Requires improvement

Leeds and York Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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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)
RGDBL	Becklin Centre	Crisis Assessment Service	LS9 7BE
RGD02	Aire Court Community Unit	Intensive Community Service: South/South East	LS10 4BS

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

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 requires improvement because:

- The crisis assessment unit was admitting patients for reasons other than its stated purpose of providing extended assessments for people experiencing acute and complex mental health crisis. The unit was not intended and was not suitable for lengths of stay significantly above 72 hours. The unit was taking admissions due to bed management and other issues for which it was not suitable.
- Compliance with mandatory training in immediate life support was 63% in the crisis assessment service. Compliance with mandatory training in essential life support and immediate life support was 64% and 44% respectively in the intensive community service. This meant in an emergency not all staff would be trained to assist.
- The crisis assessment service and the intensive community service were below 75% compliance with staff appraisal targets.
- The crisis assessment service was not regularly collecting and sharing data with other agencies to monitor compliance with all aspects of the crisis care concordat.
- The crisis assessment service had significant gaps in section 136 documentation, including for example the time taken between detention and assessment.
- The crisis assessment service and the intensive community service did not have effective governance systems in place to accurately monitor and share information about the service with the Care Quality Commission in a timely manner.

However,

- Feedback was positive from current and former patients and their carers about both the crisis assessment service and the intensive community service.
- The crisis assessment service operated 24 hours a day, seven days a week and was able to respond to high risk cases quickly.
- The intensive community service provided a clear pathway from admission to discharge which stabilised recovery and reduced crisis symptoms.
- The crisis assessment service had established several new approaches to multi-agency working. These included employing nurses to work in the local police control centre, establishing a team specifically to support the police with initial mental health assessments and forming a partnership with the local substance misuse services to secure early access for patients.

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:

- Compliance with mandatory training in immediate life support was 63% in the crisis assessment service. Compliance with mandatory training in essential life support and immediate life support was 64% and 44% respectively in the intensive community service. This meant in an emergency not all staff would be trained to assist.
- Neither service had a thermometer in their clinic room to monitor adherence to the trust's medicines code. The crisis assessment service addressed this during inspection but when the temperature was higher than the established limit the service had no way to reduce it. Both services were unable to monitor their compliance with the trust's policy for the safe storage of medication in clinic rooms.
- Both the section 136 suite and the crisis assessment unit had issues in relation to mixed sex accommodation. The crisis assessment unit had designated male and female sections. However the doors were left open between them. The section 136 suite did not have bathrooms designated specifically male and female and patients had to walk past bedrooms to access bathrooms.
- Vacancy and sickness rates were high in the crisis assessment service which meant that staff were regularly working extra hours to cover shifts.

However,

- The crisis assessment service had a clear system for managing referrals which established the level of priority and risk and was able to respond quickly to referrals where the patients had high risks.
- The crisis assessment service had been refurbished since the previous inspection which had addressed concerns about the safety of the environment.
- Staff in both the crisis assessment service and the intensive community service knew how to report incidents and could describe a process for receiving feedback from incidents and complaints.
- Most staff in the crisis assessment service and the intensive community service had a good understanding of the duty of candour.

Requires improvement

Summary of findings

Are services effective?

We rated effective as requires improvement because:

- Not all admissions to the crisis assessment unit were for its stated purpose of providing extended assessment for adults experiencing acute and complex mental health crises for a period of assessment of up to 72 hours. The unit was also taking admissions due to bed management and other issues for which it was not suitable.
- Staff in the crisis assessment service and the intensive community service did not have a shared understanding of the purpose of the crisis assessment unit.
- Compliance with training in the Mental Health Act and Mental Capacity Act were below 75% in both the crisis assessment service and the intensive community service. In the crisis assessment service there were significant issues in documentation used for detentions under section 136 of the Mental Health Act.
- Compliance rates with staff appraisal targets were low in both the crisis assessment service and the intensive community service. This meant that staff were not given opportunities to review their performance.
- Clinical supervision rates were low in the intensive community service which meant that staff were not regularly given an opportunity to reflect on their practice in one to one sessions.
- Staff in the crisis assessment service and the intensive community service were unable to reference how guidance from the National Institute for Health and Care Excellence informed their practice.
- It was not clear from the data provided by the trust how the service complied with the target for management supervision.
- Staff in the crisis assessment service did not have access to the electronic records of patients known to mental health services who were admitted to the section 136 suite for children and young people.

However,

- The crisis assessment service was a member of the crisis care concordat and had established several new approaches to multi-agency working. These included employing nurses to work in the local police control centre and forming a partnership with the local substance misuse services to secure early access for patients.
- People who used both the crisis assessment service and the intensive community service received a thorough and comprehensive assessment of their needs.

Requires improvement

Summary of findings

- Care plans from the crisis assessment service responded to immediate risks.
- Care plans from the intensive community service focussed on reducing crisis symptoms and stabilising recovery.
- Staff in the crisis assessment service and the intensive community service were prompted to consider and assess capacity of patients who were unable to make some specific decisions at the time
- Both the crisis assessment service and the intensive community service assessed the physical health of patients during their first appointments.

Are services caring?

Good

We rated caring as good because:

- Feedback on the crisis assessment service and the intensive community service from current and former patients was positive.
- We observed kind and respectful interactions between patients and staff in both the crisis assessment service and the intensive community service.
- Staff in the crisis assessment service and the intensive community service were knowledgeable about patients and spoke about them in a professional and non-judgemental way.
- The intensive community service the team worked collaboratively with volunteers from a MIND led project which encouraged former patients to work within the service to use their experience to support current patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Neither the crisis assessment service nor the intensive community service had criteria for referrals which excluded patients, for example by not excluding patient patients who were intoxicated from the section 136 suite.
- The crisis assessment service had established a team specifically to support the police with initial mental health assessments which had led to a reduction in section 136 detentions.
- The crisis assessment unit, when used for its primary purpose, had demonstrated a reduction in inappropriate admissions to inpatient wards. The extended assessment allowed a more detailed review of patient risks which had led to reduced admissions to inpatient wards.

