ward staff agreed to check the inconsistency with the professionals involved.

Best practice in treatment and care

- The CRHT teams followed national institute for health and care excellence (NICE) guidance relevant to their practice, for example, guidance on prescribing, depression, psychosis and schizophrenia, service user experience in adult mental health, generalised anxiety disorder and panic disorder and borderline personality disorder.
- The CRHT teams adopted a psychosocial model of care that looked at a whole range of factors to help understand a patient's mental ill health. Following assessment, staff planned appropriate social, psychological and medical interventions for patients to address the full range of needs. For example, the Chesterfield CRHT team had a support worker dedicated to supporting patients with housing-related needs.
- The CRHT teams used health of the nation outcomes scales (HoNOS) to measure the health and social functioning of people with mental illness. Performance data from the Chesterfield and High Peak teams for May 2016 showed a 100% rate for completion of HoNOS. The CRHT teams also used the mental health clustering tool to assign patients to a care cluster following assessment. This was in line with Department of Health requirements, which aimed to classify patients with similar needs and inform the development of payment by results system for mental health services.
- The trust, managers and staff completed specific audits and reviews to help identify issues and make changes. Clinical staff participated in the audits, as appropriate, for example, a psychiatrist and senior nurse completed an audit on medicines reconciliation in the Chesterfield and High Peak and Dales teams. Some audits were underway but not yet completed, for example, audits on referral criteria and capacity to consent documentation. The CRHT teams had no formal audits of patients' records at team or service level. However, staff took the opportunity to identify any gaps or issues in patients'

records when they discussed cases at multidisciplinary meetings. At these meetings, staff projected the patient's electronic record onto a large screen, and added to notes as discussions took place. Managers also discussed any issues with care records in staff's supervision sessions.

- The teams worked in line with the Department of Health's mental health crisis care concordat 2014, which aimed to ensure people experiencing mental health crisis can get timely help when they need it. The concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It focuses on four main areas:
 - access to support before crisis point– making sure people with mental health problems can get help 24 hours a day, and are taken seriously
 - urgent and emergency access to crisis care– making sure that a mental health crisis is treated with the same urgency as a physical health emergency
 - quality of treatment and care when in crisis– making sure that people are treated with dignity and respect, in a therapeutic environment.
 - recovery and staying well– preventing future crises by making sure people are referred to appropriate services.
- In October 2014, the trust completed a thorough audit of section 136 practice, which resulted in recommendations for improvements. The audit highlighted issues such as lack of access to patients' records for non-trust staff, poor coordination of information gathered, and inconsistency in communicating outcomes of assessments to GPs. During 2015, the trust developed an action plan to address these issues, which was ongoing. Progress made included improvements in data collection and information sharing.

Skilled staff to deliver care

- All CRHT teams were multidisciplinary and comprised psychiatrists, social workers, nurses, support workers and administrative staff. The Derby City and County South team also had occupational therapists. The teams had an in-reach service, which linked with inpatient wards to support discharge planning.
- Staff had access to managerial and clinical supervision, and regular access to support in case conferences, reflective practice sessions, handovers and

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multidisciplinary team meetings. The trust's new supervision policy had introduced professional supervision. The trust's policy stated that staff should receive six hours of managerial supervision and up to 10-12 hours of clinical supervision each year. In 2015-16, the average rate for managerial supervision was 76% for the Chesterfield team, 89% for the High Peak team and 6% for the Derby City and County South team. The compliance rates for clinical supervision for each of the teams varied significantly. Chesterfield had a compliance rate of 74%, High Peak achieved 0% and Derby City and County South achieved 13%. Up-to-date data at the time of our inspection showed improvement in the managerial and clinical supervision rates for the Derby City and County South team. Compliance with managerial supervision was 20%, and for clinical supervision, 26%. The compliance rate for clinical supervision for the High Peak team had increased to 63%.

- Staff received appraisals but this was not consistent across the teams. At the time of our inspection, all staff in the High Peak team and 75% of staff in the Chesterfield team had received appraisals. The remaining staff had appraisal meetings scheduled. As of 31 January 2016, 50% of staff in the Derby City and County South team had received appraisals. Although this was low, the team managers had plans to address this as part of the ongoing improvements for the team.
- Staff were qualified for their roles, and had access to specialist training appropriate to their role. The Chesterfield and High Peak teams had staff trained to administer patient group directions (PGD). The team also had two nurse prescribers. Training for staff to administer PGDs and prescribe was underway in the Derby City and County South team. CRHT team staff also had the opportunity to develop special interests in areas related to their work, and become champions. This helped to promote improvements in practice through training and audits. For example, a support worker had become an expert in housing and welfare issues, a nurse had taken a lead in medicines management, and another nurse had started the green light toolkit for learning disabilities.

