Good

Humber NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Willerby Hill
Beverley Road
Willerby
HU10 6ED
Tel: 01482 301700
Website: www.humber.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)
RV936	Willerby Hill	East Riding Crisis Resolution and Home Treatment Team	HU10 6ED
RV945	Miranda House	Hull Crisis Resolution and Home Treatment Team and health-based place of safety	HU3 2RT

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- The service had effective systems to assess, monitor, and manage risks to people who used services.
- Staff supported people who used services with their recovery with care plans that focused on the person's needs.
- There was good multi-disciplinary and inter-agency working in the crisis teams and the health-based place of safety.
- Staff provided kind and compassionate care and treated people who used services with dignity and respect.
- Staff supported people who used services and their carers. Family members were involved in the person's care where appropriate and according to the person's wishes.
- There was a clear pathway for people to access services including those people who referred themselves to the crisis teams.
- There were a low number of complaints from people who used the crisis teams and health-based place of safety.
- Staff were committed to providing good quality care in line with the trust's vision and values.

However:

- The health-based place of safety was not fit for purpose. There was a lack of provision to adequately maintain people's privacy, dignity, and confidentiality. There were apparent risks, which meant that the health-based place of safety compromised the safety of people who were detained under Section 136 and staff.
- There were gaps in staffing which meant appointments for people who used the crisis teams were sometimes cancelled or re-arranged. Assessments for people detained under Section 136 at the health-based place of safety were sometimes delayed.
- Mandatory training and appraisal compliance was low overall across the crisis teams and health-based place of safety and did not meet the trust's mandatory training targets.
- The service used paper and electronic systems of care recording, which meant comprehensive information relating to people who used services was not easily accessible.
- The systems to provide feedback to staff following incidents and audit activity in the crisis teams and health-based place of safety were not robust.

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 Miranda House was not fit for purpose and did not meet the Mental Health Act 1983 revised code of practice and guidance from the Royal College of Psychiatry on Section 136 standards. The environment did not maintain people's privacy, dignity, and confidentiality. There were risks, which meant that the health-based place of safety compromised the safety of people detained under Section 136 and staff.
- Mandatory training compliance was low overall across the crisis teams and health-based place of safety and did not meet the trust's mandatory training target. This included training in safeguarding adults and children.
- Notes were not easily accessible, which may impact on staffs' knowledge of risk, particularly for new or temporary staff.
- There were gaps in staffing, which meant that appointments with patients were sometimes cancelled or re-arranged.
- Training compliance was low for adult and children safeguarding.
- Staff were not able to tell us about how lessons learnt from serious incidents were shared with them, and we could not find clear discussions about this in staff meetings.
- The systems to provide feedback to staff following incidents in the crisis teams and health-based place of safety were not robust.

However:

- The service had effective systems to assess, monitor, and manage risks to people who used services.
- Staff were aware of their duty of candour and were open and transparent when things went wrong.
- Staff had a good knowledge of the risk each patient presented and this was discussed and updated at the daily handover meeting.
- Staff recognised safeguarding concerns and made appropriate safeguarding referrals.

Requires improvement

Summary of findings

- Staff new how to report incidents and used a datix system. Managers appointed a psychologist to support the teams with reflective practice and develop formulations for patients with complex needs following the findings from a serious incident.

Are services effective?

Good

We rated effective as good because:

- Staff supported people who used services with their recovery with care plans that were centred on the person's needs.
- There was good multi-disciplinary and inter-agency working in the crisis teams and the health-based place of safety.
- Staff in the crisis teams were skilled and offered people who used services psychological therapies and physical health care interventions that took account of National Institute for Health and Care Excellence guidelines and best practice.
- There was a range of staff in the crisis teams, which included medical, nursing, psychology, Approved Mental Health Professionals social workers, support, and administrative staff. There was active recruitment for the vacant occupational therapy post.
- Staff used a range of recognised tools to inform their clinical judgements and measure the outcomes of people using the service.
- The crisis teams had established good working relationships with other services such as in-patient wards, community mental health teams, general practitioners and the police.
- There were shared care protocols in place with the general practitioners to support people's physical health care needs and medication management.

However;

- There were multiple systems of care recording using both paper and electronic records. Comprehensive information relating to people detained under Section 136 at the health-based place of safety was not easily accessible.
- Appraisal rates for staff in the crisis teams and health-based place of safety were low and clinical supervision was not fully embedded in the teams.
- Staff had a good understanding of the Mental Capacity Act. However, staff did not record mental capacity assessments sufficiently in patient files.

Are services caring?

Good

We rated caring as good because:

Summary of findings

- Staff provided kind and compassionate care and treated people who used services with dignity and respect.
- Staff supported people who used services and their carers. Family members were involved in the person's care where appropriate and according to the person's wishes.
- We received positive feedback from the people who used services and their carers.

Are services responsive to people's needs?

Good

we rated responsive as good because:

- There was a clear pathway for people to access services including those people who referred themselves to the crisis team. Staff assessed people who used services within agreed targets.
- Staff offered appointments to people who used services to suit their needs and staff took active steps to engage with people who found it difficult or were reluctant to engage with services.
- There were a low number of complaints from people who used the crisis team and health-based place of safety. Staff were aware of their duty of candour and were open and transparent when things went wrong.

Are services well-led?

Good

We rated well led as good because:

- Staff were committed to providing good quality care in line with the trust's vision and values.
- Managers provided good leadership and were aware of the issues concerning the crisis teams and health-based place of safety and taking action to address these.
- Staff morale had improved. There was some uncertainty amongst staff about plans to transform the service.However, staff were positive towards changes that made improvements for people who used the services.
- The manager was actively recruiting to all vacant posts in the crisis teams and staff had been recently appointment to senior roles in the teams.
- The manager used key performance indicators to gauge the performance of the teams and used this information to inform staff where performance was good and where improvements needed to be made.
- The crisis teams were accredited with the Royal College of Psychiatrists' home treatment accreditation standards.

Summary of findings

- The senior manager attended regular care group meetings such as the monthly risk meeting, performance meeting, and quality assurance meeting and communicated information to the team manager.

Summary of findings

Information about the service

The crisis service provided short-term work to support patients at home when in a mental health crisis. They provided care and treatment at home to prevent hospital admission and supported patients with an earlier discharge from hospital.

The crisis service provided by Humber NHS Foundation Trust comprises two crisis resolution and home treatment teams for adults of working age across the East Riding of Yorkshire and Hull. The East Riding operated a satellite base at Bridlington and worked from 08.00am until 8.00pm The team based at Hull operated 24 hours per day, seven days per week and covered the East Riding area after 8.00pm until 08.00am. The trust has one health-based place of safety at Hull.

The trust operated one health-based place of safety at Miranda House This is a place where people are arrested under Section 136 of the Mental Health Act. Police have the powers to detain people under this act and bring them to the 136 suite to have their mental health assessed in a safe environment.