Summary of findings

- The intensive community service had a clear pathway for the patient from accessing the service to being discharge.

However,

- In the period January 2016 to June 2016 46% of patients referred to the crisis assessment service waited more than four hours for assessment.
- The doors dividing the crisis assessment unit and the section 136 suite were not fully obscured which meant that patients on the unit could see patients in a state of crisis being admitted to the section 136 suite.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff in the crisis assessment service and the intensive community service did not know the trust vision and values.
- The crisis assessment service did not regularly collect and share data with other agencies to monitor compliance with all aspects of the crisis care concordat.
- Governance systems did not support the staff of the crisis assessment service to operate the crisis assessment unit within its stated purpose of providing extended assessment for adults experiencing acute and complex mental health crises for a period of assessment of up to 72 hours.
- The crisis assessment service and the intensive community service did not have an effective governance system in place to allow it to respond quickly to requests for information.

However,

- Staff felt supported by their local managers and local managers were positive about the trust senior managers.
- Key performance indicators were monitored in both the crisis assessment service and the intensive community service, for example the four hour target from referral to crisis assessment.
- Both the crisis assessment service and the intensive community service maintained a local risk register and service managers were clear about the process for escalating risks to the services.
- The crisis assessment service had undertaken evaluations which had reviewed the performance of several aspects of the service.

Summary of findings

Information about the service

The Crisis Assessment Service is provided by Leeds and York Partnership NHS Foundation Trust. It provides assessment and support to people over the age of 18 years who are experiencing a sudden and acute mental health crisis, which requires an urgent response. It is based at the Becklin Centre which is located on the St. James University Hospital site in Leeds. The service had the main function of providing assessments for patients in a state of mental crisis both in the community and in the health based places of safety. It also provided:

- the crisis assessment unit
- the Leeds single point of access
- the mental health crisis triage team
- the early intervention district control room nurse team
- a bed management/gatekeeping team.

The service provided two section 136 health based places of safety. One of the section 136 health based places of safety was for adults over the age of 18 and had facilities for up to four patients to be admitted for assessment. The other section 136 health based place of safety was for young people under the age of 18 years old and had facilities for up to two patients to be admitted for assessment.

Section 136 of the Mental Health Act 1983 grants the police powers to detain people who are suspected of having an urgent mental health need which poses a risk to themselves or others. A section 136 health based place of safety is a specifically designed unit which allows mental health professions to assess a patient and judge whether he or she requires detention and compulsory admission to hospital.

The crisis assessment unit is a specialist unit within the service providing extended mental health assessments for people over the age of 18 years old for a period of up to 72 hours. This six-bedded unit opened in 2015.

The district control nurses work within the police control centre in Leeds with the aim of reducing police interventions in situations where interventions by mental healthcare professionals is more appropriate. The mental health crisis triage team are a team who assess people in the community to help police officers make a clinically informed judgement on whether a section 136 admission is necessary and appropriate.

Leeds and York Partnership NHS Foundation trust provide intensive community services across three localities.

- South/South East Locality team based at Aire Court in Middleton, South Leeds
- East/North East Locality team based at St. Mary's House in Potternewton, North East Leeds
- West/North West Locality team based at St. Mary's Hospital in Armley, West Leeds

The intensive community services provide an alternative to hospital admission through intensive community and home based treatment. The service is provided for people over the age of 18 years old and includes older people over the age of 65 years old.

We last inspected the services provided by Leeds and York Partnership NHS Foundation Trust in 2014. At this time, the mental health crisis services and health-based places of safety were found to not be compliant with all the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The service was not meeting the essential standards relating to care and welfare of patients (Regulation 9) and the management of medicines (Regulation 13). The service received three compliance actions following the inspection in 2014, two under Regulation 9 and one under Regulation 13. These compliance actions were inspected as part of the comprehensive review and the requirements had been met.

Our inspection team

The team was led by:

Chair: Phil Confue, chief executive of Cornwall Partnership NHS Foundation Trust

Head of Hospital Inspection: Nicholas Smith, Head of Hospital Inspection (North West), Care Quality Commission

Summary of findings

Team leaders: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

Chris Watson, Inspection Manager, Care Quality Commission

The team comprised an inspector together with an expert by experience and three specialist advisors; two mental health nurses, and a social worker. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example, as a patient or carer.

Why we carried out this inspection

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

How we carried out this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information

During the inspection visit, the inspection team:

- visited the crisis assessment service at the Becklin Centre, St. James University Hospital
- visited the South/South East Locality team at Aire Court in Middleton, South Leeds
- undertook a further unannounced inspection of the crisis assessment service at the Becklin Centre, St. James University Hospital
- toured the section 136 health based place of safety, the section 136 health based place of safety for children and adolescents and the crisis assessment unit to look at the quality and safety of the environment
- toured the intensive community service facilities at Aire Court to look at the quality and safety of the environment
- spoke with the managers of both the crisis assessment service and the intensive community service
- interviewed 16 staff from both the crisis assessment service and the intensive community service
- spoke with 6 former and current patients including one volunteer who was herself a former patient
- spoke with three carers of patients of the intensive community service
- reviewed 11 records of patients from both the crisis assessment service and the intensive community service
- observed a handover meeting in the crisis assessment service
- observed a multi-disciplinary team meeting in the intensive community service
- observed the discharge of a patient from the section 136 suite health based place of safety
- observed two patient home visits with the intensive community service and one assessment of a patient with the crisis assessment service.

Summary of findings

What people who use the provider's services say

We talked to six current and former patients and carers. All the feedback we received about both the crisis assessment service and the intensive community service was positive. Patients of both services described the staff as caring, kind and patient. Patients in the crisis assessment unit described the unit as calm and safe.

