Requires improvement

North Essex Partnership University NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Trust Headquarters, Stapleford House,103
Stapleford Close,
Chelmsford, Essex, CM2 0QX
Tel:01245546400
Website: http://www.nep.nhs.uk/

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRDX1	The Lakes	Access, assessment and brief intervention team Health-based place of safety	CO4 5JY
RRDY3	The Linden Centre	Access, assessment and brief intervention team	CM17LF
RRDX6	The Derwent Centre	Access, assessment and brief intervention team	CM20 1QX
RRDY1	The St. Aubyn Centre	Health-based place of safety (CAMHS)	CO4 5HG
RRDI8	Shannon House	Health-based place of safety	CM20 1QX

Summary of findings

This report describes our judgement of the quality of care provided within this core service by North Essex Partnership University 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 North Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of North Essex Partnership University 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 gave an overall rating for mental health crisis services and health-based places of safety of **requires improvement** because:

- Environmental risks were identified in the three HBPoS used for adults. This included potential ligature points and limited ability to observe people who were detained under S136 of the MHA. Two people had absconded from the HBPoS in Colchester between 1 September 2013 and 31 August 2015 by jumping over the fence.
- Staff were relocated from the local acute ward when a person was brought into the HBPoS rather than having dedicated staff. The number of staff on the acute wards was only uplifted to reflect the needs of the HBPoS in Colchester.
- There were some delays in people being discharged from S136 due to a lack of awareness of the the doctor's ability to discharge the S136 following their assessment if no AMHP was available.
- Some staff we spoke with were mistaken about the point of time that a person was detained under S136. This could result in an incorrect calculation of the period of detention and time the S136 would expire
- The AMHP and doctor did not always attend within three hours as recommended in the MHA Code of Practice.
- People detained under S136 were usually transported to the HBPoS by police rather than by ambulance.
- Some information was missing in many of the S136 records we reviewed. This included physical health, whether the person had a learning disability, the person's language and the times the doctors or AMHPs were called or assessed the person. This meant it was difficult to audit that the MHA was being applied correctly.
- The trust's new policy on S136 did not reflect the requirements of the MHA Code of Practice in monitoring that the MHA was being applied correctly in relation to S136.
- There was no clear lead for the HBPoS in the St Aubyn Centre and the Christopher Unit in the Linden Centre.
- There was no clock visible from the assessment room to help avoid disorientation in time in any of the four HBPoS. There was no shower in the HBPoS in the St. Aubyn Centre.
- There was limited space to store medicines for the access, assessment and brief intervention teams in Colchester and Chelmsford.
- Learning from some serious incidents had not been shared across the three access, assessment and brief intervention teams.
- Target times for assessment were set for the access and brief intervention teams in Colchester and Chelmsford but not in Harlow.

However:

- The trust had set safe staffing levels and these were followed in practice in the access, assessment and brief intervention teams.
- Risk assessments were undertaken at initial assessment and updated regularly.
- Comprehensive holistic assessments and care plans were completed and reviewed in a timely manner. Interventions included support for housing, employment and benefits. People who used the service had access to a range of psychological therapies. People's physical health needs were considered and discussed at the point of assessment.
- Staff treated people who used the service with respect, listened to them and were compassionate.
- Proactive steps were taken to engage with people who find it difficult or are reluctant to engage with mental health services.
- The trust's innovative partnership with the Samaritans and the introduction of street triage had improved access to services for people with a mental health crisis.
- Staff generally had good morale.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Environmental risks were identified in the three HBPoS used for adults. This included potential ligature points and limited ability to observe people who were detained under S136 of the MHA. Two people has absconded from the HBPoS in Colchester in the period from 1 September 2013 to 31 August 2015 by jumping over the fence.
- None of the HBPoS had designated staff provided by the trust. Staff were relocated from the local acute ward when a person was brought into the HBPoS. The number of staff on the acute wards was only uplifted to reflect the needs of the HBPoS in Colchester.
- There was limited space to store medicines for the access, assessment and brief intervention teams in Colchester and Chelmsford.
- Learning from some serious incidents had not been shared across the three access, assessment and brief intervention teams.

