Good

South Essex Partnership University NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Trust Head Office, The Lodge, The Chase, Wickford,
Essex SS11 7XX
Tel: 0300 123 0808
Website: www.sept.nhs.uk

Date of inspection visit: 29 June 2015 to 03 July 2015
Date of publication: 19/11/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWN20	Trust Head Office	Essex West Crisis Resolution Home Treatment Team (CRHT)	SS16 5NL
RWN20	Trust Head Office	Essex East Crisis Resolution Home Treatment Team (CRHT)	SS4 1RB
RWN20	Trust Head Office	A&E liaison Basildon	SS16 5NL
RWN20	Trust Head Office	A&E liaison Southend	SS4 1RB
RWN20	Trust Head Office	RAID Basildon	SS16 5NL
RWN20	Trust Head Office	RAID Southend	SS0 0RY
RWN20	Trust Head Office	South Essex street triage	SS16 5NL

Summary of findings

RWN10	Rochford Hospital	Section 136 place of safety	SS4 1RB
RWN40	Basildon MHU	Section 136 place of safety	SS16 5NL

This report describes our judgement of the quality of care provided within this core service by South 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 South Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of <South 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

- All clinic rooms seen were clean and environmental risk assessments and audits took place.
- CRHT and RAID patients had individualised risk assessments.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and do this when appropriate.
- We found good patient safety protocols including lone working practice except at the places of safety.
- CRHT and RAID staff were able to explain how learning from incidents was shared with staff via team meetings.
- CRHT patients' physical health needs were assessed and physical healthcare observations were routinely carried out for the first three days.
- Across all teams we found that assessments were completed quickly with urgent referrals being prioritised and assessed within one hour.
- Staff teams were aware of the specific needs of the patient they were supporting and discussed plans to address their care needs.
- Staff teams had a level of trained staff within their teams which enabled them to consider a range of psychosocial interventions such as cognitive behavioural therapy and brief solution focused therapy.
- Patients and carers were positive about the support they received and the 'family and friends' satisfaction survey April and May 2015 results reflected this.
- Patient and carers told us the CRHT staff were accessible and responsive and information was given to them as to whom to call when support was needed.
- A gatekeeping assessment report on A&E liaison and West RAID in 2014 showed that staff were effectively gatekeeping admission to hospital.
- The street triage team had led to a decrease in patients being brought by the police to a place of safety for assessment under section 136 MHA.
- Staff referred to various ways they could give feedback or raise concerns such as team meetings and 'take it to the top'.
- Trust magazines and emails gave staff opportunities to keep up to date with trust developments and sharing good practice.
- Teams had staff champions to lead and monitor areas further for example on safeguarding and involving carers.
- Meetings took place with acute hospital and police staff to review trust interagency working.
- Both CRHTs had achieved home treatment accreditation scheme accreditation in 2015, a peer led review. East CRHT had achieved 'excellent' status.

However:

- Staff vacancies of 28% and cover for A&E liaison, GP crisis line and RAID meant that not all rotas were covered despite use of bank and agency staff who knew the service. Psychology staff support was limited for patients.
- One CRHT patient's assessment had not been updated following self harm and two patients' care plans were not completed. This posed a risk that patients may not receive the support they needed. Place of safety risk assessments were not robust and lacked detail across sites.
- Medicines management processes across CRHTs needed improvement relating to safe storage and records.
- Basildon Mental Health Unit place of safety was small and furnishings did not meet the Royal College of Psychiatrists' 2011 national standards. The entrance was accessed by a busy car park and did not afford patients' privacy or dignity when they were being brought by the police for assessment.
- CRHT and staff at the places of safety showed little understanding of the MCA and how it applied to their work. Gaps were identified in MHA training for four CRHT staff.
- In West CRHT complaints were resolved within the team and not recorded as a complaint which was against trust policy.

Summary of findings

- The governance and leadership structure for the place of safety was not clear and effective as staff were from other wards. Forums such as unit meetings for reviewing issues were not robust as staff attendance could be poor.

Summary of findings

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

Are services safe?

Good

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

- All areas seen were clean and environmental risk assessments and audits took place.
- CRHT managers booked regular bank and agency staff to help cover vacancies who were familiar with services and had received induction.
- CRHT and RAID patients had individualised risk assessments.
- CRHTs had systems to track and monitor patients care.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and do this when appropriate.
- We found good patient safety protocols including lone working practice, except at the places of safety.
- CRHT staff knew how to report incidents and were encouraged to use the trust's electronic reporting system. CRHT staff were able to explain how learning from incidents was shared with staff via team meetings.

However:

- Staff vacancies of 28% and cover for A&E liaison, GP crisis line and RAID meant that CRHT staffing levels were compromised.
- Place of safety risk assessments were not robust and lacked detail across sites.
- Medicines management processes across CRHTs needed improvement relating to safe storage and records.
- Basildon Mental Health Unit place of safety was small and furnishings did not fuly meet the Royal College of Psychiatrists' 2011 national standards.

Are services effective?

Good

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

- CRHT and RAID referrals were flexible and could be made to each team by telephone call, letter or in person.
- Patients' physical health needs were assessed and physical healthcare observations were routinely carried out for the first three days.
- Most patients had multi-disciplinary assessments and care plans in place that were reviewed regularly.

Summary of findings

- Across all teams we found that assessments were being completed quickly with any urgent referrals being prioritised and assessed within one hour.
- The teams had daily handovers. Staff teams were aware of the specific needs of the patient they were supporting and discussed plans to address their care needs.
- Staff teams had a level of trained staff within their teams which enabled them to consider a range of psychosocial interventions such as cognitive behavioural therapy and brief solution focused therapy.
- We saw examples of audits with actions discussed at team meetings.
- Staff gave examples gave of specialist training offered including 'time to learn' CRHT teaching sessions.
- There was evidence of working with others including internal and external partnership working with other trust teams and external agencies such as the police. A street triage worker said their role was helping to improve communication between the trust and police.

However:

- There was limited use of recognised rating scales used to assess severity and outcomes across CRHTs.
- Breathalysing of patients varied across sites which was not consistent with trust policy.
- CRHT and staff at the places of safety showed little understanding of the MCA and how it applied to their work.