Prior to the inspection we received feedback from one former patient of the crisis assessment unit who told us that the staff had been empathetic, understanding and very supportive during their time on the unit.

There were no negative comments from patients or carers. We did not receive any comment cards related to the crisis assessment service or the intensive community service.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the crisis assessment unit is used according to its statement of purpose to provide services for patients experiencing acute and complex mental health crises that require a period of assessment of up to 72 hours.
- The trust must routinely collect and share data with other agencies to monitor compliance with all aspects of the crisis care concordat.
- The trust must improve compliance with section 136 documentation standards.
- The trust must ensure that the crisis assessment service and the intensive community service has effective governance systems in place to share information in a timely manner.
- The trust must improve compliance with annual appraisal targets.
- The trust must improve compliance rates with mandatory training, including essential and immediate life support training.

Action the provider SHOULD take to improve

- The trust should ensure that the privacy and dignity of patients admitted to the section 136 suite is maintained.
- The trust should consider privacy and dignity with regards to gender of patient in the section 136 suite and crisis assessment unit.
- The trust should ensure that staff in the crisis assessment service have timely access to records of patients admitted to the section 136 suite for children and adolescents.
- The trust should improve compliance with response time targets for referral to assessment in the crisis assessment service.
- The trust should ensure that clinic room temperatures are within those stated in the trust's medicines code.

Leeds and York Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Crisis Assessment Service	Becklin Centre
Intensive Community Service	Aire Court Community Unit

Mental Health Act responsibilities

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

Training in the Mental Health Act was mandatory for all staff. The trust had a target of 90% compliance with mandatory training. However compliance was poor in both services. The crisis assessment service had a compliance rate of 60% with the inpatient user module of the Mental Health Act training. The intensive community service had a compliance rate of 50% with community module of the Mental Health Act training.

Staff that we spoke to had an understanding of the principles of the Mental Health Act (1983) and the guiding principle of least restriction. The immediate plan of care document used by staff prompted to consider capacity to consent to treatment to document if patient were read their rights in relation to detention under the Act. However, the crisis assessment service had significant issues with gaps in documentation in section 136 paperwork.

The crisis assessment unit had a notice on the front door for informal patients with details of their right to leave at any time.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act and the Deprivation of Liberty Safeguards was mandatory for all staff. However, compliance with training was poor with the crisis assessment service at 74% and the intensive community service 56% compliance. This mean that the trust could not be sure patients' rights were upheld.

Staff had a general understanding of the Mental Capacity Act (2005) and its principles. Staff were aware of the trust policy on the Mental Capacity Act and how to access it on the trust's internal network. Documentation used by both the crisis assessment service and the intensive community service prompted staff to consider capacity and reminded staff that capacity is assessed on a time and decision specific basis. Care records showed evidence of capacity assessments.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Crisis Assessment Service

The crisis assessment service was based in the Becklin Centre which was located at the St. James Hospital site in Leeds. The service was located entirely on the ground floor of the Becklin Centre in an area which was split into four sections. The first section was the crisis assessment unit. This was a ward with six bedrooms off a central corridor, three for males and three for females. Male and female bedrooms were separated by a pair of doors. The doors had a clear glass panel that had been partially obscured. Bedrooms were not en suite. Both the male and female sections of the corridor had a wet room which contained a shower and toilet.

The crisis assessment unit consisted of:

- a corridor split into two sections with locked doors separating the unit from the section 136 suite for adults at one end.
- one section for female patients which included three bedrooms, a shared shower room with toilet facilities, a female-only lounge and an office for nursing staff. This section of the corridor was separated by locked doors from the section 136 suite at one end and the male section at the other end.
- one section for male patients which included three bedrooms and a shared shower room with toilet facilities. This section was separated by locked doors from the female section of the corridor at one end and the communal area at the other end.
- a communal area which included; a communal lounge with a television and seating area and a kitchen area with a microwave and kettle for hot drinks; an interview room which doubled as a visitors room for patients in the crisis assessment unit only; and a clinic room.
- a pre-assessment area used by the crisis assessment service for unit-based assessments. This area was separate to the crisis assessment unit and had two interview rooms, a small seating area and a space for making hot drinks.

There was a female only lounge and a lounge for all patients. The mixed sex lounge contained a television, sofas, board games and books. The nurses office was on the female side of ward, meaning that men could not access the office without walking through the female corridor, despite there being a sign telling men not to walk through this corridor. The design of the ward meant that nurses in the office were not able to observe all areas of the ward from the office. Staff mitigated this by being in the communal areas to observe patients. The ward had been designed to a high anti-ligature standard which meant that there were no obvious potential ligature points. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures. There was a nurse call system in place on the unit.

The second section of the crisis assessment service was the section 136 health-based place of safety for adults, called the section 136 suite. section 136 is a part of the Mental Health Act (1983) which the Mental Health Act (1983) Code of Practice explains as “an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety, if the person appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control”. The section 136 suite was next to the female section of the crisis assessment unit and was separated from this by double doors. The doors contained a glass panel that had been partially obscured. Staff told us that the doors had been only partially obscured so that staff in the crisis assessment unit responding to incidents in the section 136 suite would have been able to see through the doors and know what was happening. However it meant that female patients in the crisis assessment unit were able to see patients in a state of mental crisis as they were admitted to the section 136 suite.

We asked staff about their understanding of how to manage patients in a mixed sex environment in relation to the layout of the section 136 suite. Whilst staff were clear that the risks of having patients in a mixed sex environment would be assessed and monitored, staff did not provide any details on how privacy and dignity would be

maintained for patients in the mixed sex environment. The layout of the suite meant that patients would in some cases have to pass bedrooms to access shower and toilet facilities. Shower and toilet facilities were not designated male or female. Staff told us that it was not possible to offer gender segregation as the nature of the suite was such that at any time both male and female patients might be admitted without warning. The layout of the suite meant that the service could not guarantee the dignity and privacy of patients using the section 136 suite.