However:

- The trust had set safe staffing levels for the access, assessment and brief intervention teams. These were followed in practice. Recruitment was in progress for vacancies. Cover arrangements for sickness, leave and vacant posts meant people who used the service could be kept safe.
- There was rapid access to a psychiatrist when required.
- Risk assessments were undertaken at initial assessment and updated regularly.
- Most staff had received and were up to date with appropriate mandatory training.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- The doctor's ability to discharge the S136 following their assessment if no AMHP was available or if there was a delay was not always understood. This meant there were some delays in people being discharged from S136.
- Some staff we spoke with were mistaken about the point of time that a person was detained under S136. This could result in an incorrect calculation of the period of detention and time the S136 would expire.

Summary of findings

- People detained under S136 were usually transported to the HBPoS by police rather than by ambulance.
- Some information was missing in many of the S136 records we reviewed. This included physical health, whether the person had a learning disability, the person's language and the times the doctors or AMHPs were called or assessed the person. This meant it was difficult to audit that the MHA was being applied correctly.
- The trust's new policy on S136 did not reflect the requirements of the MHA Code of Practice in monitoring that the MHA was being applied correctly in relation to S136.

However:

- Comprehensive holistic assessments and care plans were completed and reviewed in a timely manner.
- Interventions included support for housing, employment and benefits. People who used the service had access to a range of psychological therapies.
- People's physical health needs were considered and discussed at the point of assessment.
- Multi-disciplinary teams and inter-agency working were effective in supporting people who used the service.
- Staff were trained in and had a good understanding of the MHA and MCA.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- People were involved in their care and treatment and were aware of their care plans. Staff encouraged people to involve relatives and friends in care planning if they wished.
- Information was available for people who used the service on access to advocacy.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Urgent referrals were seen quickly by skilled professionals.
- Proactive steps were taken to engage with people who find it difficult or are reluctant to engage with mental health services.

Summary of findings

- People who used the service told us that appointments ran on time and they were kept informed if there were any unavoidable changes. They knew how to get help from mental health services in a crisis.
- The trust's innovative partnership with the Samaritans and the introduction of street triage had improved access to services for people with a mental health crisis.
- A good range of information was available for people in appropriate languages.
- People who used the service knew how to complain.

However:

- Target times for assessment were set for the access and brief intervention teams in Colchester and Chelmsford but not in Harlow.
- The AMHP and doctor did not always attend within three hours as recommended in the MHA Code of Practice.
- Due to an increase in referrals people in Colchester were not always seen within the four to six week target. Plans were in place to address this.
- There was no clock visible from the assessment room to help avoid disorientation in time in any of the four HBPoS. There was no shower in the HBPoS in the St. Aubyn Centre.

Are services well-led?

Good

We rated well led as **good** because:

- Staff were aware of the trust's values and vision.
- Teams were using the trust's star quality process to identify their strengths and areas for improvement and had made plans to address these.
- Good governance arrangements were in place locally which supported the quality, performance and risk management of the services. Key performance indicators were used to gauge performance.
- Team Managers had sufficient authority.
- There was effective team working and staff felt supported by this. Staff generally had good morale.

However:

- The services we visited were not participating in national quality improvement programmes but managers told us they planned to do so once the recent changes had been embedded.
- There was no clear lead for the HBPoS in the St Aubyn Centre and the Christopher Unit in the Linden Centre.

Summary of findings

Information about the service

The access, assessment and brief intervention teams provided a single point of access and assessment for all adults who presented with a mental health need that required a specialist mental health service. Their primary function was to undertake a comprehensive assessment of needs, whilst providing a range of short term treatment/therapies aimed at a quicker recovery for people who did not need long term care and treatment and as an alternative to hospital admission. The teams supported people being discharged from hospital. The teams were based at the Lakes in Colchester, the Linden Centre in Chelmsford and the Derwent centre in Harlow.

The access, assessment and brief intervention teams also provided an assessment service for people presenting with mental health needs in the accident and emergency departments of Colchester Hospital University NHS Foundation trust, Mid Essex Hospital Services NHS trust in Chelmsford and the Princess Alexandra Hospital NHS trust in Harlow.

A health based place of safety (HPBoS) is a place where someone who may be suffering from a mental health problem can be taken in order to be assessed. The HBPoS for adults were at the Harbour Suite at the Lakes in Colchester, the Christopher Unit at the Linden Centre in Chelmsford and Shannon House at the Derwent Centre in Harlow. A HBPoS specifically for young people under the age of 18 was based at the St. Aubyn Centre in Colchester.