Are services caring?

Good

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

- Patients and carers were positive about the support they received and the 'family and friends' satisfaction survey April and May 2015 results reflected this.
- We saw good examples of positive staff and patient interaction and individual support.
- Staff demonstrated that they had a good understanding of their specific care and treatment needs of patients.
- Patients and carers told us that they were actively involved in their care planning and explained treatment options available.

However:

Summary of findings

- There was no system for obtaining feedback from patients concerning their experience of the place of safety. This was not in accordance with the Royal College of Psychiatrists' 2011 national standards.

Are services responsive to people's needs?

Good

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

- CRHTs and RAID teams had a single point of contact and clearly identified referral process. RAID and A&E liaison were staffed 24 hours a day.
- Patient and carers told us the CRHT staff were accessible and responsive and information was given to them as to whom to call when support was needed.
- 95% of patients were seen within seven days of discharge from hospital.
- The street triage team support had led to a decrease in patients being brought by the police to a place of safety for assessment under section 136 MHA.
- Staff gave examples of meeting patients' diverse needs such as considering gender specific workers.
- CRHTs had designated pathways for carers and teams had carer's champions.

However:

- There could be delays in patients having Mental Health Act assessments at places of safety out of hours.
- In the West CRHT complaints were resolved within the team and not recorded as a complaint which was against trust policy.
- Patients at places of safety did not have easy access to written information about services including at Rochford hospital, complaints information.

Are services well-led?

Good

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

- Information about the trust's visions and values was available in each team.
- Staff referred to various ways they could give feedback or raise concerns such as team meetings and 'take it to the top'.
- Managers provided data on performance to the trust and received data and feedback from this to compare their service with others.

Summary of findings

- Trust magazines and emails gave staff opportunities staff to keep up to date with trust developments and sharing good practice.
- Teams had staff champions to lead and monitor areas further for example on safeguarding.
- Meetings took place with acute hospital and police staff to review trust interagency working.
- As part of the rapid response measures, the East team had taken over part of the West team location/caseload to ensure more equal numbers.
- Both CRHTs had achieved home treatment accreditation scheme accreditation in 2015, a peer led review. East CRHT had achieved 'excellent' status.
- West RAID team had a quality improvement report comparing their work in 2015 to 2013 with positive results of staff satisfaction with the referral process and the experience of working with the team.

However:

- The trust collected data against indicators which helped to gauge the performance of the teams for gatekeeping. This was not robust because staff did not always complete feedback in a timely way.
- Staff morale was varied. Five CRHT staff told us that decisions were made by senior trust staff without consultation or explanation.

Summary of findings

Information about the service

The two crisis resolution home treatment teams (CRHT) work with working age and older adult patients, who, without this support, would need to be admitted to hospital, or who cannot be discharged from hospital without intensive support. The service operates 365 days a year and enables patients who are in crisis and not able to function at their normal level to be supported in their own homes. The CRHTs also provide a GP crisis line and A&E liaison service to patients referred from Basildon and Thurrock University Hospitals NHS Foundation Trust and Southend University Hospital NHS Foundation Trust accident and emergency (A&E) staff.

South West Essex crisis resolution and home treatment team provides services for patients in Basildon, Brentwood, Billericay, Wickford, Grays and Thurrock. East Essex crisis resolution and home treatment team provides services for patients in Southend on Sea, Shoeburyness, Rochford, Rayleigh and Castlepoint.

The two rapid assessment, intervention and discharge (RAID) teams are based at Basildon Mental Health Unit and at Southend University Hospital NHS Foundation Trust in Westcliff. They provide a service to acute hospital inpatients referred from Basildon and Thurrock University Hospitals NHS Foundation Trust and Southend University Hospital NHS Foundation Trust staff.The two health based place of safety provisions inspected were based at Basildon Mental Health Unit and Rochford Hospital. When patients were detained by the police under section 136 of the Mental Health Act 1983 they were taken to a safe place where a mental health assessment can be undertaken. Additionally, the trust provided a night 'street triage' service in liaison with Essex Police and a neighbouring mental health trust. This was a new initiative.

None of these services has been previously inspected by the CQC. However, in December 2015 the CQC carried out a thematic review of mental health crisis care in Essex (not specific to this trust) and we reported separately on this.

Our inspection team

Our inspection team was led by:

Chair: Karen Dowman, Chief Executive, Black Country Partnership NHS Foundation Trust

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

Inspection Manager: Lyn Critchley, Inspection Manager, CQC

The team that inspected the mental health crisis services and health based places of safety consisted of eight people: an expert by experience, a Mental Health Act reviewer, two CQC inspectors, a social worker, two nurses and a doctor.

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 trust 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 trust:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to patients' needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- Spoke with nine patients who were using the service.
- Spoke with six carers.
- Reviewed 40 care and treatment records of patients.
- Examined six sets of medication recording cards.
- Spoke with two team leaders and another manager,
- Spoke with 51 staff including support workers, doctors, nurses, social workers, occupational therapists.
- Spoke with two students on placement.
- Spoke with one professional from another team.
- Visited four patients receiving the service in their home and observed with their consent how staff were caring for them.
- Met with Essex police and the Essex approved mental health practitioners service.
- Attended a team meeting, three team handover meetings and a joint referrals meeting with the first response team.
- Observed an A&E liaison assessment and a crisis response home treatment assessment
- Observed care being given to two patients in the Section 136 MHA place of safety suites.
- 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

- Patients and carers were positive about the support which they received and said staff were kind, caring and considered their well-being. They said that staff were professional.
- The East CRHT 'family and friends' satisfaction survey April and May 2015 results (five responses), showed that patients had given a 9.2 (out of ten) rating for 'were staff kind and caring?' 60% of patients were 'extremely likely' and 40% 'likely' to recommend the team to others.
- Patients and carers told us that they were actively involved in their care planning and explained treatment options available and gave examples. However, the electronic notes system gave limited details about this. Patient and carers told us the CRHT staff were accessible and responsive and information was given to them as to whom to call when support was needed.
- There was no system for obtaining feedback from patients concerning their experience of the place of safety. This was not in accordance with the Royal College of Psychiatrists' 2011 national standards.