The suite had been designed to a high anti-ligature standard which meant that there were no obvious ligature points. The service had undertaken a ligature risk assessment in April 2016 which detailed the actions required to mitigate ligature risks.

The third section of the crisis assessment service was the section 136 health-based place of safety for children and adolescents. This section 136 suite had its own entrance, kitchen and bathroom facilities. There were two bedrooms in the suite which meant that up to two patients could be admitted in a state of mental crisis for assessment. The suite had been designed to a high anti-ligature standard which meant that there were no obvious ligature points. This section 136 suite was formerly the services section 136 suite for adults. Although the suite was designated for children and adolescents, we did not note any specific adaptations to make it a child-centred environment.

The fourth section of the crisis assessment service was the staff area. This area contained various offices and staff rooms. It was not accessible to patients of either section 136 suite or the crisis assessment unit.

There was a fully equipped locked clinic room which contained a medicines fridge, resuscitation equipment, emergency drugs and a 'grab bag'. A grab bag is a small, accessible bag which contains emergency equipment for first aid. An anti-ligature knife was located in the clinic room for patients in the crisis assessment unit and the section 136 suite for adults. We raised with staff about accessing the anti-ligature cutter in emergencies and were told that as all staff carried keys for the clinic room, the cutter was accessible to staff in an emergency. The clinic room did not have an examination couch. Staff explained to us that checks such as blood pressure monitoring would be conducted in patient's bedrooms.

The service had recently acquired an electronic prescribing system which required additional computer support, including a network server which had been installed in the clinic room. The trust's medicine code stated that medicine storage units should be placed in environments below 25 degrees. During our first visit, we raised with the service manager that the clinic room temperature felt noticeably warm but there was no thermometer to accurately monitor the temperature. Staff told us that the server for the electronic prescribing system was a major contributor to the temperature in the clinic room. On our return visit a thermometer had been installed. Staff had placed an air conditioning unit in the clinic room to reduce the temperature; however we saw that the clinic room temperature was 29 degrees meaning the unit had not reduced the temperature to the required level.

There were no seclusion facilities in any part of the crisis assessment service.

All staff carried personal alarms for staff to request support in an emergency. The service was connected to the internal alarm system within the Becklin Centre. If an alarm was activated then one member of staff from each ward within the centre was designated as a responder and would attend.

The crisis assessment unit and the section 136 suites had been recently cleaned. The cleaning roster indicated that there was a regular schedule of cleaning. Handwashing facilities were available in the clinic room and there were hand gel points located in the service. We found that furniture was clean and well-maintained. In 2014 the Care Quality Commission issued a compliance action stating that 'the provider must ensure that the seating is appropriate at the section 136 suite at the Becklin Centre, Leeds, as this could potentially be used to cause injury'. The service had replaced the seating with new heavier furniture which could only be moved with difficulty. We found that the provider had met this compliance action.

The service had undertaken a full environmental ligature assessment of both section 136 suites and the crisis assessment unit in April 2016. This assessment identified potential ligature risks and the procedure for staff to mitigate identified risks. In 2014 the Care Quality Commission issued a compliance action stating that 'the provider must ensure that the ligature points (sink taps and door handles) in the bathroom at the section 136 suite at the Becklin Centre, Leeds, are removed'. The section 136

suite had been relocated and was designed to a high anti-ligature standard which meant that there were no obvious ligature points and that the provider had met the terms of this compliance action.

Intensive Community Service

The intensive community service – South/South East operated from Aire Court located in Middleton, South Leeds. The service primarily offered home-based treatment and as such had seen a decline in the past twelve months in the number of patients coming into Aire Court for treatment. The rooms at Aire Court were not fitted with alarms, however staff could access personal alarms and the service was in the process of reviewing arrangements for personal alarms for staff working in the community.

All patient accessible rooms were clean and tidy. The service had a clinic room which was well-equipped and stocked. There was an examination couch and equipment necessary to carry out physical examinations including venepuncture. Venepuncture is a medical procedure used to obtain blood samples. Hand washing facilities were available in the clinic room for staff to use. The clinic room had a fridge to store medication. The fridge temperature was checked regularly to ensure that the medicines in the fridge were stored safely at the correct temperature. The clinic room did not have a thermometer to monitor temperature, as per the trust policy.

Safe staffing

Crisis Assessment Service

Establishment levels in the period 1 January 2016 to 31 March 2016 for the crisis assessment service were:

- Qualified nurses whole time equivalents – 43.5
- Nursing assistants whole time equivalents – 15
- Vacancies qualified nurses – 7.9
- Vacancies nursing assistant – 2.9
- Qualified nurse vacancy rate (%) - 18%
- Nursing Assistant vacancy rate (%) - 19%
- Shifts filled by bank and agency staff to cover sickness, absence or vacancies - 27
- Shifts not filled by bank or agency staff for sickness, absence or vacancies – 10
- Total % of staff leavers in the last 12 months – 5%
- Total permanent staff sickness overall – 5%

The crisis assessment service had a vacancy rate of 18% whole time equivalents qualified nurses. This was higher than the trust average vacancy rate of 14%. The vacancy rate of nursing assistants was 19% which was higher than the trust average of 14%. Staff told us that the high number of vacancies had increased pressures on the rest of the team. The service relied on staff regularly working overtime to cover shifts. The service completed an incident report every time a shift could not be filled by overtime, bank or agency staff. Examples of the impact of these incidents included a patient not phoned back after referral, an assessment under section 136 delayed until the following shift, and the service having to cancel the mental health crisis triage service for one night to free staff to cover other areas of the service.

The permanent staff sickness rate was 5% which was higher than the trust average and NHS average of 4%. Staff told us that the service was reported as 'under pressure' as it had five staff on maternity leave and an additional staff member on long term sick leave. The service did not use agency staff which meant that staff regularly worked paid overtime to cover staff shortages.