Our inspection team

Our inspection team was led by:

Chair: Professor Moira Livingston

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Peter Johnson, Inspection Manager, mental health hospitals, CQC

The team that inspected the mental health crisis services and health-based places of safety consisted of CQC inspectors, two Mental Health Act reviewers, two nurses and a social worker all of whom had recent mental health service experience.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

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?

Summary of findings

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

During the inspection visit, the inspection team:

- Visited the access, assessment and brief intervention teams based at the Lakes, the Linden Centre and the Derwent Centre. We also visited the health based place of safety (HBPoS) at the Lakes, the Linden Centre and Shannon House and the CAMHS HBPoS at the St. Aubyn Centre.
- Spoke with 18 people who used the service and two carers of people who used the service.
- Spoke with 44 staff members; including doctors, nurses, support workers, social workers, psychologists, occupational therapists, pharmacists, managers and administrators.
- Spoke with representatives from the police and approved mental health professionals.
- Attended and observed three meetings of staff with people who used the service with the prior permission of those involved.
- Attended and observed five handover meetings.
- Looked at 49 care records of people who used the services.
- Looked at 23 prescription charts for people who used the services.
- Carried out a specific check of the medication management in the teams that we visited.
- Looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider's services say

People were positive about the support provided to them and praised the staff. They told us staff treated them with respect, listened to them and were compassionate. They said they were involved in their care and treatment and were aware of their care plans. Many felt their mental health had improved as a result of the service they received.

People told us that appointments ran on time and they were kept informed if there were any unavoidable changes. Some told us they saw different members of staff due to the nature of the service which meant they had to repeat information.

People knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them.

Good practice

The trust's innovative partnership with the Samaritans provided telephone support for people in emotional distress or experiencing feelings of suicide. Staff were able to refer people who used the service, carers and staff members to the Samaritans who committed to respond within a maximum of 48hrs at times of the referred person's choosing. Information from the trust showed that the Samaritans had successfully contacted 74% of the service users referred to them. The training component of the partnership aimed to develop the capacity of non-clinical staff, such as consultant secretaries and reception staff, to respond to people who they may encounter in emotional distress and improve their abilities to manage the situation safely whilst arranging assistance. Six training sessions had been delivered by the time of our inspection.

The introduction of street triage had improved access to assessments for people who come to the attention of the police and may have mental health needs. Two vehicles operated in the north of Essex and two vehicles in the south of the county staffed by police officers and mental health professionals. Information from the trust showed

Summary of findings

that 33 detentions under S136 were prevented in the period April to June 2015 in the area covered by the trust. The people concerned were either supported in other ways by the trust or referred to other forms of support.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must address the identified safety concerns in the health-based places of safety.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that policies procedure and practice on the use of S136 adhere to the MHA Code of Practice.
- The trust should review its staffing arrangements for the health based place of safety to ensure sufficient staff are available promptly without impacting on other services.
- The trust should identify a lead for the HBPoS in the St Aubyn Centre and the Christopher Unit in the Linden Centre.
- The trust should ensure there is sufficient space to store medicines for the access, assessment and brief intervention teams in Colchester and Chelmsford.
- The trust should ensure learning from some serious incidents is shared across the three access, assessment and brief intervention teams.
- The trust should agree target times for assessment were set for all access and brief intervention teams.

North Essex Partnership University 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
Access, assessment and brief intervention team Health-based place of safety	The Lakes
Access, assessment and brief intervention team	The Linden Centre
Access, assessment and brief intervention team	The Derwent Centre
Health-based place of safety (CAMHS)	The St.Aubyn Centre
Health-based place of safety	Shannon House

Mental Health Act responsibilities

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

Staff received training in the application of the MHA. Information provided by the trust showed that 86% of staff in the access, assessment and brief intervention team in Colchester, 100% of staff in the team in Chelmsford and 91% of staff in the team in Harlow had received e-learning training on the MHA. Staff we spoke with were knowledgeable about the MHA and Code of Practice.

We found that the relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety in those records reviewed.

Detailed findings

There were some delays in people being discharged from S136 due to a lack of awareness of the the doctor's ability to discharge the S136 following their assessment if no AMHP was available.

Some staff we spoke with were mistaken about the point of time that a person was detained under S136. Some believed this was the time when the person was detained by the police in the community rather that the time they arrived at the place of safety. This could result in an incorrect calculation of the period of detention and time the S136 would expire.

The AMHP and doctor did not always attend within three hours as recommended in the MHA Code of Practice. No target times had been set.