Good practice

- RAID and street triage staff were providing MHA and MCA training for other external agencies, such as the police and acute hospital staff.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

Action the trust SHOULD take to improve mental health crisis and health based place of safety:

- The trust should review the care planning process for CRHTs.
- The trust should review patients' risk assessments for places of safety.
- The trust should review its MHA and MCA training for CRHT and place of safety staff.
- The trust should ensure that patients' privacy and dignity is maintained while they are using the place of safety.
- The trust should review their process within the CRHTs for safe transport of medication, safe storage of medication and safe administration of medication.
- The trust should review the governance structure for places of safety to ensure there are quality assurance systems in place.
- The trust should improve the environments in the places of safety or provide new facilities.
- The trust should work with partners to ensure that waiting times for assessment by the approved mental health practitioners of patients in the health based place of safety assessments are reduced.

South 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
Essex West Crisis Resolution Home Treatment Team (CRHT)	Trust Head Office
Essex East Crisis Resolution Home Treatment Team (CRHT)<Placeholder text>	Trust Head Office
A&E liaison Basildon	Trust Head Office
A&E liaison Southend	Trust Head Office
RAID Basildon	Trust Head Office
RAID Southend	Trust Head Office
South Essex street triage	Trust Head Office
Section 136 place of safety	Rochford Hospital
Section 136 place of safety	Basildon MHU

Detailed findings

Mental Health Act responsibilities

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

- Staff referred to information being available on the trust staff intranet for MHA and Mental Capacity Act for them to refer to. The trust advised that they did not have a centralised system of recording MHA training.
- Staff had access to approved mental health practitioners should a mental health assessment need coordinating for a patient.
- The trust's Section 136 policy was under review to reflect the revised MHA Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff's understanding of the MCA varied across teams. Some staff were unable to describe the guiding principles or all of the elements of the capacity test.

Good

Are services safe?

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

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

Summary of findings

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

- All areas seen were clean and environmental risk assessments and audits took place.
- CRHT managers booked regular bank and agency staff to help cover vacancies who were familiar with services and had received induction.
- CRHT and RAID patients had individualised risk assessments.
- CRHTs had systems to track and monitor patients care.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and do this when appropriate.
- We found good patient safety protocols including lone working practice, except at the places of safety.
- CRHT staff knew how to report incidents and were encouraged to use the trust's electronic reporting system. CRHT staff were able to explain how learning from incidents was shared with staff via team meetings.

However:

- Staff vacancies of 28% and cover for A&E liaison, GP crisis line and RAID meant that CRHT staffing levels were compromised.
- Place of safety risk assessments were not robust and lacked detail across sites.
- Medicines management processes across CRHTs needed improvement relating to safe

Our findings

Safe and clean environment

- CRHT staff had access to interview rooms at office bases fitted with alarms. A&E liaison staff had access to interview rooms in the acute hospital. Managers told us A&E liaison staff and RAID staff had access to acute hospital alarms as required. It was part of the trust's operational policy that most patients of CRHT services were seen at their own homes wherever possible.
- CRHTs did not have designated clinic rooms (apart from East CRHT where the room was not used by all staff), instead medication and equipment was stored in offices. We found necessary equipment to carry out physical examinations, except at West CRHT where the bag had gone missing and was on order. Staff had implemented a log book to track the equipment. Other equipment was well-maintained, clean and checked regularly.
- Environmental risk assessments were carried out in areas such as health and safety and infection control and prevention. All of the areas seen were clean and we saw records of audits of cleaning.

Safe staffing

- Core staffing levels had been set by the trust. May 2015 trust data showed 28% vacancy.
- Measures were implemented by senior managers from April to June 2015 following concerns about staffing, caseloads and potential for increase in risks to the CRHTs. Workshops with senior staff were arranged to review staffing resources (numbers and skills mix) needed.
- At 29 June 2015 caseloads were 33 for West and 54 for East CRHTs. The Royal College of Psychiatrists' policy implementation guide recommendations on caseload size were exceeded by East CRHT during our visit. In April 2015 the West team also exceeded the recommended number.
- At our visit to East team there were insufficient staff to cover all appointments and telephone duty. This caused changes to appointments. We found other examples of insufficient staffing. West CRHT had 285 and East CRHT had 239 bank and agency shifts used between February and April 2015. Five shifts had not been fully covered. Staff rotas showed continued use of bank staff across CRHT and agency staff at West team. Managers told us these were regular staff who knew patients well.

Good

Are services safe?

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

Assessing and managing risk to patients and staff

- Each patient had an individualised risk assessment and these had been reviewed by the multi-disciplinary team. Risk assessments took into account historic risks and identified where additional support was required. However, one patient's assessment had not been updated following self-harm. We brought this to the attention of staff.
- Crisis plans were part of care plans. However, we found two care plans were not completed.
- Staff were able to respond quickly to a sudden deterioration in peoples' health. The teams reported the ability to increase the frequency of their visits if the patient required an enhanced level of support.
- CRHT has physical and virtual whiteboards to track and monitor patients care. Staff used traffic light systems (red, amber and green) as a visual guide for risks. These were used during regular daily multi-disciplinary team handovers to update and check.
- Staff had systems for monitoring patients who did not attend for appointment. For example, in West CRHT, a patient had not had contact within 24 hours and the manager organised a police welfare check.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and do this when appropriate. They knew who the trust's safeguarding leads were. All staff had undertaken level one safeguarding training; 100% West and 94% East CRHT staff had completed level two; 93% West and 83% East had completed level three safeguarding children training and all staff identified had completed level three safeguarding adults training.
- We found good personal safety protocols including lone working practices. CRHT staff had lone worker electronic devices which could be used to call emergency support. 87% of East and 93% of West CRHT staff had received safe break away training (May 2015).
- One patient's supervised medication was not signed for by staff for one week so it was unclear if they had taken it. One patient had not had a review of an as required diazepam medication after 14 days as is best practice. Medication storage area temperatures were not regularly monitored with gaps in records at both CRHTs. At East team the medicines fridge temperature was recorded as 30 degrees celsius for the second day and medicines stored were warm to the touch. This was brought to the attention of staff. The bag used for transporting medication in West CRHT was not secure. All staff had completed medication management training.