Section 136 of the Mental Health Act sets out the rules for the police to arrest a person in a public place where they appear to be suffering from mental disorder and are in immediate need of care or control in the interests of that person or to protect other people. The arrest enables the police to remove the person to a place of safety to receive an assessment by mental health professionals. This would usually be a health- based place of safety unless there are clear risks, for example, risks of violence that would require the person being taken to a police cell instead. The health- based place of safety offers a 24 hour, seven day a week service, and is open 365 days per year.

Humber NHS Foundation Trust has been inspected nine times since registration. The CQC last inspected Humber's mental health crisis services in May 2014. This inspection did not give any ratings and there were no actions the teams needed to take.

Our inspection team

The team was led by:

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission.

Team Leader: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission.

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team that inspected the mental health crisis services and health-based place of safety comprised one CQC inspector, a CQC Mental Health Act reviewer, and two nurse specialist advisors.

Why we carried out this inspection

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

Summary of findings

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, we reviewed information that we held about Humber mental health crisis services and health–based place of safety and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the two mental health crisis services teams and the one health–based place of safety
- spoke with five patients or carers who used the service
- spoke with 16 staff members from a range of disciplines and roles, including the service manager and team manager, medical staff, nurses and students, psychology, social workers and approved mental health practitioners, administrative and support staff
- reviewed 10 care records and pathway tracked two care records
- accompanied staff on two home visits observing how they provided care and treatment to patients
- attended and observed two hand-over meetings

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

During the inspection, people who use services had the opportunity to comment on the services they received on comment cards. We received seven completed comment cards from people who were receiving support or had received support from the crisis team based at Hull.

We spoke with five people who had used or were currently using the crisis services. We also looked at the patient satisfaction survey provided by the trust and reviewed comments received via the Care Quality Commission website. Overall, we found people who use services were happy with the service they received and many people complimented the teams on their helpful manner. We received two comments from people who had found it difficult to access the service initially but were very pleased with the teams support once they were accepted by the service.

We were able to observe staff on the telephone and in the community and we heard and saw very positive interactions with people who use services both on the telephone and during home visits.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that the health-based place of safety at Miranda House is fit for purpose.

Action the provider SHOULD take to improve

The trust should ensure that sufficient staff are available in the crisis teams and health based place of safety to minimise the impact of delays for people who use services.

The trust should ensure that all information relating to patients' care with the crisis teams and health-based place of safety is comprehensive, accessible, and readily available.

The trust should ensure the key to the medicine cupboard at East Riding crisis team is kept securely.

The trust should ensure that all staff based in the crisis teams and health-based place of safety are compliant with mandatory training and appraisals.

Summary of findings

The trust should ensure that all staff in the crisis teams and health-based place of safety receive feedback from incidents and there is shared learning when things go wrong.

The trust should ensure that the crisis teams and health-based place of safety have a robust audit process in place.

Humber 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
East Riding Crisis Resolution and Home Treatment Team	Willerby Hill
Hull Crisis Resolution and Home Treatment Team and health-based place of safety	Miranda 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.

The trust had a Mental Health Act administration office that gathered information about the use of the Mental Health Act and conducted audits. However, we could not find any evidence of audits relating to the use of Section 136 at the health-based place of safety.

Training in the Mental Health Act was not mandatory and it was difficult to establish what training staff had completed. The staff that we interviewed had a good understanding of the Mental Health Act and the guiding principles and knew where to seek additional advice.

Staff read and explained the rights under the Mental Health Act to people who were detained in the health-based place of safety. However, the service did not display this information on the premises.

The crisis teams staff had clear and accessible information about Section 17 leave requirements for people they supported in the community. The teams were not supporting anyone on a community treatment order at the time of our inspection.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a low percentage of staff across the crisis teams and the health-based place of safety that had completed the Mental Capacity Act training. This was a mandatory requirement and the trust reported overall compliance was 39%, which was below their target of 75%. The manager monitored compliance in the crisis teams via monthly performance reports. We reviewed figures between April 2015 and February 2016 and saw that compliance had not reached above 9%.

Despite this, staff were aware of the trust policy for the Mental Capacity Act and demonstrated an understanding of the assessment of mental capacity. Staff discussed a person's capacity to make decisions at the crisis team meetings and sought additional advice from experts within the teams and the trust.

Staff supported patients to make decisions about their care and treatment and assumed patients had capacity unless staff had concerns. However, documentation about how staff made decisions about capacity was poor. We reviewed nine patient care records and saw four had documented evidence of informed consent.

Staff ensured that people who used services were treated with the least restrictive interventions as possible.

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

Crisis Resolution and Home Treatment Team East Riding

Crisis Resolution and Home Treatment Team Hull

Safe and clean environment

The crisis teams generally visited people who used services in their own homes or local clinics for assessment and treatment. Where there were concerns about risks, staff arranged to visit in pairs or arranged visits in safer environments such as interview rooms at the local GP surgeries.

The crisis team based at East Riding did not have the facilities to see patients at the team base whereas the crisis team based at Hull had access to interview rooms at Miranda House. These rooms were all fitted with call bells and meant staff could raise the alarm if they felt unsafe or there was an incident and staff would respond.

Safe staffing

There were gaps in staffing which meant staff sometimes cancelled or re-arranged appointments for people who used the service. The crisis teams acted as gatekeepers that meant all requests for admissions to the adult in-patient wards were directed to the crisis teams first. This ensured that people were treated with the least restrictive practice depending on their clinical need. Figures reported by the trust showed that crisis teams consistently met the trust gatekeeping targets.

Nurses made up the majority of the teams, however there were other disciplines such as support workers, social workers, Approved Mental Health Practitioners, and a psychologist. Nurse vacancies varied across the teams between 01 March 2015 and 29 February 2016. The trust reported the team at East Riding had15% overall vacancies, which was higher than the trust average of 8.7% for vacancies. However, the team at Hull was reported as over established for health care support workers and had -12% overall vacancies. The manager recently appointed staff to vacant band 7 posts across both teams and active recruitment was ongoing for band 6 nurses and a vacant occupational therapist post.

The nursing staff worked 12-hour shifts and the crisis team based at Hull was in operation 24 hours a day, seven days a week. The crisis team based at East Riding operated seven days per week from 07.45am until 8.30pm and handed over the operation of the service to the Hull team outside of these hours.

The manager used an electronic staffing tool called e-roster to plan the number of staff on duty. Where there were identified gaps in staffing, regular staff worked additional hours or bank staff were called on. Bank staff were staff who were familiar with the service and agency staff were rarely used. The trust reported that between 01 March 2015 and 29 February 2016, 50 shifts were filled with bank or agency staff and 42 shifts not filled at East Riding crisis team. At Hull crisis team 97 shifts were filled with bank or agency staff and 17 shifts were not filled in the same period. The manager reported unfilled shifts occurred when all options for getting additional staff were exhausted. We did not find any significant impact on patient safety. We saw that staff considered patient safety and planned their work in advance through daily team meetings and re-prioritised their work throughout the shift.