Multidisciplinary and inter-agency team work

- CRHT Teams held multidisciplinary meetings on a daily basis to discuss new referrals and assessments, and review risks and care plans. These meetings

incorporated detailed handovers. We observed three meetings in which the team discussed the risks, home treatment plan, and discharge plan for each patient. All members of the team contributed to the discussions, as appropriate.

- The teams had an in-reach service, which linked with inpatient wards to support discharge planning. The in-reach team offered early discharge where home treatment was appropriate.
- The CRHT teams held gate keeping responsibilities for all acute inpatient beds for adults at the Hartington Unit (Chesterfield), the Radbourne Unit (Derby) and the Stepping Hill hospital in Stockport (for Derbyshire patients only).
- The CRHT teams worked closely with other health care staff, for example, diabetes nurses, care co-ordinators and district nurses. The teams occasionally experienced challenges when trying to work with services provided by other trusts because of different access criteria or operating systems. For example, the Chesterfield and High Peak CRHT teams experienced difficulties accessing CAMHS and the High Peak team had different systems and processes to its local inpatient facility in Stockport.
- Although the CRHT teams had access to trust pharmacists, this was not sufficient for their needs. For example, the trust pharmacists visited CRHT teams to complete audits but were not available to undertake medicine reconciliation or contribute to multidisciplinary team meetings. The Derby City and County South team had recruited a pharmacist for their team. The other teams did not have the same facility although they had a senior nurse who took a lead on medicines management.
- The CRHT teams did not include psychologists, which the teams regarded as a huge gap in their services. As such, the teams had to refer patients to the trust's psychology services, which had lengthy waiting lists. Staff and patients complained about the delays in accessing psychological services.
- The trust participated in the multi-agency group with other organisations involved in the operation of section 136 of the Mental Health Act. These included the police, ambulance services and the local authority. Staff received communications and notifications from the group.

Are services effective?

Requires improvement 

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

- Staff received training in the Mental Health Act (MHA). As of May 2016, training compliance rates were 100% for the Chesterfield team and 87% for the Derby City and County South team. The compliance rate for the High Peak team was 71%, below the trust's target of 85%.
- Staff had a good understanding of the MHA. They knew when to consult other professionals such as approved mental health practitioners, and where to seek advice on the MHA, if they needed it.
- Records showed that medical staff completed capacity to consent or refuse treatment assessments appropriately. They completed the appropriate treatment certificates, and attached them to the patients' prescription charts.
- The CRHT teams undertook specific audits on MHA requirements relevant to their services, for example, capacity to consent to, or refuse treatment, assessments and documentation.
- We reviewed assessments records for 10 patients who had used the health-based places of safety in the six months prior to the inspection. Discussions with staff and the mental health act administrator, and sight of the section 136 admission checklist, suggested that staff routinely gave patients their rights. However, none of

the records noted that patients had received their rights under section 132 of the Mental Health Act. However, trust staff acknowledged the gap in recording this activity.

- Trust staff, on behalf of the section 136 multi-agency group, monitored HBPOS admissions to ensure that they applied the MHA correctly.

Good practice in applying the Mental Capacity Act

- Staff received training in the Deprivation of Liberty Safeguards. As of May 2016, training compliance rates were 100% for the Chesterfield team and 87% for the Derby City and County South team. The compliance rate for the High Peak team was 71%, below the trust's target of 85%.
- Staff had a good understanding of, and applied, the principles of the MCA, in particular, the presumption of capacity and its decision-specific application. They knew when to consult other professionals such as the responsible clinician, and where to seek advice on the MCA, if they needed it.
- Following an admission to the health-based place of safety under section 136 of the MHA, medical staff undertook capacity to consent or refuse treatment assessments as part of the assessment under the MHA.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with four former and current patients of the CRHT teams and three of their relatives. Patients and relatives were complimentary about the service, for example, patients from Chesterfield CRHT team said “staff are kind and helpful” and “the service has been excellent”. Patients described the CRHT service as a ‘safety net’ that helped them feel less alone. They said staff were always available when needed, and doctors and staff visited them in their homes. A patient who had used the service on a number of occasions described the care as prompt and consistent.
- We observed good patient and staff interactions for all CRHT teams. Staff listened and showed empathy to patients. Staff spoke about patients respectfully.
- Staff gave patients information about the services provided by the CRHT teams, including contact details, and encouraged patients to make contact when they felt unsafe or unwell.
- Staff understood the range of physical, psychological and social needs that contributed to a patient’s ill health. They gave patients information about other services that might be useful, for example, debt advice, domestic violence support groups, and provide appropriate support where available, for example, a support worker helped patients with housing issues.