Track record on safety

- There were four serious incidents recorded for 2014 and two since April 2015 with investigations in progress.

Reporting incidents and learning from when things go wrong

- The trust reported concerns through the national reporting and learning system (NRLS) and other national reporting mechanisms.
- Staff knew how to report incidents on the trust's electronic reporting system. 51 incidents were reported since January 2015. The trust had systems for monitoring themes and had identified that self harm accounted for ten of these. Staff told us they could raise concerns via meetings for consideration for the trust risk register. The governance framework encouraged staff to report incidents. We reviewed some incidents during our visit and these showed that investigations and analysis took place, with actions for staff and were shared within the team.
- Staff were able to explain how learning from incidents was shared with staff via team meetings. Managers and staff gave examples of changes made following incidents, for example advising patients of 'therapy for you' support, part of the improving access to psychological therapies programme, following crisis.
- Staff received feedback from investigation of incidents both internal and external to the service. Safeguarding and 'lessons learnt' were standing agenda items for business meetings.
- Post incident debriefing was available for staff to reflect on incidents and identify actions.

Health-based places of safety Basildon MHU and Rochford Hospital

Safe and clean environment

- Both places of safety were clean.
- Neither assessment room fully met the Royal College of Psychiatrists' 2011 national standards. The Rochford Hospital assessment unit was purpose built and spacious. The Basildon Mental Health Unit assessment

Good

Are services safe?

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

room was small and narrow. The furniture in the assessment room was not fixed to the ground, but was of a weight that made it impossible to throw. The air-conditioning unit presented a ligature risk, but was at a height (over 2 metres) that presented a limited risk and people were observed in that room. Each assessment room had an alarm system. Neither place of safety had a two way observation mirror for staff to observe the assessment room, nor closed circuit television (CCTV).

- The Basildon Mental Health Unit clinic room was well equipped. At Rochford place of safety, a bag with equipment was available for physical health emergencies. There was no checklist for staff to identify equipment that should be in the bag. A reservoir for the 'ambu bag' (self-inflating resuscitator) was missing. Staff resolved this during the inspection.

Safe staffing

- Rochford Hospital and Basildon MHU had a 'unit officer' 24 hours a day. This was a senior nurse who was responsible for dealing with any incidents or issues on the site, including the wards. They had responsibility for the place of safety. This meant they would be one of the staff who stayed with a patient in the place of safety throughout their time there. If they were needed elsewhere on the site, there were contingency plans in place to ensure another member of staff replaced the site officer in the place of safety.
- At Basildon Mental Health Unit a psychiatrist was available at all times of the day. At Rochford hospital, a psychiatrist was available 09.00-17.00hrs. After those hours if they were not on site they would be at Southend A&E. This was approximately 20 minutes away by car. In the event of a medical emergency during this time, staff would call for an ambulance.

Assessing and managing risk to patients and staff

- Patients had a risk assessment undertaken by a nurse when they were admitted to the place of safety. This document was used by the police and trust staff. The document did not detail the range of risk areas which should be assessed, for example self harm. One Basildon patient's notes did not record their 'behaviour on arrival' as part of the assessment.
- The document included a risk rating of 'standard', 'medium' or 'high' which the police and healthcare staff decided jointly. There was no evidence that a patient's potential risks were further explored, reviewed or updated during their time in the place of safety whilst awaiting the approved mental health practitioner and Section 12 MHA approved doctor assessment.
- All patients were searched by the police on arrival to the place of safety. Any items which could be used by the patient to harm themselves or others were given to nursing staff until the person left although this was not clearly recorded.
- The police stayed with the patient until there was an agreement with nursing staff that they could safely leave.
- Staff told us that they would not accept any patient to a place of safety where CS spray or a taser had been used by police on them.
- Staff carried personal alarms. At Basildon, the place of safety was located near to a ward and staff passed by frequently. At Rochford, the place of safety was some distance from any of the wards. Some staff told us that during the night they asked for another staff member to stay with them to ensure their safety.
- Medicines were stored appropriately and could be accessed in an emergency.

Track record on safety

- There were no serious incidents in the places of safety reported in 2014.
- There were two incidents in 2014 at Rochford hospital. One concerned the lack of a site officer and closure of the place of safety. The other concerned both places of safety (Rochford and Basildon) being occupied at the same time.

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.

Summary of findings

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

- CRHT and RAID referrals were flexible and could be made to each team by telephone call, letter or in person.
- Patients' physical health needs were assessed and physical healthcare observations were routinely carried out for the first three days.
- Most patients had multi-disciplinary assessments and care plans in place that were reviewed regularly.
- Across all teams we found that assessments were being completed quickly with any urgent referrals being prioritised and assessed within one hour.
- The teams had daily handovers. Staff teams were aware of the specific needs of the patient they were supporting and discussed plans to address their care needs.
- Staff teams had a level of trained staff within their teams which enabled them to consider a range of psychosocial interventions such as cognitive behavioural therapy and brief solution focused therapy.
- We saw examples of audits with actions discussed at team meetings.
- Staff gave examples gave of specialist training offered including 'time to learn' CRHT teaching sessions.
- There was evidence of working with others including internal and external partnership working with other trust teams and external agencies such as the police. A street triage worker said their role was helping to improve communication between the trust and police.

However:

- There was limited use of recognised rating scales used to assess severity and outcomes across CRHTs.
- Breathalysing of patients varied across sites which was not consistent with trust policy.
- CRHT and staff at the places of safety showed little understanding of the MCA and how it applied to their work.