Staff did not have individual caseloads and managed the needs of the people who used services as a team. This was the most effective way to ensure staff met key performance targets such as assessing people within four hours of referral. Both teams held daily handover meetings. Staff discussed the team caseload according to the level of risk and reviewed the workload for the shift as people's needs changed.

The trust reported sickness levels for Hull crisis team as 5.8%, which was slightly above the trust and national target of around 5%. The East Riding team sickness levels were low and reported as 2.6%. The manager used the trust policy to support staff to return work.

The teams each had good access to a psychiatrist although the psychiatrists also covered the in-patient services. They worked in a flexible way to meet the needs of both the in patients and the people who used services in the crisis teams. Medical staff attended daily handover meetings where possible or staff contacted them by e-mail or telephone. Appointments could be made on the same day or within the same week and doctors saw people in their

own home or at clinics. During the evenings and weekends, the crisis teams had a duty doctor on call. The response times for on call doctors was not monitored however staff felt arrangements for medical cover in the teams was sufficient and provided continuity of care when people were admitted to the in-patient wards.

We reviewed the mandatory training performance report for February 2016 across both teams The mandatory training compliance across both teams was lower than the trust target of 75%. Hull crisis team reported the lowest overall compliance at 59.9%. East Riding team had a higher compliance at 74.7% .Hull crisis team were non-compliant with 11 out of 13 training courses which included fire training, health and safety, infection control, moving and handling, adult and children safeguarding, information governance, PREVENT, control of substances hazardous to health, equality and diversity and mental capacity act training. East Riding team were non-compliant with six training courses which included safeguarding adults, information governance, PREVENT, Equality and Diversity, managing conflict and the Mental Capacity Act.

Assessing and managing risk to patients and staff

Staff worked in accordance with the trust clinical management policy and used a recognised risk assessment tool called the Galatean Risk and Safety Tool. This was an evidence- based tool used alongside clinical judgment to help staff make decisions about risks. Staff completed the tool on paper at every initial assessment and when risks changed. Staff also transferred this information on the electronic record, which meant that all staff had access to the most recent risk assessment.

We reviewed 10 care records during our inspection from across both teams and found completed risk assessments present in all 10 records. The risk assessment appeared to reflect the risk identified at the initial assessment in most cases. However, four (40%) of the risk assessments had not been updated. The risk assessment document was held as a separate document from the initial assessment document on the electronic recording system, which meant staff needed access to both documents to gain a clear understanding of the person's risks.

Where staff had not updated the risk assessments on the template, we found that everyone had an updated evaluation sheet/care plan/communication sheet. This was a paper document that staff used to communicate their care and any risks and management plans. We saw staff refer to these records during their daily handover meetings. Staff used this information in conjunction with the electronic record and the medical notes to ensure they were always up to date with risks and management plans.

We observed two daily handover meetings where staff discussed people who used services according to their risks based on a red, amber, and green traffic light system. Staff discussed people in the red category who were identified as the highest risk, daily and updated the paper record during the meeting. Staff discussed people in the amber and green zones less frequently and staff altered patients' zones according to any changes in risk. The shift co-ordinators ensured that staff discussed all people in the red zone and updated the visual control board throughout the meeting. The co-ordinators also kept a shift log of all activity during the day and when the East Riding team handed over to the Hull team, the shift co-ordinator faxed the completed log over. This meant that staff in the crisis teams had the most up to date information about people's risks and management plans available to them.

Although staff training compliance was overall low for adult and children safeguarding, we found staff recognised safeguarding concerns and knew how to make safeguarding referrals. For example, we heard staff discuss issues around self –neglect and parental behaviour that may affect children. Staff knew who the safeguarding leads were in the trust and their team and said they would refer to those people for advice if needed. We reviewed incident data that showed evidence that staff made appropriate safeguarding referrals.

Both crisis teams followed the trust lone worker policy and guidelines. Staff visited in pairs when there were concerns about risks such as visiting at night. Staff carried mobile phones and updated a board in the office with their intended whereabouts before they left on visits. The shift co-ordinators held a record of everyone's contact numbers and accounted for staffs' safety. Staff rang the shift co-ordinator and used a coded phrase when they needed additional assistance in the community, All staff we spoke with were aware of the agreed protocols.

Crisis teams had access to a secure medicines cupboard at each team base. Nurses occasionally used the cupboards to store patients' medication until it could be disposed of according to the trust policy. At Hull, staff kept the key to

the medicines cupboard securely with a coded keypad access. However, at East Riding staff kept the key in an unlocked drawer. This meant access to the medicines cupboard was not secure.

Track record on safety

The crisis teams had a combined number of four serious incidents between April 2015 and March 2016. Three of these incidents were categorised as death of a patient and one was categorised as a near miss.

Following an investigation of the most recent serious incident, the investigating manager had provided individual verbal feedback to staff who had been involved We reviewed team and business meetings from November 2015 until April 2016 and could not find clear evidence of where staff discussed serious incidents. However, we saw that practice had changed because of lessons learnt from serious incidents. For example, each team had carer leads to ensure families, and carers were included and supported during patient care. Managers appointed a psychologist to support the teams with reflective practice and develop formulations for patients with complex needs following the findings from a serious incident. Part of their role was also to contact staff individually following an incident to offer support.

Reporting incidents and learning from when things go wrong

The trust used the electronic incident reporting system called datix. All staff we spoke with understood what to report and knew how to report incidents using the datix system. We reviewed 76 incidents from 04 April 2015 until 25 March 2016 and saw that the majority of these incidents resulted in low or no harm. We received mixed feedback from staff about how they received feedback from incidents and most staff could not tell us about how they received feedback.

When we asked staff about their understanding of their duty of candour, staff knew of the trust policy and how to access it. Staff referred to the duty of candour as being open and honest with people when things go wrong. Staff did not receive specific training on the duty of candour but said this was included in their defensible documentation training. The datix system also prompted them to consider duty of candour. One member of staff was able to give an example of how they applied the duty of candour and described how they gave feedback to a former patient following an incident.

Health-Based Place of Safety Miranda House Hull

Safe and clean environment

The health-based place of safety operated 24 hours a day, seven days per week, and 365 days per year.

The health-based place of safety appeared clean and well maintained. However, there were environmental concerns that meant it did not meet the Mental Health Act 1983 revised code of practice and guidance from the Royal College of Psychiatry on Section 136 standards.

Arrangements for provision and laundering of bedding at Miranda House did not include the health-based place of safety. We observed there was a quilt and pillow without covers, which appeared dirty. This meant people could be at risk of infection.

There were potential ligature anchor points in the room. A ligature anchor point is a place where someone intent on self-harm might tie something to strangle themselves. There was a ligature risk assessment to identify the ligature risks and staff mitigated these risks by ensuring people were always under supervision. The toilet area contained the most ligature risks, which meant that staff could not support people safely without compromising their privacy and dignity. The number of ligature points present in the room meant that the health-based place of safety did not meet the needs of people who might be in crisis and was not safe.