- Staff tailored support to individual patients that helped their recovery. For example, one patient had lost her confidence in going swimming alone. Staff helped the patient take this up again by attending with her. In another case, staff supported a patient to attend church, which was important to their wellbeing.
- Staff allocated to the health-based places of safety responded to patients’ personal needs. For example, a female staff member stayed in work to support a vulnerable female patient. Where it was safe to do so, staff spent time with distressed patients to comfort and reassure them.

The involvement of people in the care they receive

- Patients said staff fully involved them in their assessments and care plans. They said they could discuss a wide range of issues affecting them such as housing issues, debt and family breakdown as well as physical and mental health.
- Staff involved relatives where patients had given their permission. They involved them in the patient’s recovery plan, kept them up-to-date with the patient’s progress, and offered advice and support, where required.
- Staff discussed the frequency and type of contact with patients as part of their home treatment plan.
- Patients had access to advocacy services provided by the trust. Each location had information leaflets and posters displayed in their reception 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

Access and discharge

- The CRHT teams operated 24-hours a day, and seven days a week and were commissioned to provide services to adults aged 18 to 64 years. The teams had no clinical exclusion criteria as long as the primary presenting issue was mental ill health.
- The teams aspired to assess urgent referrals within four hours and all other referrals within 24 hours unless agreed otherwise with the referrer and/or patient. The trust did not formally monitor referral to assessment times so it was difficult to confirm if the teams met these service expectations. The average duration of a home treatment episode was four to eight weeks for all CRHT teams.
- Staff visited patients in their own homes, which helped reduce cancellations and non-attendance by patients. Staff maintained frequent contact with patients in their care, and escalated any concerns, such as not being able to make contact, to their managers and other colleagues, as necessary.
- At the time of our inspection, the CRHT teams accepted referrals from professionals such as GPs and care coordinators, but did not accept self-referrals from patients. This meant new patients (including former patients and those receiving community mental health services) could not access CRHT services directly. The CRHT team leaders recognised this was an issue for patients and a gap in their services, and they were developing a proposal to change this.
- The CRHT teams experienced high access rates and an increase in demand from year to year. In the year 2015-16, the CRHTs received 3794 referrals. Following triage, the teams assessed 83% of these referrals. The overall referral to treatment rate was 52%, that is, 1967 patients received home treatment. Data showed that the number of referrals received by CRHTs from 2008 to 2015 had increased by 15%. Estimates based on forecasted activity to date for 2016 showed an increase of 26% since 2008. The trust included the actual and projected increase in activity in its review of the CRHT service specification and operational policy.
- The CRHT teams aimed to prevent unnecessary hospital admissions by offering home treatment. As such, the service acted as a gatekeeper to all hospital admissions, with the exception of detentions under the MHA. This meant that staff assessed all patients for CRHT services prior to any hospital admission. The teams achieved very high rates for assessing patients' suitability for home treatment, often exceeding their targets. For example, since 2013, the CRHT teams had consistently achieved 98% to 100%, above their target of 95%. The average number of patients assessed was 82 each month.
- The CRHT teams had responsibility for following up all patients discharged from inpatient wards who were not in the care of the community mental health teams. The in-reach team, which was a sub-team within the CRHT team, completed the follow-ups within two to seven days.
- All teams regularly received referrals for patients 65 years and over because there was no CRHT service commissioned for this age group. The CRHT teams redirected those referrals received during office hours to the older people's community teams. The CRHT teams reviewed referrals received out-of-hours and where appropriate, that is, where the presenting issue was a functional issue such as depression rather than organic mental health problem such as dementia, the teams supported the patient overnight and then referred them to the older people's teams the following day. During 2015-16, data showed that the CRHT teams supported 125 patients aged 65 years and over, and 21 patients under the age of 18 years. Referrals for young people under the age of 18 presented challenges to the High Peak and Chesterfield teams who struggled to refer these patients on to appropriate services in a timely manner. This was because in the north of the county, a different NHS trust provided the children and adolescent mental health services (CAMHS), for which there was specific access criteria. The Derby City and County South CRHT teams had good access to their local community CAMHS provided by their own trust.
- The High Peak and Chesterfield CRHTs worked closely with community mental health teams and reported no delays in referring and transferring patients to these services. This was not the case for the Derby City and County South CRHT team, which reported delays in transfers to community mental health teams of four to six months due to long waiting lists. There was a risk that the long waiting lists would have a detrimental impact on some patients' mental health so staff assessed each patient's risks to determine if they could discharge them safely. This meant that the CRHT team

Are services responsive to people's needs?