Our findings

Essex West and East Crisis Resolution Home Treatment Teams (CRHT), A&E liaison Basildon and Southend, RAID Basildon and Southend teams, South Essex street triage

Assessment of needs and planning of care

- RAID staff liaised with acute hospital staff to ensure patients were medically fit before assessment. A&E liaison staff breathalysed patients to establish when patients were fit to be interviewed.
- Following an initial assessment CRHT staff undertook a full assessment within three days.
- Patients' physical health needs were assessed and physical healthcare observations were routinely carried out for the first three days.
- Most patients had multi-disciplinary assessments and care plans in place.
- Street triage staff held brief assessment paper records with copies held by the police and trust. A full needs assessment was carried out by the team accepting the referral.
- The teams had daily handovers. Staff teams were aware of the specific needs of the patient they were supporting and discussed plans to address their care needs. Staff coming in for afternoon shifts were reminded to have handovers
- CRHT staff had started using the trust electronic patient record. Most staff were positive about the introduction and said support and training was available. We met support staff on site.

Best practice in treatment and care

- The CRHT policy stated patients' treatment and care could include counselling and family support/ intervention. A manager referenced CRHT practice being in line with the Department of Health, 'guidance statement on fidelity and best practice for crisis services'. Occupational therapists had a graded approach and ran community groups such as hearing voices, recovery, anxiety management and 'your health your life' self-management courses. There was limited use of recognised rating scales used to assess severity and outcomes. RAID staff used the geriatric depression scale self rating assessment.

Are services effective?

Good

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

- Staff teams had staff trained in a range of psychosocial interventions such as cognitive behavioural therapy and brief solution focused therapy. Staff referred long term psychological treatments to the community mental health team. We saw that teams also referred to 'therapy for you'.
- We saw examples of audit of care plans and record keeping with actions discussed at team meetings.

Skilled staff to deliver care

- CRHTs had access to a range of mental health disciplines. This included psychiatrists, nurses, occupational therapists and social workers. The recent home treatment accreditation scheme peer review had identified the need for psychology staff. Managers said this was not initially budgeted for in the team. However, at the CRHT steering group it was agreed and plans were being developed for recruitment.
- New staff had a trust and local induction programme prior to working in teams.
- Regular team meetings took place and most staff told us that they felt supported by colleagues and managers. In the East team, five staff told us supervision had not been regular due to changes in line manager and records showed this for January 2015. June 2015 data showed 72% of staff received supervision in the East team and 94% in the West (overall 83%). A West manager said a family therapist provided clinical supervision for individual staff and groups.
- 91% of staff had received an appraisal across the CRHTs. Managers offered an open door policy ensuring they were available for ad-hoc supervision when required.
- Staff performance was monitored and measured using the trust wide key performance indicators and the "workforce dashboard". Poor staff performance was addressed promptly and effectively.
- As of May 2015 over 93% of staff had completed mandatory 'refresher' training identified by the trust. Checks were in place to ensure that agency staff used had received the required training prior to being booked to work shifts.
- Staff gave examples of specialist training such as family inclusive practice and social system, blood interpretation workshop training, 'time to learn' CRHT teaching sessions and personality disorder. Guest speakers were also invited to team meetings. Occupational therapy staff had access to a practice development forum.

Multi-disciplinary and inter-agency team work

- Patients were referred to specialists for assessments/ treatment for example dieticians.
- We saw that multi-disciplinary team care programme approach meetings took place.
- There was evidence of working with others including internal and external partnership working, such as multi-disciplinary working with community mental health, substance misuse, the police, acute hospital, independent sector and local authority. There were opportunities for joint assessment and review with other teams. The CRHT and first response team held a regular joint referrals meeting. This ensured a proactive approach to the co-ordinated care of patients.
- The street triage team acted as a liaison between the police and other trust teams and their role helped to improve communication between the two agencies.

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

- Information was available on the trust staff intranet for MHA and MCA. The trust did not have a centralised system of recording MHA training.
- Staff had access to approved mental health practitioners should a mental health assessment need coordinating. Street triage staff could request an approved mental health practitioners if required.

Good practice in applying the Mental Capacity Act

- Managers reported MHA and MCA mandatory training online.100% of West CRHT and 94% of East CRHT staff completed safeguarding level two training, which included MCA and DoLS awareness training. A MCA/ Deprivation of Liberty Safeguards specialist was booked to deliver specialist training for the team. We found staff understanding and knowledge varied across teams. Most CRHT staff showed little understanding of the MCA and how it applied to their work.
- RAID staff told us they liaised with acute hospital staff regarding mental capacity assessments. East RAID staff organised MCA training for A&E staff re MHA and MCA, with plans to extend to the fire department and

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.

paramedics. Staff told us they discussed with their manager in the first instance and then with the MCA lead within the Mental Health Act administration team if they had questions about mental capacity.
- We saw consent to share information documents for patients regarding whom to share information with and contact in an emergency.

Health-based places of safety Basildon MHU and Rochford Hospital

Assessment of needs and planning of care

- At Basildon Mental Health Unit, patients were assessed by the duty psychiatrist and the senior nurse. At Rochford hospital, patients did not receive any formal mental state assessment until the arrival of the approved mental health practitioners and section 12 approved doctor. This meant that when a patient was admitted during the early evening, they may not be assessed until the morning.
- We found variations in record keeping. Patients' records were stored on up to three separate electronic systems. Staff initially completed paper records. Staff at Basildon MHU reported that these were sent to medical records and that trust's electronic patient record was only used for patients who were subsequently admitted. Staff at Rochford hospital told us that these were scanned and uploaded onto a shared electronic folder for senior nurses at Rochford hospital. When we looked at this we found folders for 2012, 2013 and 2014 and none for 2015. Staff told us that it took up to three weeks for these records to be uploaded onto the trust's electronic patient record. During the inspection staff said this would be reduced to one week.
- Records were not stored consistently or in such a way that other professionals would be able to access those records easily. For example, a patient could attend both places of safety in a short period of time, and neither place of safety would necessarily be aware that the patient had been to the other one.

Best practice in treatment and care

- Staff routinely breathalysed people for their alcohol level on admission to the place of safety, regardless of the circumstances of their detention. This was not in keeping with the trust's Section 136 policy and the AMHP manual. Staff told us that if the patients' alcohol level was above the legal drink driving limit AMHPs did not always attend to conduct an assessment. We found an example of this where they attended nine hours after contact.