People detained under S136 were given oral and written information about their rights and the process of assessment. People who used the service and AMHPs we spoke with told us that detained people were informed of their rights.

People had access to an independent mental health advocate (IMHA) in the access, assessment and brief intervention teams and in the HBPoS.

People detained under S136 were usually transported to the HBPoS by police rather than by ambulance.

Regular meetings took place between the trust, AMHP service and the police to review issues at an operational level. We saw effective inter-agency working in assessing and supporting those people detained under S136 at the HBPoS. Staff reported good working relationships with the police and with local AMHPs.

Some information was missing in many of the S136 records we reviewed. This included physical health, the person's language and the times the doctors or AMHPs were called or assessed the person. This meant it was difficult to audit that the MHA was being applied correctly.

The trust's new policy on S136 did not reflect the requirements of the MHA Code of Practice in monitoring that the MHA was being applied correctly in relation to S136.

Mental Capacity Act and Deprivation of Liberty Safeguards

Information provided by the trust showed that 96% of staff in the access, assessment and brief intervention team in Colchester, 100% of staff in the team in Chelmsford and 100% of staff in the team in Harlow had received training in applying the MCA. Staff we spoke with were aware of the MCA and the implications this had for their clinical and professional practice.

We looked at 49 care records and found capacity assessments were being completed appropriately.

Requires improvement

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

- Staff from the access, assessment and brief intervention teams had access to alarms in interview rooms. Staff said that there was a quick response should an alarm be used.
- Clinic rooms were available with the necessary equipment to carry out physical examinations. Equipment was well maintained.
- Environmental risks were identified in the three HBPoS used for adults.
- The Christopher Unit in Chelmsford contained potential ligature points from the toilet handle and taps in the ensuite of the HBPoS. Potential ligature risks were also identified from the handles on two exit doors. The mirror in the ensuite was breakable and the bin and towel dispenser moveable. There was graffiti on some walls. The environment limited the ability of staff to observe people who used the service. There was a blind spot along the wall with a small observation window in the door from the nursing office. There was no CCTV or observational mirrors. Staff told us people who used the service were never left alone but there was usually only one member of staff in the unit.
- The HBPoS in the Shannon Centre in Harlow had potential ligature points from the windows in the main room, handles on the toilet and sink in the ensuite. A blind area that was not covered by CCTV limited the ability of staff to observe people who used the service. A corner of the heating has a sharp 90 degree angle on which people could self-harm. Staff were aware of these risks and told us that where a risk of self-harm was identified two staff would be used to maintain the line of sight. A new HBPoS was being built and was due to open in May 2016.
- The Harbour suite in the Lakes in Colchester had potential ligature points from the door handles. Staff were aware of these risks and told us they had taken mitigating action to ensure people who used the service were observed at all times. Information from the trust showed that two people has absconded from the HBPoS between 1 September 2013 and 31 August 2015 by jumping over the fence.

Safe staffing

- The trust had carried out a review of staffing as part of the development of the access, assessment, and brief intervention teams through the "Journey" programme. This had set staffing levels in each locality. Recruitment for vacant posts was underway. Recruitment for social workers had proved difficult and each team had vacancies with plans in place to cover this work.
- Managers told us they were able to allocate additional staff if more staff were required for some shifts. Staff told us they could respond promptly to the needs of the people who used the service but some said that they needed more staff to meet high levels of demand.
- Cover arrangements for sickness, leave and vacant posts ensured patient safety. We reviewed the staff rotas for the weeks prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the trust as safe. Bank staff and overtime for existing staff in the teams were mainly used to cover any vacant shifts. A limited number of agency staff were used who were given an induction, written guidance and regular shifts so that they could get to know the service.
- Rapid access to a psychiatrist was available when required.
- Staff received mandatory training such as basic life support, fire safety and infection control. Information provided by the trust showed that 76% of staff in the access, assessment and brief intervention team in Colchester were up to date with all mandatory training. 88% of staff in the access, assessment and brief intervention team in Chelmsford were up to date with all mandatory training. 88% of staff in the access, assessment and brief intervention team in Harlow were up to date with all mandatory training.
- None of the HBPoS had designated staff provided by the trust. Staff working on the nearby acute wards covered

Requires improvement

Are services safe?

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

the HBPoS when the police brought a person into the HBPoS. The numbers of staff on the acute wards was only uplifted to reflect the needs of the HBPoS in Colchester.