Good 

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

continued to support some patients to reduce the risks. Staff generally offered these patients weekly visits, which affected the team's throughput of patients by creating 'bottlenecks'. Furthermore, the Derby City and County South CRHT team reported receiving re-referrals from discharged patients who became ill again while waiting for services.

- We observed a discharge visit for a patient supported by the High Peak CRHT team and known to the community mental health team. Staff had arranged the discharge visit with the patient's care co-ordinator. The discharge meeting was positive and focused on the progress the patient had made. Staff discussed the detailed care plan and strategies for managing crises. Staff ensured that the patient and their relatives had the telephone numbers of the CRHT and community mental health teams.
- The health-based places of safety (HBPoS) were accessible 24 hours a day, seven days a week. Only patients detained under section 136 of the Mental Health Act accessed the health-based places of safety, brought by police or ambulance services. We reviewed admission data for each of the health-based places of safety for a five-year period from April 2011 to March 2015. This showed 599 admissions for the Radbourne Unit, and 597 admissions for the Hartington Unit. Each unit received an average of 119 admissions each year, which equated to an average of two to three admissions every week.
- The section 136 multi-agency group monitored HBPoS admissions and their appropriateness, which informed service planning and improvements. For example, an activity report for Derby City and Derby County local authority areas, for January to March 2016, showed that of those patients admitted to the health-based place of safety, only 27% of them needed hospital admission following assessment. Similar data for previous years had led to the section 136 multi-agency group to participate in pilot street triage schemes to assess the impact, if any, on section 136 admissions.
- Staff ensured assessments of patients detained in health-based places of safety began as soon as possible after their admission. The police or ambulance staff contacted the bleep holder in advance to tell them a

patient was on their way. The bleep holder contacted staff and the relevant professionals to prepare them for the patient's arrival. This helped ensure timely assessments and avoid delays for the patient.

- There was a lack of clarity from staff and managers about whether people under the age of 18 could use the health-based places of safety. The trust policy designated it for use by adults of 18 years and over, however, it allowed for contingencies assessed on a case-by-case basis. The multi-agency section 136 operational policy allowed use of the facility for young people under 18 years old where there was no specific local facility for this age group. In such cases, the policies made it clear, and staff knew, to request appropriate staff to assess and care for the patient, for example, CAMHS or paediatric services.
- Records showed that the health-based place of safety at the Hartington Unit had admitted a 17-year-old patient in the past but the Radbourne Unit referred young people to the nearby paediatric or child and adolescent mental health services (CAMHS) facilities.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff and doctors from the CRHT teams visited patients in their own homes. Staff worked flexibly and occasionally saw people in other venues, if needed. The in-reach team visited patients on hospital wards. Staff negotiated and agreed the type and frequency of visits and contact with their patients. They gave patients the names and contact details of their named workers. Staff introduced any new workers to the patient to help ensure continuity of care and relieve the patient's anxieties.
- Staff gave patients advice about other services they may benefit from, for example, housing, welfare rights, advocacy, debt advice, drug and alcohol groups, long-term conditions groups, and domestic violence support agencies.
- The patient area in the health-based place of safety at the Hartington Unit contained six weighted (strong, heavy and durable) chairs but nothing for patients to lie down on. However, staff could bring a mattress from a storeroom. Although most patients stayed only for short periods, they could stay for up to 72 hours.

Are services responsive to people's needs?

Good 

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

- In the HBPOS, staff ensured patients had access to snacks, meals and drinks, spare clothing, toiletries, and a telephone, as required.