Skilled staff to deliver care

- As staff were from other wards, staff training, supervision and appraisal was captured within these teams and we have reported this within other core services reports.

Multi-disciplinary and inter-agency teamwork

- Relationships between the trust and other agencies were reported to be good. The Section 136 policy used by the trust had been developed together with a nearby trust.
- A regular multi-agency meeting took place between the trust, the police and local authority. Discussion topics included improving the handover and joint risk assessment between police and healthcare staff at the place of safety.

Adherence to the MHA and MHA code of practice

- Patients were provided with verbal and written information concerning their legal status shortly after their arrival at the place of safety.
- The trust's policy did not detail the roles and responsibilities of different professionals, staff training, and that police transport should be used exceptionally. This was not in accordance with the MHA Code of Practice. The Section 136 policy was under review to reflect the revised MHA Code of Practice.
- Managers told us that CRHT staff were contacted when a MHA assessment was being coordinated to consider when an alternative to hospital admission was required.

Good practice in applying the MCA

- Staff we spoke with showed a poor understanding of the MCA. Staff were unable to describe the guiding principles or all of the elements of the mental capacity test. An example of this was given, when six staff said medication would be administered under 'common law' if medication was assessed as being required, and the patient had not given their consent, even when there was no urgent necessity. Joint police and trust records showed that staff considered if a patient had a learning disability or not.

Are services effective?

Good

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

- We saw examples of staff seeking patients' consent and who they wanted to be notified of their assessment at the place of safety.

Good

Are services caring?

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

Summary of findings

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

- Patients and carers were positive about the support they received and the 'family and friends' satisfaction survey April and May 2015 results reflected this.
- We saw good examples of positive staff and patient interaction and individual support.
- Staff demonstrated that they had a good understanding of their specific care and treatment needs of patients.
- Patients and carers told us that they were actively involved in their care planning and explained treatment options available.

However:

- There was no system for obtaining feedback from patients concerning their experience of the place of safety. This was not in accordance with the Royal College of Psychiatrists' 2011 national standards.

Our findings

Essex West and East Crisis Resolution Home Treatment Teams (CRHT), A&E liaison Basildon and Southend, RAID Basildon and Southend teams, South Essex street triage

Kindness, dignity, respect and support

- Patients and carers were positive about the support they received and said staff were kind, caring and considered their well-being. They said staff were professional.
- In the East CRHT 'family and friends' satisfaction survey for April and May 2015, patents had given a 9.2 (out of ten) rating for 'were staff kind and caring?' Across CRHTs for January to December 2014 the rating was 9.
- We saw good examples of positive staff and patient interaction and individual support. However, in two assessments we observed staff focused on completing assessment forms rather than developing a working rapport.
- Staff demonstrated that they had a good understanding of their specific care and treatment needs of patients.

The involvement of people in the care that they receive

- Patients and carers told us that they were actively involved in their care planning and explained treatment options available and gave examples.
- We observed that the services were involved in identifying carers for a carer's assessment when it was required.
- Information on advocacy and support groups was available and promoted across the teams.
- CRHTs referenced "my relapse prevention plan" and the 'Newman's' form where patients were encouraged to identify things that helped them when in crisis.
- In the East CRHT 'family and friends' satisfaction survey for April and May 2015, patients had given positively an 8.8 rating out of ten for 'do you understand what was said?'

Health-based places of safety Basildon MHU and Rochford Hospital

Kindness, dignity, respect and support

- We observed staff displayed warmth and understanding and gave time for patients to discuss any concerns. Staff explained how they would manage and support a patient being assessed in what were often confusing and distressing circumstances
- One patient said they felt able to speak with staff and had been made to feel comfortable in the place of safety. They confirmed their consent was sought regarding notifying a relative about the assessment.

The involvement of patient in the care they receive

- We were informed that advocacy was available to patients during weekday work hours. However, patients were not routinely informed of the service.
- There was no system for obtaining feedback from patients concerning their experience of the place of safety. This was not in accordance with the Royal College of Psychiatrists' 2011 national standards.

Are services responsive to people's needs?

Good

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

Summary of findings

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

- CRHTs and RAID teams had a single point of contact and clearly identified referral process. RAID and A&E liaison were staffed 24 hours a day.
- Patient and carers told us the CRHT staff were accessible and responsive and information was given to them as to whom to call when support was needed.
- 95% of patients were seen within seven days of discharge from hospital.
- The street triage team support had led to a decrease in patients being brought by the police to a place of safety for assessment under section 136 MHA.
- Staff gave examples of meeting patients' diverse needs such as considering gender specific workers.
- CRHTs had designated pathways for carers and teams had carer's champions.

However:

- There could be delays in patients having Mental Health Act assessments at places of safety out of hours.
- In the West CRHT complaints were resolved within the team and not recorded as a complaint which was against trust policy.
- Patients at places of safety did not have easy access to written information about services including at Rochford hospital, complaints information.

Our findings

Essex West and East Crisis Resolution Home Treatment Teams (CRHT), A&E liaison Basildon and Southend, RAID Basildon and Southend teams, South Essex street triage

Access and discharge

- CRHTs provided a daily 08:00 to 20:00hours staffed service with out of hours telephone contact. RAID and A&E liaison was staffed 24 hours a day. At night, staff covered A&E liaison.
- CRHTs and RAID teams had a single point of contact (SPOC) and a clear referral process. CRHTs had a duty worker rostered to deal with new referrals and allocate appointments and these were discussed at multidisciplinary team handovers.
- Out of hours a junior doctor was on site. A more senior doctor and consultant were available by telephone for contact.
- CRHTs had a timeframe for responding to patients within one to four hours and assessing in 24 hours. A&E liaison had a response target of assessing patients within four hours which is outside the Joint Commissioning Panel Mental Health standards.
- RAID responses were within one, four and 48 hours according to risk. West team showed ten referrals were seen over a 24 hour period during the inspection. Referrals via the GP crisis line received telephone contact from CRHT within 24 hours or if urgent the patient could be advised to attend A&E for assessment. Street triage staff identified the majority of patient they were called to were referred to mental health services or signposted to other services.
- We found that assessments were completed quickly with any urgent referrals prioritised and assessed within one hour.
- Teams had agreed criteria for admission to a service. CRHTs were flexible in how they accepted referrals. This was either by telephone, email or referrals from professionals in person.
- Patient and carers told us the CRHTS team were accessible and responsive and information was given to them as to whom to call when support was needed.
- A gatekeeping assessment report on A&E liaison and West RAID showed, out of 101 patients referred during an 8 week period in December to January, the majority were discharged to care of their GP. Some were referred to other teams such as the first response team, community drug and alcohol and improving access to psychological therapies. Nine patients were followed up by CRHT and 34 were admitted to the assessment unit.