The service did not have a tool to calculate the required staffing. The trust explained that establishment levels were determined by the service manager based on the whole time equivalent demand, the percentage of worked hours allocated to bank and agency, the percentage skill mix of registered and unregistered staff, the percentage of newly qualified staff operating on the unit, and the percentage vacancy factor on the unit.

When a patient was admitted, the section 136 suite for children and adolescents was staffed by an approved mental health professional from the crisis assessment service and a consultant from the community mental health service for children and adolescents provided by Leeds Community Health Trust. Staff told us that there was a positive working relationship between the crisis assessment service and Leeds Community Health Trust and that doctors would attend quickly when needed for the mental health assessment of a young person.

Staff in the crisis assessment service were required to undertake 21 modules of mandatory training. The trust target for mandatory training compliance was 90%. As of February 2016 the crisis assessment service was below this target with a compliance rate of 85%. Modules below 75% compliance were clinical risk (60%), fire – level three (70%), immediate life support (63%), infection control – clinical (63%), low level physical interventions with promoting safe

and therapeutic services and breakaway skills (50%), Mental Capacity Act and Deprivation of Liberty Safeguards – level two (74%), Mental Health Act – inpatient user level two (60%), and moving and handling principles (68%).

Two staff members described how they had experienced difficulties accessing mandatory training due to high staff vacancies, with one undertaking her prevention and management of violence and aggression training through paid overtime. The low compliance with breakaway skills meant that the service could not be assured that all staff who were caring for patients were safeguarded from physical danger. The low compliance with immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.

Intensive Community Service

Establishment levels in the period 1 January 2016 to 31 March 2016 for the intensive community service – South/ South East were:

- Trust levels qualified nurses whole time equivalents – 11.5
- Trust levels nursing assistants whole time equivalents – 5
- Vacancies qualified nurses – 1.2
- Vacancies nursing assistant – 0
- Qualified nurse vacancy rate (%) - 10%
- Nursing assistant vacancy rate (%) - 0%
- Shifts filled by bank and agency staff to cover sickness, absence or vacancies - 19
- Shifts not filled by bank or agency staff for sickness, absence or vacancies – 12
- Total % of staff leavers in the last 12 months – 15%
- Total permanent staff sickness overall – 2%

The intensive community service had vacancy rates for both qualified nurses and nursing assistants that were lower than the trust's overall average vacancy rate. The intensive community service had a vacancy rate of 4% which was lower than the trust's average of 14%. The service had a sickness rate of 2% which was lower than the trust and NHS average of 4%. As with the crisis assessment service, the intensive community service did not have a tool to determine staffing levels.

Staff in the intensive community service were required to undertake 19 modules of mandatory training. The trust target for compliance with mandatory training was 90%. The service average compliance with mandatory training as of February 2016 was 77% which was below the trust target. Seven modules were below 75% compliance. These were essential life support (64%), fire – level three, immediate life support (44%), infection control – clinical (74%), Mental Capacity Act and Deprivation of Liberty Safeguards – level 2 (56%), Mental Health Act – community (50%), and safeguarding level 3 (70%).

The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.

Assessing and managing risk to patients and staff

Crisis Assessment Service

We examined seven records of patients which included patients admitted to the section 136 suite and the crisis assessment unit. In records for the 136 suite we saw that patients had an immediate plan of care.

The service used two risk assessments; the functional analysis of the care environments risk profile and a gate assessment. These were the recognised assessment tools used across the trust.

The crisis assessment unit was primarily intended for informal patients, although there had been occasions where people detained under the Mental Health Act (1983) had been admitted to the unit. We saw that there was a sign on the door advising informal patients that they were free to leave the unit at will.

Patients on the crisis assessment unit were allowed keys to their own bedrooms. However, none of the patients on the unit during the inspection had their own key. The unit's bedroom key log stated that 'all patients are entitled to a bedroom key whilst on the crisis assessment unit and should be offered one on arrival', however the last entry on the log was dated 26 Feb2016. We concluded that patients were not routinely given a key to their bedrooms.

The service had a swipe card and intercom system to access the different areas within the building. Staff undertook different observation levels of patients as the layout of the section 136 suites and the crisis assessment unit did not permit staff to observe all patients from a central point. Observation levels were determined by risk assessment and could range from one-to-one observations; fifteen/thirty minute observations and general observations.

Requires improvement

Are services safe?

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

Patients admitted to the section 136 suites were usually searched by the police before admission. Managers told us that staff would usually check with the police that a search had been carried out. The crisis assessment unit did not regularly search patients or patient areas, however we noted that the unit's information leaflet stated that 'if staff have a reasonable suspicion they are able to search you, and any part of the ward environment including [patient's] rooms'.

Staff described excellent working relationships between the service and Leeds Community Health trust in relation to the section 136 suite for children and adolescents. However the staff of the crisis assessment service did not have access to patient records held by the community mental health service for children and adolescents. This meant that staff in the service would have to manage risks to the patient without any previous history to inform this.

There were 29 uses of restraint on 21 different services users between 1 October 2015 and 31 March 2016, seven of which resulted in the use of prone restraint and all seven of the prone restraints resulted in rapid tranquilisation. The Care Quality Commission defines prone restraint as 'holding chest down whether face down or to the side'. Rapid tranquilisation is defined by the National Institute for Health and Care Excellence as when 'when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them… to reduce any risk to themselves or others, and allow them to receive the medical care that they need'.

There were no recorded uses of seclusion or long-term segregation. Twenty uses of restraint were recorded in the 136 suite and nine were recorded in the crisis assessment unit. All staff had received training in personal safety with breakaway skills and 90% of staff were trained in high level physical interventions with promoting safer and therapeutic services and breakaway skills. Staff told us that the use of restraint was limited and was always considered the last resort. Staff were aware of the trust rapid tranquilisation policy. All uses of restraint were regarded as an incident that needed to be reported using the trust's electronic incident reporting system.