There was no area or equipment for staff to carry out physical examinations, monitor people's physical health, or respond to emergencies. There was no telephone in the room. Staff had access to an alarm system that would alert other staff in the building to respond.

However, the health-based place of safety was situated on the ground floor and isolated from clinical staff, which meant there could be delays in accessing help in emergencies.

Staff told us that emergency services staff generally accessed the health-based place of safety through the door into the main reception area of Miranda House. This meant that staff compromised people's privacy and dignity, as they had to pass through a public area to access the health-based place of safety. Staff opened the door with a key and the door opened outwards into the public area. This meant there were risks to people detained under Section 136, staff and the public in the event of any incidents. There was

another door to the health-based place of safety accessible from directly outside the reception area, which was rarely used and highly visible to other people accessing Miranda House.

The health-based place of safety had access to a toilet and washing facilities but no shower. There were no arrangements in place to provide toiletries or clothing if people needed to wash and change. There were no facilities to provide food and drinks, which meant staff sought refreshments from other areas in Miranda House and brought them to the person detained under Section 136.

The health-based place of safety was furnished with two, two seater sofas This meant there was not enough seating for everyone who might be in the room or anywhere for people to lie down. There was no separate room with facilities for professionals to make notes, use the telephone, or hold confidential conversations. This meant staff had to leave the health-based place of safety to find a suitable room.

We observed there was a lack of facilities such as air conditioning, adjustable lighting, or access to television or music in the health-based place of safety. We observed there were no blinds on the window and no visible clock.

Safe staffing

Staffing for the health-based place of safety was provided by qualified members of the Hull crisis team and two bank health care support workers who were available on a standby rota covering the 24 hour period. This meant there was no dedicated qualified staff to respond to the needs of the health-based place of safety. The crisis team had to review and prioritise their workload to ensure they were available for the health-based place of safety when required.

People who were detained under Section 136 were brought in by emergency services and crisis staff carried out a triage risk assessment with the police officers in attendance. Crisis staff had responsibility to contact the doctor and Approved Mental Health Practitioner to coordinate a Mental Health Act assessment. An Approved Mental Health Practitioner provided expertise in the Mental Health Act and Mental Capacity Act. The Section 136 pathway relied on the Police to contact the crisis team to give information and their expected arrival time at the Section 136 room. However, should this not happen this might lead to delays for people who were detained under Section 136. The Mental Health Act allows people to be detained in a health-based place of safety for up to 72 hours. We reviewed records detailing wait times from April 2015 until March 2016 and saw that no one waited in excess of this time.

The Hull crisis team had an Approved Mental Health Practitioner working in the team and staff referred to an Approved Mental Health Practitioner rota when required. Generally, response times were good. However, Approved Mental Health Practitioners were not always available to respond to requests for Mental Health Act assessments. There were identified gaps in their working arrangements between 5.00pm and 7.30pm. Staff raised four datix incidents between April 2015 and March 2016 concerning the unavailability of Approved Mental Health Practitioners, which included one period of over 24 hours. We reviewed one record of a patient detained in the health-based place of safety at 04.30am. Staff documented the Approved Mental Health Practitioners was not available until after 08.30am and the assessment was arranged for 10.45am. This meant that people waited in the health-based place of safety until an Approved Mental Health Practitioner was available.

The team did not have an identified police liaison officer. This mental health professional works alongside emergency services supporting people in a mental health crisis to avoid Section 136 admissions. This initiative is called street triage and was not commissioned for Humber.

Assessing and managing risk to patients and staff

There was no closed circuit television coverage of the health-based place of safety which meant that the safety and security of people detained under Section 136 and staff could not be monitored at all times. Staff had access to an alarm system that would alert other staff in the building to respond. The health-based place of safety was situated on the ground floor, which meant it was isolated from the upstairs areas where clinical staff were based in Miranda House. This meant staff were potentially at risk of harm.

Staff were always available to observe people detained under Section 136 to ensure they were never left alone in the room. Nurses from the crisis team always attended to undertake a risk assessment with the Police and

Requires improvement

Are services safe?

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

considered risks to the patient and the public. Where staff assessed people detained under Section 136 as high or medium risk the police remained with the person detained under Section 136 at the health-based place of safety.

Track record on safety

There were no serious incidents relating to the health-based place of safety in the past 12 months reported by the trust.

The trust had signed up to the crisis care concordat and submitted an action plan. A joint agency protocol for the implementation of Section 136 of the Mental Health Act 1983 (2007) had been amended in July 2015 to include the new Mental Health Act code of practice. This is a nationwide scheme, which provides a multi-disciplinary approach to improve the system of care and support so that people in crisis are kept safe and helped to find the support they need.

Reporting incidents and learning from when things go wrong

The Hull crisis team staffed the health-based place of safety and the same protocols for reporting incidents were used. Staff were aware that their duty of candour applied to all areas of their work.

There were five incidents reported in relation to the health-based place of safety from April 2015 – March 2016. All incidents were categorised as low harm and related to staffing level shortages.

Are services effective?

Good

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

Our findings

Crisis Resolution and Home Treatment Team East Riding

Crisis Resolution and Home Treatment Team Hull

Assessment of needs and planning of care

We reviewed ten care records of people receiving care from both crisis teams. Records were held on the trust's secure electronic recording system called Lorenzo, which was accessible to all staff and on a paper based system held securely at the team bases. We found that 100% of the records we reviewed had a care plan present and 80% of these were up to date.

The crisis teams had several functions;

- gatekeeping for all adult mental health in-patient beds, which included assessing people detained under section 136 of the Mental Health Act
- bed management
- working with in-patient wards to assess and support early discharge plans
- assessing people in crisis and providing short-term interventions to support them
- triaging telephone calls from people in crisis and assessing for the most appropriate service. This could range from signposting people to other services or arranging a Mental Health Act assessment.

Staff completed timely assessments on a paper document. Staff developed appropriate crisis assessment and interim care plans with people who used services. Crisis plans contained information about how to access help and included referral to other services where appropriate. At East Riding, band five nurses carried out the initial assessments and then discussed the outcome with senior colleagues. Staff gave people who used services an information leaflet about the service and all people we spoke with were aware of their care plans and how to contact services.

Clinical or administrative staff entered the paper record of the assessment into the electronic system as soon as possible. We found that 100% of the records we reviewed had a care plan present and 80% of these were up to date. Staff managed people who used services as a team rather than by individual clinicians, which meant the patient saw different members of staff throughout their pathway. The information we found within the assessments had sufficient detail to inform staff about the needs of the people who used services.