Assessing and managing risk to patients and staff

- The 49 case records reviewed showed that staff had undertaken a risk assessment at the initial assessment and then reviewed and updated this when required. Care plans were in place to address the identified risks.
- Risk levels for people who used the service were discussed at handover meetings in order to detect any increases and take prompt action. Staff demonstrated a good understanding of the needs and assessed risks of people who used the service.
- Good personal safety protocols including lone working practice were used to reduce the risks to staff. Principles and practice guidance on worker safety including visits to people in their own home were given to staff. Some staff had recently been issued with skyguard electronic devices that were able to track their location and communicate remotely to gain assistance if needed. Plans were in place for all staff to be issued with such devices. Staff we spoke with were positive about the lone working practices which they felt increased their safety.
- Staff had received training in physical interventions to manage violent and challenging behaviour and were aware of de-escalation techniques.
- Staff had received training in safeguarding. We spoke with 44 staff and they knew how to recognise and report a safeguarding concern. The safeguarding lead had a weekly advice session with the access, assessment and brief intervention teams.
- There was limited space to store medicines for the access, assessment and brief intervention teams in Colchester and Chelmsford. Medicines were disposed of safely.
- Regular pharmacist visits took place in each access, assessment and brief intervention team to review medicine management practice.
- A recent printing error on the prescription charts could have caused confusion regarding medicines prescribed on a regular basis and those on an as required basis. The trust's lead pharmacist had sent out an email notifying staff of the error and remedy and newly amended prescription charts had been ordered. We found that the prescription charts used by the access, assessment and brief intervention teams in Chelmsford and Harlow contained this error and staff were not aware of this. We raised this with staff on the day of our visit.

Track record on safety

- Information provided by the trust showed there had been seven serious incidents in the period from 1 April 2014 and 31 March 2015 relating to the access, assessment and brief intervention teams. The findings from the reviews of these incidents had been used to improve safety. Examples included introducing seven day follow up for people completing brief intervention in Colchester and contacting carers of people who used the service in Chelmsford to assess any risks before discharge.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents and were able to describe what should be reported.
- We saw that service management meetings and team meetings were used to discuss feedback from incidents. Learning from some serious incidents had not been shared across the three access, assessment and brief intervention teams.
- Staff told us that they were de-briefed and supported after a serious incident.

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

- The needs of people who used the service were assessed and care was delivered in line with their individual care plans. We looked at 49 care records for people who used the service. We saw that care plans considered all aspects of the person's circumstances, were centred on them as an individual and were regularly reviewed. People we spoke with gave us examples of how their individual needs were met.
- All information needed to deliver care was recorded on an electronic record system that operated across the trust. All staff involved in a person's care could access the system. This meant that information needed to deliver care was readily available for appropriate staff.

Best practice in treatment and care

- Staff followed NICE guidance when prescribing medication and conducted regular audits to ensure this.
- People who used the services had access to a range of psychological therapies such as cognitive behaviour therapy and anxiety management.
- Our review of 49 records showed that people's physical health needs were considered and discussed at the point of assessment. Some specific care plans were put in place to ensure the person's physical health needs were met. We found good practice in the access, assessment and brief intervention team in Colchester where all people who used the service were referred to a track and trigger clinic run by nurses in the team to gain baseline and ongoing monitoring of physical health.
- Interventions included support for housing, employment and benefits and these issues were considered as part of the assessment and care plans.

Skilled staff to deliver care

- The access, assessment and brief intervention teams consisted of staff from a range of professional backgrounds including nursing, medical, occupational therapy, and psychology. There were social worker vacancies in each team.
- Staff were experienced and qualified. Specific training was available for staff although this was limited for staff working in the team in Harlow.
- New staff had a period of induction before being included in the staff numbers on a shift. This included attending a corporate induction and a period of shadowing experienced staff.
- Staff were regularly supervised. Staff we spoke with told us they had managerial supervision and had access to clinical supervision. All felt that there was good ad hoc supervision on a daily basis during the shift and in handover meetings.
- There were regular team meetings and staff told us they found these useful to reflect on practice and discuss any issues, concerns or good practice.

Multi-disciplinary and inter-agency team work

- Different professionals worked together to assess and plan people's care and treatment. Staff told us there was effective team working within the service. Care plans included advice and input from different professionals involved in people's care.
- We observed five handover meetings and found they were effective in sharing information about people and reviewing risks and progress in delivering their plan of care.
- We saw effective inter-agency working in assessing and supporting those people detained under S136 at the HBPoS. Staff reported good working relationships with the police and with local AMHPs.