Meeting the needs of all people who use the service

- Patient feedback and internal service reviews had identified continuity of care as a key issue for patients. The CRHT teams tried to ensure that patients received consistent and continuous service from the same small group of staff. Patients who received services from the Chesterfield and High Peak CRHT teams described them as consistent, while some patients described the Derby City and County South CRHT service as more responsive than it had been in the past.
- The CRHT teams worked with a diverse population of patients, including black and minority ethnic patients, transgender patients, Eastern European patients, and patients with physical disabilities. Staff assessed the individual needs of patients taking into account any special needs or circumstances, and planned care accordingly.
- The CRHT teams had access to language services commissioned by the trust. Interpreters were available for face-to-face and telephone interviews. The Chesterfield team gave an example of using an interpreter for a deaf patient. The High Peak team occasionally struggled to obtain face-to-face interpreting services in their area.
- Information was available in different languages, for example, medicine information leaflets.
- The trust's section 136 operational policy included transport arrangements for patients discharged home or conveyed to hospital. Some records showed that staff had arranged transport home for patients.
- Where possible, staff tried to meet the specific needs of the patient detained in the HBPOS, for example, ensuring the presence of a female worker for a vulnerable female patient.

Listening to and learning from concerns and complaints

- In the 12 months to 31 January 2016, the CRHT teams received eight complaints, seven of which related to the Derby City and County South team. The team received six of these complaints between February 2015 and May 2015. Most of these complaints were about the poor quality of care received, for example, one complaint was about the level of contact offered to a patient, four complaints were about the responses received from the team and another was about medication delivered to the wrong address. Five of the complaints were partially upheld. None were referred to the ombudsman. We reviewed a summary of the complaints and noted that the trust was open and honest about the difficulties the Derby City and County South team had faced.
- In the 12 months to 31 January 2016, the CRHT teams received 90 compliments mostly about the good care patients had received. The Derby City and County South team received 51 compliments, the Chesterfield team received 38 and the smaller High Peak and Dales team received one compliment.
- Patients and relatives knew how to complain about the service. There was information about making complaints and compliments displayed in the reception area of the Hartington Unit and the Radbourne Unit.
- Staff knew how to handle and report complaints and compliments. They logged them onto the trust's electronic system, and followed the trust's complaints policy for investigating and responding to complaints. Staff received feedback on the progress and outcomes of complaints from local managers and benefited from opportunities to discuss them in one-to-one and group meetings.

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

Vision and values

- Staff were aware of the trust's vision and values, and knew of some of the senior managers in the trust. However, staff felt detached from the trust on a day-to-day basis and preferred to focus on their own service. Although the team's objectives reflected some of the trust's objectives, for example, delivery quality care and investing in staff, the teams' main priority was on achieving the standards of the mental health crisis care concordat.
- Staff in the Derby City and County South CRHT team expressed disappointment with the management at trust level. Staff said senior managers had not listened to their concerns when their service was unsafe and in crisis. Although the team had since received support, some staff had lost trust and confidence in the trust.
- Staff were aware of future plans to develop ageless services, which involved integration with other community teams such as older people's mental health teams and community mental health teams. However, they expressed concerns and anxieties about business continuity and did not feel assured there were robust plans to ensure the delivery of safe and effective care during the transition period.

Good governance

- Governance systems and processes to help ensure effective practice were inconsistent across the teams. The Chesterfield and High Peak CRHT teams had good governance arrangements whereas the Derby City and County South team recognised theirs needed improvement.
- The CRHT service had good compliance with the trust's core mandatory training (91%). However, the average rate for role-specific training was 72%, with low compliance for essential courses such as medicines management and basic life support.
- Supervision and appraisal compliance was inconsistent across the teams. Supervision and appraisal rates were low for the Derby City and County South team.
- The trust, managers and staff completed specific audits and reviews to help identify issues and make changes, and clinical staff participated in the audits.

- Staff reported incidents appropriately and received feedback. The team shared and implemented any learning to prevent further incidents or improve practice.
- The CRHT services followed procedures in relation to the Mental Health Act and Mental Capacity Act. Staff identified and reported safeguarding issues internally but there were no safeguarding referrals made to the local authority by the Derby City and County South team.
- The trust only applied one key performance indicator to the CRHT teams, which related to the gatekeeping role of the service to assess patients for their suitability for home treatment, as an alternative to hospital admission. The trust did not routinely measure performance on key activities such as four-hour response times to referrals. However, the managers of the Chesterfield and High Peak CRHT teams regularly requested and received quality reports from the trust that showed a range of performance data that was readily available, for example, staff turnover, the number of assessments and treatments, supervision and training rates and the quality of patients' records. The managers used this data to assess the performance of their teams.
- Team managers had sufficient authority to lead their teams effectively although this was a relatively recent development for the Derby City and County South team. The Derby City and County South team received dedicated support from a nurse consultant who provided oversight and strategic direction to the team. The nurse consultant had good knowledge of the team's history and needs, having been instrumental in highlighting serious concerns in the past, and since then helping the team achieve stability. The nurse had direct access to senior managers to raise any issues that could affect safe care and treatment. The nurse worked closely with the team leaders to develop robust systems and processes and improve service delivery. This included ensuring all teams adopted a clinical leadership model that ensured designated managers and clinical leads had specific leadership responsibilities in the teams.
- Team leaders could submit items on to their team's electronic risk register, which linked to the trust's risk register. We saw examples of items that managers had added to the risk register, for example, lone working arrangements in the High Peak office.