Staff offered people who used services a duplicate copy of their interim care plan at the initial assessment. We found all care plans were personalised and focused on their individual strengths and goals with a recovery focus. However, the care plans we looked at did not contain information relating to physical health monitoring or needs. For example, in one initial assessment document staff had recorded that a patient was an insulin controlled diabetic but we could find no evidence that staff had considered this in the care plan or in the daily evaluation/ communication sheets.

Staff co-ordinated multiple systems of paper and electronic records to ensure that all information was readily available. We saw how effectively this worked during their handover meetings. The trust was working to introduce fully integrated electronic records to improve accessibility of records and reduce duplication of work for staff. Both teams had identified staff champions who were working with the trust on this project.

Best practice in treatment and care

Staff used National Institute for Health and Care Excellence guidelines in their practice. For example, staff supported the care programme approach by undertaking seven-day follow-up arrangements. This was good practice and ensured that people who use services were supported in the community following discharge from hospital. Staff integrated best practice into their risk assessments. We saw how staff accounted for historical risks and significant anniversary dates when considering current risks. Staff could use a range of other recognised tools to help inform their clinical judgement during assessment such as the hospital anxiety and depression scale and the beck depression inventory, which helps staff to understand the levels of anxiety and depression a person may be experiencing. Staff said they used the Liverpool university neuroleptic side effect rating scale that helps understand any side effects a patient might be feeling when they take certain medications for their mental health.

Crisis staff provided intensive short-term intervention for up to 72 hours. Beyond this, staff used the home treatment pathway to support people who used services. This meant

Are services effective?

Good

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

that staff provided regular interventions on an on-going basis to help keep people safe in the community. Staff used Interventions such as anxiety management, relapse prevention strategies, and medication concordance across both teams.

The teams had access to a psychologist who covered both the crisis teams and the in-patient wards. There was effective working between the psychologist and staff in the crisis teams. The psychologist was available to attend team meetings with both crisis teams and the wards. In the crisis teams, the psychologist worked with people with complex needs for up to four weeks to develop formulation plans. Crisis team staff worked with patients on the ward and the psychologist before discharge. This meant that staff provided a timely and consistent approach to patient care.

Staff considered the physical health care needs of people who used services and identified staff were trained to take blood if required and carry out physical health care checks. The teams had physical health care monitoring equipment such a weighing scales and blood pressure monitors. Staff at Miranda House had access to electro-encephalogram monitoring in the building or asked people to attend their GP. We did not see evidence of how staff documented physical health care in the patient care plans. Staff considered physical health care needs during the team meetings. For example, staff referred to supporting people to attend their GP surgery and hospital appointments. Staff identified that one person had not had any bloods taken for over one year and planned to arrange this with the person and their GP. Staff also held a detailed discussion about how environmental factors in the home were affecting a person's physical health and how best to ensure they received the support they needed.

Pharmacy staff were available for consultation about drug interactions and acted as a useful resource for staff. A pharmacist attended the team meeting at Hull. Staff who prescribed medication referred to the Maudsley guidelines, which are evidence-based prescribing guidelines. The guidelines include the necessary physical health checks to ensure staff prescribe medications in a safe and effective way.

Staff completed the mental health clustering tool for every patient and completed an electronic audit called survey monkey. Staff said they audited two care records per week. Managers completed caseload audits through individual supervision, which looked at both the quantity and the quality of the content of care records. They discussed any issues with the individual clinician and agreed actions to make improvements.

Skilled staff to deliver care

The majority of staff in the teams were band six and band five nurses who were all experienced at working in the crisis team. Three staff from within the teams had recently been recruited to vacant band seven posts in both teams which meant people would be supported by experienced higher grade nurses. There was one nurse prescriber based at East Riding. Other staff included social workers, approved mental health practitioners, and administrative staff. There was a vacant post for an occupational therapist to work across both teams to which the manager was actively recruiting. Teams had access to a psychologist and medical staff including consultant psychiatrists and a staff grade doctor. This meant that people who used services were supported by a range of mental health disciplines who provided input to the teams.

All new staff received a five day induction from the trust, which included mandatory classroom training. Staff had local induction at their team base, and managers signed off as completed within 20 days. The local induction included lone working arrangements, safeguarding procedures and confidentiality awareness.

Compliance with performance appraisal and development reviews across both teams was overall low. The manager monitored compliance with appraisal against a trust target of 85% via monthly performance reports. We reviewed the performance target for both teams and saw compliance had been steadily improving month by month. The Hull team had reached 73% and East Riding 48% compliance.

All staff had access to supervision and regular team meetings. We saw minutes of a range of meeting, which occurred between November 2015 and April 2016. We saw that representatives from all disciplines attended these meetings on a regular basis. The trust reported compliance with supervision in the Hull crisis team was 72% and 80% for the East Riding crisis team. We reviewed one supervision file and saw evidence of discussion around training and performance. The manager had a supervision matrix and log of supervisions completed. In the Hull team, the manager supervised 11 band six staff nurses, and band six nurses supervised band five nurses and support workers. The log showed not all staff received regular

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supervision and we were told this was a similar situation in East Riding. The manager planned to review the matrix when the new band seven nurses were in post in order to increase the frequency of supervision.

Managers supported staff to undertake specialist training for personal development and to enhance the skills within the teams. For example, some staff had training in systemic family work and three had completed training for people with dual diagnosis. The manager supported one member of staff to complete mentorship training and another to top up their nursing degree.

The psychologist facilitated a reflective practice group held for all staff to attend. The group was given protected time which meant it was always available. Staff recorded their attendance and discussions on the trust peer supervision form. The psychologist monitored attendance that averaged about five staff from a range of disciplines and bands. Staff described how they used the group to support a cognitive behavioural therapy approach when working with people who used services.

There were appropriate measures in place to manage poor staff performance. This was not a current issue for the teams but where it had been an issue this managers addressed and monitored performance.

Multi-disciplinary and inter-agency team work

There was good multi-disciplinary working in the crisis teams. Staff met daily to review people who used the service. The consultant psychiatrist and the psychologist attended these meetings on a regular basis and in Hull, the pharmacist sometimes attended. We observed two meetings where medical and nursing staff were present and found these meetings ran well. The process across both teams was consistent and staff discussed people according to a red, amber, and green traffic light system. The meetings were comprehensive and staff discussed issues such as physical health care, mental health assessments, risk management, medication management, and discharge plans. All staff in attendance at the meeting took an active part. Clinicians and administrative staff updated the information in a timely way.

There were effective working relationships between the crisis teams. Staff ensured that all relevant information was communicated across the teams and shared at the beginning and end of the shifts.

The crisis teams had established good working relationships with other services such as in-patient wards, community mental health teams, general practitioners and the police. Staff liaised with their colleagues and attended ward meetings to facilitate early discharge plans and support people in the community. Both crisis teams supported a number of in-patients or patients under the care of the community mental health teams with telephone calls and home visits. There were shared care protocols in place with the general practitioners to support people's physical health care needs and medication management. Staff referred people who used services to community services such as MIND, "Let's Talk", and the emotional wellbeing service to provide additional support with their mental health needs. Staff arranged joint visits with the police when there were concerns about risks.