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

- Staff received training in the application of the MHA. Information provided by the trust showed that 86% of staff in the access, assessment and brief intervention team in Colchester, 100% of staff in the team in Chelmsford and 91% of staff in the team in Harlow had received e-learning training on the MHA. Staff we spoke with were knowledgeable about the MHA and Code of Practice.
- We found that the relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety in those records reviewed.

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.

- The doctor's ability to discharge the S136 following their assessment if no AMHP was available or there was a delay was not always understood. This meant there were some delays in people being discharged from S136.
- Some staff we spoke with were mistaken about the point of time that a person was detained under S136 with some believing this was the time when the person was detained by the police in the community rather that the time they arrived at the place of safety. This could result in an incorrect calculation of the period of detention and time the S136 would expire.
- Information from the trust showed the AMHP and doctor did not always attend within three hours as recommended in the MHA Code of Practice. No target times had been set.
- People detained under S136 were given oral and written information about their rights and the process of assessment. People who used the service and AMHPs we spoke with told us that detained people were informed of their rights.
- People had access to an independent mental health advocate (IMHA) in the access, assessment and brief intervention teams and in the HBPoS.
- People detained under S136 were usually transported to the HBPoS by police rather than by ambulance.
- Regular meetings took place between the trust, AMHP service and the police to review issues at an operational level.
- Some information was missing in many of the S136 records we reviewed. This included physical health, whether the person had a learning disability, the person's language and the times the doctors or AMHPs were called or assessed the person. This meant it was difficult to audit that the MHA was being applied correctly.
- The trust's new policy on S136 did not reflect the requirements of the MHA Code of Practice in monitoring that the MHA was being applied correctly in relation to S136.

Good practice in applying the Mental Capacity Act

- Information provided by the trust showed that 96% of staff in the access, assessment and brief intervention team in Colchester, 100% of staff in the team in Chelmsford and 100% of staff in the team in Harlow had received in applying the MCA. Staff we spoke with were aware of the MCA and the implications this had for their clinical and professional practice.
- We looked at 49 care records and found capacity assessments were being completed appropriately.

Good

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 18 people who used the service and two carers of people who used the crisis service. All were very positive about how staff behaved towards them. People told us staff treated them with respect, listened to them and were compassionate.
- We attended and observed three visits by staff to people who used the service and observed telephone based assessments of people. Staff treated people who used the service with respect and communicated effectively with them. They showed the desire to provide high quality and responsive care.
- When staff discussed people who used the service in handover meetings or with us, they discussed them in a respectful manner and showed a good understanding of their individual needs. They were aware of the requirement to maintain confidentiality at all times.

The involvement of people in the care that they receive

- People who used the service told us they were involved in their care and treatment and were aware of their care plans. Many felt their mental health had improved as a result of the service they received. People
- Information was available for people who used the service on access to advocacy.

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

- Target times for assessment were set for the access and brief intervention teams in Colchester and Chelmsford but not in Harlow. Each team had agreed criteria for which people will be offered a service.
- Urgent referrals were seen quickly by skilled professionals in all the teams we visited. Non-urgent referrals were seen within an acceptable time although due to an increase in referrals people in Colchester were not always being seen within the four to six week target. Plans were in place to address this.
- Information from the trust indicated the proportion of admissions to acute wards gate kept by the crisis services fell below the England average in quarter two of 2014/15 where it remained throughout quarter three and quarter four of 2014/15.
- The trust had set targets for the times from referral to assessment for those people in the accident and emergency departments of the local acute hospitals. Targets were being met.
- We observed that people were given a degree of choice in the times of appointments on the first contact by the service following a referral.
- The access, assessment and brief intervention teams took a proactive approach to engaging with people who find it difficult or are reluctant to engage with mental health services. This included re-engaging with people who did not attend their appointments.
- We spoke with 18 people who used the service and two carers of people who used the service. People told us that appointments ran on time and they were kept informed if there were any unavoidable changes. Some told us they saw different members of staff due to the nature of the service which meant they had to repeat information.
- People we spoke with were aware of how to get help from mental health services in a crisis. The trust scored better than most trusts for people who knew who to contact out of office hours if they had a crisis in the 2014 CQC Community Mental Health Patient Experience Survey. Some people said they had not felt supported by the trust's out of hours phone line which is operated by another provider on behalf of the trust. Managers told us that options to improve the out of hours crisis response were being explored.
- A proactive approach had been taken to improve the discharge pathway from the service. Seven day follow up for people who were discharged from the service to primary care had been introduced in Colchester as a result of learning from a serious incident. Similarly one and two month follow up for people who were discharged from the service to primary care had been introduced in Chelmsford as a result of learning from a serious incident.
- The trust's innovative partnership with the Samaritans provided telephone support for people in emotional distress or experiencing feelings of suicide. Staff were able to refer people who used the service, carers and staff members to the Samaritans who committed to respond within a maximum of 48hrs at times of the referred person's choosing. Information from the trust showed Samaritans had successfully contacted 74% of the service users referred to them. The training component of the partnership aimed to develop the capacity of non-clinical staff, such as consultant secretaries and reception staff, to respond to people who they may encounter in emotional distress and improve their abilities to manage the situation safely whilst arranging assistance. Six training sessions had been delivered by the time of our inspection.
- The introduction of street triage had improved access to assessments for people who come to the attention of the police and may have mental health needs. Two vehicles operated in the north of Essex and two vehicles in the south of the county staffed by police officers and mental health professionals. Information from the trust showed that 33 detentions under S136 were prevented in the period April to June 2015 in the area covered by the trust. The people concerned were either supported in other ways by the trust or referred to other forms of support.