90% of staff were trained in safeguarding adults which was a mandatory training module. Safeguarding children level three was a mandatory training for band five staff and above, and 79% of staff were trained in this module. This was below the trust target of 90%. Although the use of the section 136 suite for children and adolescents was rare, the low compliance with this module of training meant that the service could not be assured that all staff had the training to deal with children who may have presented with safeguarding concerns. Staff told us they knew how to recognise abuse and how to make safeguarding referrals. Managers described a positive working relationship with the trust's safeguarding team who were available for advice and support in safeguarding. Staff knew how to contact the designated trust leads for adult safeguarding and for child safeguarding.

The clinic room in the crisis assessment unit had a fridge which allowed the service to safely store medication. Fridge temperatures were routinely monitored. The service manager was also a member of the trust-wide medicines safety group. Medicines were checked every Monday by a qualified nurse. The trust's medication storage policy required that clinic room temperatures should not exceed 25 degrees. Whilst we noted that the temperature in the clinic room was warmer than other areas of the crisis assessment unit, there was no thermometer in the room to accurately monitor whether the temperature exceeded 25 degrees. We raised this with the service manager during the inspection and were told that a thermometer would be installed in the clinic room.

Children were allowed to visit the crisis assessment unit and the unit had an interview room which doubled as a visitor's room. Children were not allowed to visit the section 136 suite for adults.

Intensive Community Service

We reviewed five care records. The service operated on the principle that referrals would include an initial risk assessment undertaken by the referrer. Whilst staff would update this risk assessment they did not routinely undertake an additional initial risk assessment when patients first entered the service.

When the service received a referral it undertook an initial engagement meeting with the patient. The initial engagement meeting could take place in the patient's home, in one of the units used as team bases or in another agreed venue and was the first interaction between the staff of the service and the patient. The engagement

meeting allowed the service to develop a recovery care plan with the patient. All patient referred into the service received a crisis plan as part of the initial engagement meeting.

The service did not operate a waiting list and was able to see patients referred into the service within 24 hours. Managers explained that whilst there was no set target for seeing patients, the 24 hour target was generally accepted as an informal target and would only be exceeded if patients requested that staff visited on a specific day or time.

The average caseload for the service as a whole in the period January to June 2016 was 25 patients. The service did not monitor caseloads per staff member as care was delivered by the whole team. Staff told us that the caseload had felt too high earlier in the year but had fallen to a manageable level in the last few months.

91% of staff were trained in safeguarding adults which was a mandatory training module. Safeguarding children level three was a mandatory training for band five staff and above, and 70% of staff were trained in this module. This was below the trust target of 90%. Whilst the service was for adults over 18 years old, the low compliance with this training module meant that the service could not be assured that all staff had the skills to recognise safeguarding concerns in situations such as where patients have responsibility for children. In interviews staff demonstrated an understanding of safeguarding which included the procedure for making referrals and how to recognise the different types of abuse.

Medicines were stored on site and were stock checked every Thursday by a trust pharmacy technician to monitor whether medication was in date and matched recorded stock levels. The service kept an emergency stock of some medicines including lorazepam and diazepam which could be prescribed by doctors in an emergency to cover weekends.

Track record on safety

In the period March 2015 to February 2016, the trust reported 48 serious incidents. None were reported for crisis assessment service or the 136 suite. In the period July 2015 to June 2016 the crisis assessment service reported 252 incidents, which was less than 2% of the total number of incidents reported in the trust in the same period. Ten of the incidents were marked as 'staff shortages'.

The trust was a member of the crisis care concordat. The crisis care concordat is a nationally agreed framework for how services and agencies should work together to support people in mental crisis. One of the main aims of the concordat is that agencies should work together to prevent unnecessary admissions to section 136 suites.

Four serious incidents were reported by the intensive community service – South/South East. Three of these incidents involved the unexpected or avoidable death or severe harm. The service reported five incidents in the period July 2015 to June 2016. All five incidents were categorised as moderate harm where patients required further treatment or procedures.

The reporting system used by the trust included a requirement that staff report the immediate action taken after an incident and the action taken to prevent the recurrence of an incident.

Reporting incidents and learning from when things go wrong

The trust had an electronic system for reporting incidents. The system allowed any staff member to report an incident. All staff knew how to report incidents using the system. Managers told us that if incidents met the criteria of a serious incident then they would first undertake a fact-finding investigation within 12 hours. Any incident involving death or serious harm to a patient would be investigated with a root cause analysis.

The monthly clinical governance forum allowed the service to discuss incident investigations. The forum included managers and members of the multidisciplinary team. The crisis assessment service had a weekly reflective session with a psychotherapist and an informal 'team talk' meeting which allowed staff to discuss cases and incidents. Staff were able to tell us about incidents that had happened in other services in the trust which had led to changes in practice in the crisis assessment service.

Managers and all but one member of staff who we interviewed had an understanding of the duty of candour, including the requirements of being open and transparent when things went wrong. Staff knew that the duty of candour included the requirement to offer an apology after an incident.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Crisis Assessment Service

The crisis assessment service had four main functions:

- triage of referrals from other services, the police and from patients and carers
- assessments of people in crisis
- managing and staffing the section 136 suites
- gate-keeping access to inpatient user beds in acute wards

Referrals would undergo initial assessment by a single point of access team which received all calls to the service. This team included administrators and clinicians who screened all calls and made an initial decision on the most appropriate service to respond to each referral.