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

People who used services had access to independent mental health advocacy services if required. These are people who are independent of mental health services and can help people who use services have their opinions heard and make sure they know their rights under the law. Staff were aware of how to refer to the advocacy services if required. However, both people who used services we spoke with said either they didn't know about or staff hadn't offered them information about advocacy services.

The crisis teams supported people who were on Community Treatment Orders This was granted to patients under the Mental Health Act to allow them to live in the community. The responsibility for Mental Health Act issues stayed with the care-co-ordinator in the community mental health teams and staff in the crisis teams said they were not currently supporting anyone on a Community Treatment Order. Where crisis staff supported patients subject to section 17 leave this information was visible and accessible for all staff to refer to.

Staff training about the Mental Health Act 1983 was not mandatory and it was difficult to establish what training staff had completed. Most staff said they had attended a half-day training session and had good knowledge of the Mental Health Act. Staff said they would seek additional advice from the trust Mental Health Act office and approved mental heath practitioners.

Crisis teams had approved mental health practitioners working in the teams. The commissioning arrangements

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across the teams differed as the approved mental health practitioners at Hull were employed by the trust and the approved mental health practitioners at East Riding remained employed by the local authority. The working arrangement meant that there were sometimes delays in accessing approved mental health practitioners for mental health act assessments particularly after 5.00pm or at weekends and bank holidays.

Good practice in applying the Mental Capacity Act

The trust had an up to date policy for the Mental Capacity Act and best interests. Training in the Mental Capacity Act was mandatory and the trust reported overall compliance as 39%, which was below the trust target of 75%. Managers monitored compliance across both teams via performance reports on a month-by-month basis. We reviewed figures between April 2015 and February 2016 and saw compliance was low across both teams. For example, Hull crisis team had not achieved more than 9% compliance and East Riding 10%. Managers acknowledged compliance was an issue and addressed this through individual supervision and appraisal and team meetings. We saw minutes of team meetings where staff discussed performance reports and the manager reminded staff to complete their mandatory training.

Staff appeared to have a good understanding of the Mental Capacity Act and knew where to seek additional support and advice if required. We saw staff carried prompt cards, which contained information about how to make capacity assessments. Staff completed a capacity prompt included on the mental health assessment form. We heard staff consider' capacity and consent during team discussions and were told medical staff documented capacity decisions in the medical files. We reviewed nine patient care records and saw four had documented evidence of informed consent however, none of the records showed evidence of how staff assessed mental capacity.

Health-based place of safety Miranda House Hull

Assessment of needs and planning of care

A band six nurse from the crisis team greeted the person detained under section 136 and the police on arrival. The band six nurses conducted a triage risk assessment to determine if the police needed to remain at the health-based place of safety. Staff from the crisis team co-ordinated calling the approved mental health practitioner and medical staff to conduct their assessments of the person detained under section 136.

Best practice in treatment and care

An ambulance brought people detained under Section 136 to the health-based place of safety wherever possible. People who were severely intoxicated or high risk could be taken into police custody and people who needed physical assessment were taken to Hull Royal Infirmary.

Skilled staff to deliver care

The health-based place of safety was situated at Miranda House and staff from the crisis team based at Miranda House managed the health-based place of safety when required. Additional bank health care support staff supported the health-based place of safety and bank staff underwent the same training as regular staff. The service manager had identified staff required additional training such as alcohol and drug related training to support people who may be under the influence of substances.

The consultant psychiatrist who covered the in-patient and the crisis services and the approved mental health practitioner in the team carried out mental health assessments jointly in the health based place of safety where possible.

Multi-disciplinary and inter-agency team work

The trust had signed up to the crisis care concordat and there was an up to date joint agency policy in place. This meant there were agreements in place for joint working protocols. The trust had an action plan in place and we saw evidence that staff represented the service at crisis care local action plan and operational meetings.

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

Staff had good working knowledge of the Mental Health Act and understood their responsibilities under Section 136. Staff read people detained under Section 136 at the health-based place of safety their rights and recorded the time and date this was done on the communication/registration form.

The trust had not completed any audits around staff compliance with this and we did not see any evidence that information about the Mental Health Act was readily available.

Are services effective?

Good

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

One of the guiding principles of the Mental Health Act is that staff should provide care and treatment in the least restrictive way possible. The crisis team, who also staffed the health -based place of safety acted as gatekeepers for all admissions. Gatekeeping means that all requests for admissions to the adult in-patient wards were directed to the crisis team first. This ensures that all patients including people detained in the health- based place of safety are treated with the least restrictive practice depending on their clinical need.

The police and approved mental health practitioners completed a section 136 form. Staff sent the document to the trust Mental Health Act office who collated information about the use of the health-based place of safety.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was mandatory for the trust and reported overall compliance was 39%, which was below the trust target of 75%. The manager monitored compliance in the Hull crisis team via monthly performance reports. We reviewed figures between April 2015 and February 2016 and saw that compliance had not reached above 9%. We learned that there had been a recent push for staff to attend half a day classroom training, which included capacity assessment and deprivation of liberty safeguards.

Staff appeared to have a good understanding of the Mental Capacity Act and knew where to seek additional support and advice if required. Crisis team staff had access to an approved mental health practitioner This is someone who provides expertise in the Mental Health Act and Mental Capacity Act.

Good

Are services caring?

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

Our findings

Crisis Resolution and Home Treatment Team East Riding

Crisis Resolution and Home Treatment Team Hull

Kindness, dignity, respect and support

We observed staff undertaking two home visits and taking telephone calls coming into the service from people who used services and carers. We observed that staff were polite and treated people with kindness and respect. Staff provided appropriate emotional and practical support. For example, we heard how staff supported one patient to attend hospital and doctor appointments. Staff were encouraging and supported people with problem solving.

We spoke with five people who were using or had used the crisis services, reviewed seven completed comment cards and one share your experience comment. They all made positive comments about staff attitude and behaviour and described staff as caring, excellent, helpful, and attentive.

We observed two handover meetings where staff demonstrated a good understanding of the needs of the people who used the service. Staff spoke in professional, non-judgemental, and compassionate manner.

Staff helped to maintain the confidentiality of people who received clinical visits in the community by parking the car away from the person's home. This was because most of the trust cars used by staff to visit people at home had an identifiable logo on the bodywork, which meant the public knew the crisis teams were visiting. Staff told us these cars would be replaced with non-identifiable vehicles in the future.

The involvement of people in the care that they receive

Staff gave all people who used services a copy of their interim care plan immediately after their initial assessment had taken place. People who used services we spoke with all said they were involved in developing their care plans. Carers we spoke with said where appropriate, staff sought their views and involvement.

People who used the crisis service could give feedback on the service they received. An electronic patient survey device, comments box and comment cards were available for people to complete in the reception area of Miranda House. Staff displayed comments received from these surveys on the notice board. People who used the crisis services could complete a friends and family survey upon discharge from the service. The manager monitored completed responses every month via the monthly performance reports.