The facilities promote recovery, comfort, dignity and confidentiality

- The access, assessment and brief interventions teams had facilities to see people in their premises. Interview rooms did not have adequate sound proofing in Harlow.

Are services responsive to people's needs?

Good

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

- Information on local services and patients' rights were available in all services we visited including the HBPoS.
- There was no clock visible from the assessment room to help avoid disorientation in time in any of the four HBPoS. There was no shower in the HBPoS in the St. Aubyn Centre.

Meeting the needs of all people who use the service

- Adjustments were made for people requiring disabled access.
- Staff had access to translation services and interpreters to help assess and provide for the needs of people using the service. We saw that interpreters accompanied staff on visits where needed.
- Information leaflets were available in languages spoken by the people who used the service.

Listening to and learning from concerns and complaints

- Most people we spoke with said they had not seen information on how to complain but all knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them.
- Staff told us they tried to address people's concerns informally as they arose. Staff we spoke with were aware of the formal complaints process.

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 we spoke with were aware of the trust's values and vision. These were displayed in the services we visited.
- Teams were using the trust's star quality process to identify their strengths and areas for improvement and had made plans to address these. These were displayed in the services we visited.

Staff told us they had regular contact with their immediate managers and occasional contact with more senior managers.

Good governance

- Good governance arrangements were in place locally which supported the quality, performance and risk management of the services. However, the trust wide systems do not support wider learning across the trust.
- Key performance indicators and other indicators were used to gauge the performance of access, assessment and brief intervention teams.
- Managers told us that they had enough time and autonomy to manage the service. They also said that, where they had concerns, they could raise them.
- Staff confirmed they could submit items to the risk register. There were local risk registers in place.
- Clinical and managerial supervision was taking place. Many staff were in newly formed teams as a result of the journey programme. This meant that some staff had not had a recent appraisal as it had been felt more productive for this to take place when the member of staff was more settled into the team and its working practices.

Leadership, morale and staff engagement

- All staff we spoke with were very positive about team working and the mutual support they gave one another. They felt supported by their immediate managers who they said would get involved in daily clinical practice if needed.
- Staff we spoke with knew how to use the whistleblowing process.
- Staff generally had good morale but were adjusting to the significant organisational and clinical changes as a result of the journeys programme. It was felt that this took too long and that this undermined the programme outcomes and that this was taking time to embed.
- There was no clear lead for the HBPoS in the St Aubyn Centre and the Christopher Unit in the Linden Centre.

Commitment to quality improvement and innovation

- The services we visited were not participating in national quality improvement programmes but managers told us they planned to do so once the recent changes had been embedded.

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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safety and suitability of premises** The trust did not protect patients from the risks associated with unsafe or unsuitable premises by means of suitable design and layout. • Environmental risks were identified in the three HBPoS used for adults. This included potential ligature points and limited ability to observe people who were detained under S136 of the MHA. Two people had absconded from the HBPoS in Colchester in the period between 1 September 2013 and 31 August 2015 by jumping over the fence. This was in breach of regulations 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.