We reviewed two care plans from the section 136 suite and five care plans from the crisis assessment unit. Patients admitted to the section 136 suite received an immediate plan of care which included a crisis plan, identified physical health problems, identified current medication, and capacity. Patients admitted to the crisis assessment unit received a functional analysis of the care environment risk assessment. Care plans included consideration of social networks, carer support and protected factors. There was evidence of risk formulation, where the assessment was used as a basis for producing a plan of care. All patients admitted to the crisis assessment unit had a modified early warning score completed. The modified early warning score is an assessment of six physiological factors; respiration rate, temperature, systolic blood pressure, pulse rate, urine output and level of consciousness. There was no evidence that the unit undertook ongoing physical health monitoring.

All information was securely stored on the trust's electronic patient record system. The system allowed staff to access the records of patients admitted to the section 136 suite and the crisis assessment unit. However when a young person was admitted to the section 136 suite for children and young people, the staff of the crisis assessment service had no access to the electronic records held by Leeds Community Health Trust.

Intensive Community Service – South / South East

The intensive community service provided support for patients with high risks and needs in the community, as an alternative to admission to an inpatient ward. We reviewed five care plans of people using the service. All five care plans included a thorough assessment of risks using the trust's recognised tool, the functional analysis of the care environment. Care plans included evidence of risk formulation, where the assessment was used as a basis for producing a plan of care, as well as crisis planning and documentation of protected characteristics. Protected characteristics are those where discrimination is illegal under the Equality Act (2010), and include age, sex and race. Care plans were recovery focussed and documented carer involvement.

Staff described the routine examination and procedures carried out during the initial appointments with the intensive community service. These included a full physical assessment including the modified early warning score, weight, body mass index, and routine blood tests when appropriate.

All care plans and case notes were stored securely, in the trust's electronic patient record system.

Best practice in treatment and care

Crisis Assessment Service

Apart from immediate medication, the crisis assessment service did not routinely provide treatment. Its purpose was to provide assessment for people showing signs of mental health crisis, to determine their best course of treatment. We observed an assessment of a patient. The assessment included a risk assessment which covered the risks to the patient and to others, the patient's social circumstances, and the patient's physical health. The clinical team explored treatment options with the patient and explained each option. The treatment options included extended assessment in the crisis assessment unit. The assessment concluded with a treatment plan agreed between the patient and the clinical team which covered both short term and long term goals.

The crisis assessment unit provided a safe space for its purpose of undertaking extended assessments of adults experiencing acute and complex mental health crises which required a period of assessment of up to 72 hours. However, the crisis assessment unit was also being used for other purposes for which it was not fit for purpose.

Are services effective?

Requires improvement

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

In the period July 2015 to May 2016 the crisis assessment unit had admitted:

- 24 detained patients
- 8 patients with a length of stay of over nine days
- 7 patients over the age of 65 including one with a diagnosis of dementia

In the period November 2015 to May 2016 the crisis assessment unit had 207 admissions. Of these 207 admissions:

- 139 were for the stated purpose of extended assessments
- 30 were for overnight support requested by the intensive community service
- 29 were for bed management reasons
- 5 were for 'short term treatment in a safe environment'
- 4 were due to the recall of a patient on a community treatment order

The crisis assessment unit had, in some cases, admitted people who required treatment and not extended assessments. The unit was not intended, and was therefore not equipped, for treatment interventions. The unit had admitted older people over the age of 65 including one with a diagnosis of dementia. However, because the unit was not designed for treatment, it did not meet the Department of Health's (2015) guidance 'dementia friendly health and social care environments'. We asked the service to clarify 'short term treatment in a safe space' and were told that the patients had been admitted for clozapine titration in one case and to manage the effects of electro-convulsive therapy in another.

The service had undertaken an evaluation of the unit in May 2016. The evaluation stated that the unit was a therapeutic space for patients because it was a 'supportive, quiet, low stimulus environment'. The evaluation noted, however, that activities were limited on the unit with five out of six former patients making comments that the they did not believe the unit provided any activities. A lack of activities fit the purpose of the unit which required a low stimulus environment to assess people in a state of crisis. It did not fit a model where people were admitted for stays of up to two weeks without meaningful activity.

We found that the additional roles the crisis assessment unit was undertaking had created a lack of clarity about the purpose of the unit both within the crisis assessment service and in other services within the trust. Staff in the intensive community service told us that they were not sure of the criteria for admitting people to the crisis assessment unit and provided examples of incidents where they had attempted referrals to the unit for people they believed matched the criteria to be told that the person was not acceptable for admission. The unit was opened in recognition of a gap in provision for the crisis assessment service to be able to undertake assessments over a longer time period, to fully assess risk and in so doing to reduce unnecessary admissions. As the beds within the crisis assessment unit had become part of the overall system for bed management, the original purpose of the unit was being undermined.

The service manager was unaware of any guidance from the National Institute for Health and Care Excellence that would apply to the service. Guidance that would apply to the service would include such areas as best practice in medication, and assessment and referral in a crisis. The guidance document CG136, 'Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services', applies to all mental health services.

The service manager had undertaken four audits of service provision which reviewed the impact and performance of the district control nurses, the mental health crisis triage team, the harm reduction workers project, and the crisis assessment unit.

Intensive Community Service

We reviewed five care plans of people using the service. All care plans showed evidence of regular review. There was evidence that the service was able to access psychological therapies. One care plan had evidence that a patient was offered interventions which included cognitive behavioural therapy and dialectical behavioural therapy. We reviewed a care plan for a patient referred to the intensive community service on discharge from an older person's inpatient ward. We were able to see that the service had undertaken additional assessments suitable for older people, including a nutritional screening within three days of accepting the referral. This followed guidance from the National Institute for Health and Care Excellence on nutrition support for adults.

Are services effective?

Requires improvement

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During an observation of a home visit we were shown a welcome pack used to introduce new patients to the intensive community service. The pack included a 'menu' for the patient to choose some specific interventions that they thought relevant.

Staff were not aware of any guidance from the National Institute of Health and Care Excellence which applied to the service. The guidance document CG136, 'Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services', applies to all mental health services. The service had participated in one clinical audit in the last twelve months which looked at Driver and Vehicle Licensing Agency advice given during admission to the service. This was a re-audit which had demonstrated improvements in practice. Two further clinical audits were in the development and implementation stage at the time of inspection.