Are services well-led?

Good 

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

- The trust was a signatory to an inter-agency policy entitled “Joint Policy for Derbyshire on the Operation of Section 136 of the Mental Health Act 1983 (As amended by section 44 of the Mental Health Act 2007) “Mentally disordered persons found in public places”. The policy was up-to date, and in line with the current Mental Health Act Code of Practice.

Leadership, morale and staff engagement

- Staff morale in the CRHT service varied between the teams. The Chesterfield and High Peak teams had good staff morale. Staff enjoyed their work, worked closely as a team, and felt they could contribute to service developments. The teams had low staff turnover and sickness absence rates. Staff felt comfortable raising concerns and knew how to use the whistleblowing process. Staff were open and transparent with patients when something went wrong and welcomed feedback from patients and relatives.
- Staff morale and team working in the Derby City and County South CRHT team had started to improve following a prolonged period of crisis in the team. The team had experienced staff turnover and sickness absence rates that were higher than the trust average. Staff had raised concerns about the service but had felt ignored. Staff remained fragile although the team had started to achieve stability under the new local leadership team. This comprised a relatively new manager, a recently recruited senior nurse, and dedicated support from a nurse consultant. The managers recognised that staff needed a lot of support and reassurance to develop their trust and confidence.
- In addition to mandatory and role-specific training, all CRHT team staff had opportunities for further training and leadership development. In particular, managers encouraged staff to become champions for specific areas of practice.
- All teams had attended team away days in May 2016, which focused on the review of the CRHT service specification and operational policy. This aimed to identify changes and improvements required to meet current and future needs and demands, including skill mix and therapeutic interventions.

- Staff supporting the health-based places of safety described good working relationship with the approved mental health practitioners. However, staff at the Radbourne Unit gave examples of difficulties they had in obtaining police support. The Hartington Unit staff described good relationships with the police saying they would stay if the patient appeared disturbed or aggressive.
- The trust’s staffing arrangements for the health-based places of safety placed additional pressure on staff. The trust recognised the need for dedicated staff for the health-based places of safety. It had requested funding from commissioners, without success.

Commitment to quality improvement and innovation

- The teams worked in line with the Department of Health’s mental health crisis care concordat 2014, which aimed to improve outcomes for people experiencing mental health crisis.
- The crisis resolution and home treatment service was undergoing a review of its service specification in the context of changes it had experienced since inception. This aimed to identify changes and improvements required to meet current and future needs and demands, including skill mix and therapeutic interventions.
- The Derby City and County South team had commenced a programme of service improvement at team level in order to improve its governance and effectiveness. This included addressing known shortfalls such as staff supervision, audits and recording. At service level, the CRHT leaders planned to adopt the new NICE guidelines for care planning, and introduce specific clinical and patient experience outcome measures for CRHT services.
- The section 136 multi-agency group, comprising, ambulance, police, health and social services supported pilot street triage schemes in the Derby City and Chesterfield areas. Their aim was to evaluate the impact on the number and appropriateness of section 136 admissions to the health-based places of safety.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- The health-based place of safety in the Hartington Unit had multiple ligature points and other sources of risks for patients.
- The health-based place of safety at Hartington Unit did not hold ligature cutters or emergency equipment.
- The health-based place of safety at the Hartington Unit contained blind spots.

This was a breach of regulation 12(2)(d)

- Medicine reconciliation and patients' allergy status was not completed on all prescription charts.
- Medicine reconciliation for patients using the service had either not been completed or completed using only the patient as its source.

This was a breach of regulation 12(1)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

- Care plans in the Derby City and County South team lacked detail and were not always up-to-date.

This was a breach of regulation 9(3)(a)

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing
· Staff did not receive one-to-one supervision on a regular basis.

· Not all staff had completed mandatory and role-specific training.

This was a breach of regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.