The facility promotes recovery, comfort and dignity and confidentiality

- Interview rooms at sites had access for wheelchair users.

Are services responsive to people's needs?

Good

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

- During our inspection the outside temperature reached 32 degress Celsius. Some CRHT and RAID open plan office temperatures exceeded 25 degrees Celsius. Managers had reported it as an incident and electric fans had been provided to help cool the air.

Meeting the needs of all patient who use the service

- Information was available for patients across all the services we visited. This was predominately in English although there was access to additional languages on request and this was based on the cultural and ethnic mix with in the local area.
- Staff confirmed that they had access to translation services and interpreters where required. We saw that most staff had received mandatory equality diversity and human rights (EDHR) training.
- CRHTs had specific pathways for carers with time frames for offering appointments and assessment. A carer's pack was developed with information and teams had carers' champions. Carers' support groups were available.
- The acute hospital had identified a need for mental health input and the trust was commissioned to pilot RAID teams. Following the pilot the service was extended and staff were based at the A&E at night.
- Staff considered the gender of worker and we heard examples of staff considering the timing of appointment. Two patients and one staff member said the team had not always notified them of appointments until the afternoon.
- We found examples of staff considering patients' religious and social needs.

Listening to and learning from concerns and complaints

- Information on how to make a complaint was displayed including leaflets from the patient advice and liaison service. Additionally at some offices comments boxes were in waiting areas. However, patients said they felt able to raise any concerns with staff.
- There were systems for processing, monitoring and responding to complaints and we saw evidence of this. Staff told us that learning from complaints was shared with the team. However, for one complaint in East CRHT it was not clear that this had happened. In West team a manager told us complaints were resolved within the team. These were recorded in individual notes but there was no log for the team. Trust policy stated that verbal and written complaints should be recorded as a complaint and records kept.
- The trust 'family and friends' patient survey was discussed at team meetings. We saw from the East team April to May 2015 survey (five responses), that three people were 'extremely likely' and two were 'likely' to recommend the service. The patient satisfaction survey report for both CRHTs from January to December 2014 had 61 responses (West 43 and East 18) with 67% of people 'extremely likely' and 20% 'likely' to recommend the service.
- CRHTs had carer's leaflets encouraging feedback via, 'how can we support you? Carers were also encouraged to give feedback from the support group via a satisfaction survey.
- We heard staff discussed patient and carer feedback on the service at handover meetings. Staff referred to family liaison officers giving support to patients and carers.

Health-based places of safety Basildon MHU and Rochford Hospital

Access and discharge

- The places of safety assessed a total of 260 patients in the previous 12 months, with Basildon Mental Health Unit assessing 60% of these.
- During weekday working hours, approved mental health practitioners and Section 12 doctor assessments usually took place within three hours. At weekends this could be up to several hours. Staff at both places of safety told us that approved mental health practitioners from the local council would not attend to assess patients at night. A street triage briefing document (which included data for the other trust also) showed 920 patients detained under S136 MHA in Essex 2013-14. 779 (84%) had no formal action taken and 141 (16%) patients were formally detained under section. On average it was 10 hours before a MHA assessment took place. During our visit we found an example of a 17 hour wait before assessment due to approved mental health practitioners non availability. Approved mental health practitioners that work out of hours are not employed by the trust.
- In the previous 12 months, 50% of patients remained at the place of safety for more than three hours, and 15% for more than five hours.

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 entrance to the Basildon place of safety was accessed by a car park at the front of the building. This did not afford patients' privacy or dignity when they were being admitted to the place of safety. The Rochford place of safety was accessed from a side road on the hospital site, which was not used frequently and afforded some privacy.
- Appropriate facilities were available for patients to have a physical examination. Patients slept on a sofa in Basildon Mental Health Unit. At Rochford hospital, patients had access to a shower room and a bed.

Meeting the needs of all patient who use the service

- The Rochford place of safety was wheelchair accessible and had a toilet for disabled people's use. Whilst Basildon Mental Health Unit was wheelchair accessible, the size and space would make it difficult to use a wheelchair.
- Staff told us that patients who were under 18 years and detained under section 136 MHA were taken to the CAMHS ward at Rochford hospital, as a more suitable environment. However, in the month prior to the inspection, a patient under 18 years had been taken to the Basildon Mental Health Unit place of safety. We noted from the December 2014 police liaison meeting minutes that limited availability of CAMHS staff out of hours was identified as a risk.
- Staff told us they could access interpreters as required.

Listening to and learning from concerns and complaints

- At Rochford place of safety there was no written information regarding how patients could complain.
- The trust does not have a method of gathering feedback from patients detained under Section 136 MHA regarding the service provided.

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.

Summary of findings

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

- Information about the trust's visions and values was available in each team.
- Staff referred to various ways they could give feedback or raise concerns such as team meetings and 'take it to the top'.
- Managers provided data on performance to the trust and received data and feedback from this to compare their service with others.
- Trust magazines and emails gave staff opportunities staff to keep up to date with trust developments and sharing good practice.
- Teams had staff champions to lead and monitor areas further for example on safeguarding.
- Meetings took place with acute hospital and police staff to review trust interagency working.
- As part of the rapid response measures, the East team had taken over part of the West team location/ caseload to ensure more equal numbers.
- Both CRHTs had achieved home treatment accreditation scheme accreditation in 2015, a peer led review. East CRHT had achieved 'excellent' status.
- West RAID team had a quality improvement report comparing their work in 2015 to 2013 with positive results of staff satisfaction with the referral process and the experience of working with the team.