Staff offered support to families and carers where appropriate. Both crisis teams had identified carer leads who conducted carers' assessments and signposted people to appropriate services such as carers groups.

None of the people we spoke with said they had been involved in decisions about the service or recruitment of staff.

Health-based place of safety Miranda House Hull

Kindness, dignity, respect and support

Staff described how they would support people who used the service in a considerate manner and how they tried to maintain people's dignity. For example, staff brought refreshments for people in the health-based place of safety from other areas in Miranda house. There was a lack of facilities to help for people feel comfortable such as a bed or air conditioning. However, staff said they tried to make people as comfortable as possible.

The involvement of people in the care that they receive

People subject to Section 136 were not routinely given an opportunity to comment on their experience of being brought in and assessed within the health-based place of safety. We saw from the minutes of the most recent crisis care concordat meetings that staff considered how to improve service user feedback.

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

Crisis Resolution and Home Treatment Team East Riding

Crisis Resolution and Home Treatment Team Hull

Access and discharge

There was a clear process of referral to the crisis teams that included people who referred themselves. External referrals such as those from general practitioners went to the single point of access teams based in each area. When the single point of access service was closed, calls were diverted through to the respective crisis teams. For internal referrals such as requests for support for in-patient or from the hospital liaison team, staff accepted direct referrals.

The shift co-ordinator who was a band six nurse triaged all the referrals to the teams, which meant the teams could prioritise assessments and determine the urgency of the response. Staff completed a triage document, which included risk indicators from the risk assessment tool to support their decision- making. Staff dealt with all referrals in an efficient and timely manner within agreed timeframes depending on the urgency. Staff assessed people at very high risk of imminent self-harm within four hours, which is the national target. Two members of the crisis team carried out the initial assessment, one of whom was a qualified member of staff.

The crisis teams acted as gatekeepers for all admissions and discharges. This meant they managed patients' admission to the wards and supported patients with a timely discharge. The crisis teams bridged the gap between community teams and in-patient wards and offered telephone support and community visits.

The teams had clear criteria for people who would be offered a service and staff took proactive steps to support people who were difficult to engage. Staff discussed how they planned to support a person who was using the service who had a history of disengaging at a team meeting. A carer told us how grateful they were that staff had been able to engage with their relative and help access the service they needed. Where people did not attend for planned appointments, staff followed a 'did not attend' trust policy and attempted to contact the person by telephone and letter. They also liaised with other agencies and relatives as appropriate before making a decision to discharge them. Staff discussed decisions about discharge at the multi-disciplinary team meetings.

Staff offered people who used services flexibility in their appointments where possible. This included times and place of visits. One person who used services told us staff arranged visits to suit their circumstances and was very appreciative of this. We heard staff discussed appropriate times to visit people at home depending on their individual circumstances taking into account for example other caring responsibilities and family availability.

The nature of the work in the crisis teams meant that staff continuously prioritised their workload. In addition to acting as a first point of contact for the health-based place of safety, they were on a rota to act as bed managers for adult in-patient wards. This meant staff had to find a vacant bed for patients to be admitted to. Sometimes this involved searching for beds outside of Humber trust, which meant patients were admitted to hospital a long way from their homes. Staff said the process could be very time consuming and affected the team's workload.

The teams worked flexibly to meet the needs of people who used the services and agreed the frequency of home visits depending on risk and needs. Sometimes this meant they contacted people to re-arrange visits due to other workload priorities and sometimes it meant different people visited. People who used services we spoke with said staff sometimes contacted them to change arrangements, which meant they had to re-tell their story to different members of staff.

The teams reported no significant delays in discharging people to community mental health teams. We saw that the crisis teams monitored the referrals to other teams at their daily handover meetings. Crisis teams maintained good working relationships with in-patient and community teams, which meant they were able to support discharge planning and facilitate joint working with other services.

The facilities promote recovery, comfort, dignity and confidentiality

At Miranda House, there were rooms that staff could use to meet with people who used the service. These interview rooms were comfortable furnished and had adequate sound- proofing to protect the confidentiality of the person using the service.

Are services responsive to people's needs?

Good

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

There was a selection of information and leaflets on display in the waiting area of Miranda House, including information on local services and information about how to complain.

Meeting the needs of all people who use the service

The East Riding crisis team served a large rural population where staff sometimes had to travel long distances of up to 45 minutes travelling to see someone at home. There was a satellite base at Bridlington where at least two members of the East Riding team were based. This meant staff were more accessible to people living in the area. Staff did not see people at the team base at East Riding or Bridlington. The Hull team served a mainly urban population with shorter travel distances and the ability to see all people at the team base. Both teams had good knowledge of the local population and their needs.

Staff had access to interpreters when needed and some of the team at Hull were able to speak Polish and had supported people directly rather than using the interpreters. Team members felt this was a more effective way to meet the needs of those people who spoke Polish as their first language.

Information leaflets on variety of topics were available for staff to give to people who used services. These were not routinely available in other languages but staff could access information in the appropriate language if required.

Listening to and learning from concerns and complaints

There were low numbers of formal complaints recorded for both teams received between March 2015 and February 2016. No complaints were referred to the parliamentary health ombudsman. The East Riding team had the highest number of complaints at four. Three of those complaints were upheld or partially upheld. Hull crisis team received two complaints, one of which was partially upheld.

We reviewed one formal complaint from each team and saw evidence that staff investigated complaints thoroughly and communicated the outcome of the investigation in a clear and timely way. For example a complaint was raised on 04 November 2015 and the outcome communicated by letter to the complainant on 02 December 2015. The investigator had identified action plans and learning for staff as part of the process.

Information about how to complain was available in the crisis teams' information leaflet. All staff we spoke with were aware of the complaints procedure and felt confident about how to manage complaints. We received mixed feedback about complaints from people who used services and their carers. Most told us they were not aware of the formal process of how to complain but would feel confident to raise any complaints directly with staff. One carer told us of a complaint they raised about the care their relative received from the Hull crisis team. We reviewed the care record and saw that staff fully documented the complaint and discussed it with the person who used services. Staff changed the care plan in response to the complaint and in keeping with the wishes of the person who used services.

Health-based place of safety Miranda House Hull

Access and discharge

The health-based place of safety was open 24 hours per day, seven days per week and 365 days per year.

The service had recently reduced the health-based place of safety facilities from two rooms to one. This was in an effort to make the environment more safe and suitable for people detained under section 136. Staff said the health-based place of safety was very busy and although not used every day, could be used more than once a day. Staff used an escalation process to refer difficulties with access to the health-based place of safety to senior managers to make them aware of any issues.

There was a pathway in place for people who were detained under Section 136 MHA and brought to the health-based place of safety. The joint agency protocol had a flow chart to help staff make decisions about the appropriate care and treatment for people detained under Section 136. For example, it prompted the police to contact the crisis team before arrival at the health-based place of safety and the decisions staff needed to take following a joint risk assessment with the police.