However:

- The trust collected data against indicators which helped to gauge the performance of the teams for gatekeeping. This was not robust because staff did not always complete feedback in a timely way.
- Staff morale was varied. Five CRHT staff told us that decisions were made by senior trust staff without consultation or explanation.

Our findings

Essex West and East Crisis Resolution Home Treatment Teams (CRHT), A&E liaison Basildon and Southend, RAID Basildon and Southend teams, South Essex street triage

Vision and values

- Information about the trust's visions and values was available in each team.
- Staff had away days when they reviewed how their aims fitted in with the trust values. Managers referred to values based recruitment and ensured new staff were recruited in line with trust values.
- Staff referred to 'take it the top' staff and patient engagement events across the trust where they could meet the chief executive officer (CEO) and other senior staff to learn about developments in the trust and give feedback. CRHT staff referred to a recent visit by senior trust staff including the CEO.

Good Governance

- The trust used gatekeeping data systems. These indicators helped to gauge the performance of the teams. Managers provided data on performance to the trust and received data and feedback from this to compare their service with others. Where performance did not meet the expected standard, action plans were put in place. For example one team leader told us daily contacts were not being fully captured and we saw across teams that staff had been reminded of the need to submit timely daily diary sheets.
- Managers attended local meetings such as 'sit rep' daily telephone conference calls and monthly staff steering groups to discuss and review safety issues, audits and incidents. The information was then discussed with staff at team meetings to ensure consistency of approach and improve the service. We found that the quality of staff team meeting minutes varied. For example West CRHT did not fully capture actions taken regarding issues raised.
- Team leaders were able to book additional staff cover when required to ensure their services continued to run when there were vacancies or occasions of staff sickness.
- Trust magazines and emails gave staff opportunities staff to keep up to date with trust developments and sharing good practice.
- Teams had staff champions to lead and monitor areas further for example on safeguarding and involving carers.
- Meetings took place with acute hospital and police staff to review trust interagency working.

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.

Leadership, morale and staff engagement

- Managers confirmed the recent restructuring had impacted on the teams. However, they now were now managed under the 'community' directorate as opposed to 'inpatient' which they felt was more appropriate due to their community work. Staff told us rapid response measures had given them additional senior management support during a difficult time. As part of this response, East CRHT had taken over part of the West team location/caseload to ensure more equal distribution.
- Staff told us they were proud of the job they did. Most staff were positive about the support they received from their manager and leadership. They were aware of the trust's whistleblowing policy and that they felt free to raise concerns and were listened to. Staff referred to other ways they could anonymously raise issues such as 'have you got something to tell us' and 'I'm worried about' where staff could email the trust anonymously with concerns and 'a groan board' had been introduced at team level to raise issues. We observed a CRHT team meeting and staff were able to raise and discuss things openly and democratically, and gave feedback for their service.
- Staff sickness for the East CRHT was 7% which is above national average; it was 2% for West CRHT. High levels of staff sickness was being managed via the appropriate trust human resources policy.
- 'Let's talk about' patient, carer and staff events took place across the trust as additional ways to give feedback and learn about developments.
- Exit interviews and feedback was sought from staff leaving the service. There were systems in place to monitor reasons for staff sickness and staff turnover.
- Staff across CRHTs spoke of the challenges of the restructuring and in East team we noted lower staff morale, which appeared to be affected by the lack of continuity of management and staff support/ supervision. Five staff told us that decisions were made from senior trust staff and cascaded down to staff without consultation or explanation. They said that feedback was not valued by the trust and did not feel safe to give it.
- Managers said they had access to training and development such as degree courses or leadership training.
- Staff members told us that recruitment of high quality staff was a problem but they were aware the trust was attempting to address this issue and revising their advertising process and induction.

Commitment to quality improvement and innovation

- Both CRHTs had achieved home treatment accreditation scheme accreditation in 2015, a peer led review to compare themselves with other similar services and national standards. East CRHT had achieved 'excellent' status.
- Both CRHTs had nurse non-medical prescribers who are specially trained nurses allowed to prescribe any licensed drugs within their clinical competence.
- West RAID team had a quality improvement report comparing their work in 2015 to 2013 with positive results. Feedback from 102 staff in 2015 showed that 86% were satisfied with the referral process compared to 26% in 2013. 89% were satisfied with the experience of working with the team compared to 27% in 2013.
- The CRHT virtual whiteboard board had been developed by a team member to improve the team's monitoring of patient contacts.

Health-based places of safety Basildon MHU and Rochford Hospital

Vision and values

- Information about the trust's visions and values was available in each team where section 136 staff worked from.

Good governance

- The governance structure for the section 136 place of safety was not clear as staff were from other wards. There were no joint local procedures or protocols in either place of safety available for staff to refer to and we requested them directly from the trust. These were then provided. All policies were available to staff on the intranet.
- At Rochford hospital there was a typed page providing guidance to staff. It did not reflect national standards or best practice and was out of date. However, the full policy was available on the intranet.
- The trust's policy did not fully reflect the revised MHA code of practice.

Are services well-led?

Good

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

- The trust captured data on the use of section 136 places of safety and street triage system regarding number of patient assessed, response times and transfer/ discharge from the place of safety.
- The trust was in consultation with the local authority about the long waiting times for approved mental health practitioners out of hours. This had also been raised through System Resilience Groups and the Local Authority was being held to account for long waits through this group by the CCGs.

Leadership, morale and staff engagement

- There was a lack of effective local leadership for the places of safety. At Rochford hospital the site officer meetings were poorly attended and two recent meetings (in March and May 2015) had been cancelled.

Commitment to quality improvement and innovation

- The trust policy referred to section 136 forums between police and the trust. We saw that police liaison meetings had taken place where agencies reviewed the quality of the service and made recommendations for improvement. We noted that the paramedics were invited to attend the Basildon meeting.