There were contributing factors, which led to increasing the length of stay of people detained in the health-based place of safety. This included availability of the doctor and Approved Mental Health Practitioners to conduct the mental health assessment, locating an available in-patient bed and availability of transport.

The trust had signed up to the crisis care concordat agreement, which enabled the trust and partner agencies such as the police to aim to reduce admission to hospital. The trust was not commissioned to provide a street triage.

Are services responsive to people's needs?

Good

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

The facilities promote recovery, comfort, dignity and confidentiality

The health-based place of safety compromised the safety, dignity, and confidentiality of people detained under Section 136. Staff from the emergency services brought people who were detained under Section 136 to the health-based place of safety either by ambulance or by police car. Emergency staff brought people through the main door of the reception area at Miranda House. The alternative entrance door outside the reception area was rarely used. Staff brought people into a public area before entering the health-based place of safety. This compromised people's privacy, dignity, and confidentiality and put the person detained under Section 136 and others at risk. Staff observed people detained in the health-based place of safety at all times to mitigate the identified risks in the room. This meant that staff observed people using the toilet facilities, which compromised their dignity.

Meeting the needs of all people who use the service

The joint agency protocol supported staff to meet the needs of those with learning disabilities, older people, and people under the age of 18 years. It ensured there was a joined up and comprehensive assessment between adult mental health services and specialists from the appropriate service.

Where language or communication might be an issue, staff had access to appropriate translation and interpretation services.

Listening to and learning from concerns and complaints

There were no formal complaints reported by the trust about the health-based place of safety. Staff were aware of how to handle complaints and said they would try to resolve any issues directly where possible.

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

Crisis Resolution and Home Treatment Team East Riding

Crisis Resolution and Home Treatment Team Hull

Vision and values

The trust vision was caring, compassionate, committed and the values were described as; putting the needs of others first, acting with compassion and care at all times, continuously seeking improvement, aspiring to excellence and be the best we can be, and value each other and develop teamwork. We reviewed the crisis teams' operational policy and saw the service aims and objectives reflected the organisations vision and values. Not all staff we spoke with could tell us the trust vision and values but all had good knowledge and understanding of the aims and objectives of the crisis team. However, we observed staff behave in a manner that supported the trust vison and values.

Good governance

The service had a development plan for 2016-2017, which addressed service improvements. Managers regularly reviewed the plan and incorporated issues such as staffing, supervision and mandatory training and the Health Service Executive stress report action plan.

The shift co-ordinator role was always a band six nurse who was more likely to spend the majority of their time on directing the activity of the teams rather than delivering direct care. Staff rotated with other band six nurses, which meant they were able to vary their role. However, in East Riding there were less band six nurses than at Hull. This meant they carried out the shift co-ordinator role more frequently and had less opportunity for delivering direct care.

The service did not appear to have a robust audit plan in place. Staff told us they completed audits through survey monkey but were not able to provide any evidence of the results.

The manager was actively recruiting to vacancies across the teams, which included band six and band five nurses and an occupational therapist.

Both teams used key performance indicators to measure the progress of the teams' activity. This included clinical information such referral activity, completion of the minimum mental health data set requirement, mental health cluster information, and gatekeeping performance. They also monitored information about staffing, training, and appraisal rates. We saw that managers discussed performance in staff meetings.

The senior manager attended regular care group meetings such as the monthly risk meeting, performance meeting, and quality assurance meeting and communicated information to the team manager. The manager held regular team business meetings and felt they had sufficient authority to carry out their role. The administrative staff were highly valued and supportive of the teams work, however the team manager did not directly manage the administrative team.

There was one item on the risk register for the crisis teams, which had been raised by staff. The risk register was not held locally.

Leadership, morale and staff engagement

The manager provided good leadership and overall the morale and teamwork across both teams was good.

The team manager had been in post since December 2015 and worked two days per week across both crisis teams. This meant the manager had very limited opportunity to provide leadership to the teams. However, staff spoke very highly of the manager and described them as being supportive and "giving 100%" to the team.

The manager had recently recruited new band seven staff to the teams. Three of these posts were promotions for band six staff within the crisis teams. The additional band seven posts meant more senior staff would be available to support the teams.

Staff told us that the work in the crisis team was both very challenging and rewarding. Morale had been low amongst some staff following a past serious incident and formal disciplinary processes. There had been changes in the leadership of the teams and staff said they felt unsupported by the trust during this time. Staff described the teams as "happy" and supportive of one another.

Staff from within the teams were engaged in specific groups such as the trust project to improve the electronic information systems and a steering group to look at making improvements following the latest staff Health and Safety Executive stress survey.

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.

Staff reported no concerns of bullying or harassment within the teams. They knew about the whistleblowing policy and felt confident to use this without fear of victimisation.

Staff we spoke with were aware of the new senior manager and were aware of plans for transformation of the service. Although staff felt they were not fully engaged in the process, most staff we spoke with were very positive about change.

Commitment to quality improvement and innovation

Both crisis teams were accredited with the Royal College of Psychiatrists' home treatment accreditation scheme until January 2017.

Health-based place of safety Miranda House Hull

Vision and values

The trust vision was caring, compassionate, committed and the values were described as; putting the needs of others first, acting with compassion and care at all times, continuously seeking improvement, aspiring to excellence and be the best we can be, and value each other and develop teamwork.

The trust had a joint agency protocol for the implementation of Section 136 that meant staff worked with police, local authority and other agencies to ensure the principles of the crisis care concordant were implemented.

Good governance

The trust collected data that supported the monitoring of the performance of the health-based place of safety, however, there were no audits provided by the trust of this data. The service carried out a ligature audit in February 2016, which identified ligature points and gave a risk rating based on a red, amber, and green traffic light system.

Staff were not clear on how to access records about people who had been detained under Section 136. We tracked one person's paper and electronic record who had been detained under Section 136 and could not find a clear account of the persons care and treatment whilst detained under section 136.

The senior manager had been proactive in setting out a briefing paper to improve the environment and arrangements for the health-based place of safety. This included relevant national guidance in relation to standards for health-based place of safety and linked with the service objectives to provide safe care and treatment. However, the plans did not address how staff maintained people's privacy, dignity, and confidentiality on arrival at the health-based place of safety.

Leadership, morale and staff engagement

There was strong leadership of the health-based place of safety. Both the manager and the senior manager also managed the crisis teams and had good oversight of the issues concerning the health-based place of safety.

Commitment to quality improvement and innovation

The senior manager was highly committed to making improvements to the environment and arrangements for the health-based place of safety for the benefit of people detained under Section 136.

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 15 HSCA (RA) Regulations 2014 Premises and equipment **The environment of the health-based place of safety at Miranda House was not suitable for the purpose for which it was being used.** **This was a breach of regulation 15, (1) (c)**