Skilled staff to deliver care

Crisis Assessment Service

The service employed a full range of mental health disciplines including nurses, doctors, social workers, occupational therapists, healthcare support workers. The handover meeting each morning allowed the service to meet as an multi-disciplinary team to review current referrals. The trust required all staff to undergo an induction and the service had a 100% compliance rate with the trust induction.

In the period June 2015 to May 2016 the service had an average clinical supervision rate of 97%. The trust's supervision policy required that all full-time clinical staff undertook clinical supervision for a minimum of an hour every two months. The service provided a number of reflective forums with psychologists and psychotherapists each week to allow staff to discuss caseloads. The service manager told us that the reflective forums were regarded as clinical supervision.

The trust policy required that management supervision was provided for at least an hour every two months and stated that good practice required at least an hour every month. The service started monitoring management supervision in January 2016. The data provided by the trust stated that the service had a compliance rate of 95%. The service had identified that it should provide 186 sessions of management supervision in a six month period.

The total number of whole time equivalent substantive staff for the service was 63.3. In the period January to May 2016 the service undertook an average of 26 supervision sessions per month. In June 2016 the service undertook 47 supervision sessions in one month. This meant that one month of supervision accounted for over 26% of the total figure used to judge compliance.

It was not clear from the data provided whether all staff were receiving one hour of supervision every two months as per the trust policy. Regular clinical supervision has a direct impact on people who use services by ensuring that they receive high quality care at all times from staff who are able to manage the personal and emotional impact of their practice.

The trust had a 90% compliance target for appraisals. As of May 2016 the crisis assessment service had a compliance rate of 59% for appraisals.

In June 2016 staff in the service attended an away day. One member of staff was able to describe additional specialist training including training on dual diagnosis and on how legal highs can affect people's mental states.

Intensive Community Service

The service employed a full range of mental health disciplines including nurses, doctors, social workers, occupational therapists, healthcare support workers. The trust required all staff to undergo an induction and the service had a 100% compliance rate with the trust induction.

In the period June 2015 to May 2016 the service had an average clinical supervision rate of 67%. The trust's supervision policy required that all full-time clinical staff undertook clinical supervision for a minimum of an hour every two months. The trust policy required that management supervision was provided for at least an hour every two months and stated that good practice required at least an hour every month.

The data provided by the trust stated that the service had a compliance rate of 117% based on a calculation that the service had provided 55 sessions of supervision and should provide 47 sessions of management supervision in a six month period. The total number of whole time equivalent substantive staff for the service was 22.61 which meant if every member of staff received management supervision every two months this would equate to over 66 sessions in

Are services effective?

Requires improvement

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total in the period. The trust later clarified that the total number of sessions to be compliant should have been 54 sessions based on establishment levels in July 2016, and that the service was seven sessions short of achieving this target. It was not clear from the data provided whether all staff were receiving one hour of supervision every two months as per the trust policy.

The trust had a 90% compliance target for appraisals. As of May 2016 the intensive community service had a compliance rate of 52%.

Multi-disciplinary and inter-agency team work

Crisis Assessment Service

We attended a morning handover meeting. The meeting was well attended by the members of the crisis assessment service and included two members of the mental health crisis triage team. The meeting included updates from the night team who gave a briefing on the calls received and the assessments which needed to be undertaken on the same day. The meeting also included a briefing on the patients who had been admitted into the section 136 suite overnight.

The trust was a member of the crisis care concordat. The crisis care concordat is a nationally agreed framework for how services and agencies should work together to support people in mental health crisis. One of the main aims of the concordat is that agencies should work together to prevent unnecessary admissions to section 136 suites. The service manager described how the local members of the crisis care concordat met once every three months to review themes, trends and issues arising from the use of the section 136 suites. These meetings including representatives of the crisis assessment service, local clinical commissioning groups, the police, ambulance services, adult social care services, liaison psychiatry services, the local authority, and the community child and adolescent mental health service provided by Leeds community health trust. Members of the crisis care concordat had an information sharing agreement.

The Mental Health Act Code of Practice (2015) states that 'hospital or ambulance transport will usually be preferable to police transport, which should only be used exceptionally, such as in cases of extreme urgency or where there is an immediate risk of violence'. Guidance from the Royal College of Psychiatrists (2013) states that the 'use of a police vehicle may give the person and others the false impression that they have committed a criminal offence and may be a cause of distress or embarrassment'.

The guidance additionally states that one agency should have responsibility for collecting information for monitoring purposes including 'the mode of transport to place of safety and if not an ambulance the reasons for this'. As the partner with responsibility for staffing the section 136 suites, the service was additionally responsible for collecting data to monitor compliance with the crisis care concordat. Staff estimated that a police car was used in over half of section 136 admissions. From 1 January 2016 to 30 June 2016, 222 of conveyances were in a police vehicle, 22 were in an ambulance, 5 were in other vehicles and 18 were not recorded. This data was not included in any of the reports submitted by the service to the multi-agency meeting from January 2015 to May 2016.

The service employed two nurses to work within the police control centre based in Leeds. The district control nurses working in the police control centre provided advice and support to the police in the community and those receiving calls in the call centre. They could access both police and trust records to ascertain whether a person was already known to mental health services and advise on an appropriate course of action. In a report from March 2016 the service had judged that intervention from the district control nurses had prevented any direct police involvement in 153 cases during the period September 2015 to January 2016. The guidance document 'Police and Mental Health' (2013) produced by Mind, a mental health charity, encourages police officers to work with 'health services… to ensure an appropriate response which meets the needs of individuals with mental health problems'. The district control nurses were an example of this in practice.

The district control nurses also regularly delivered a training programme with police officers to train them in how to deal with people presenting with mental health needs. We reviewed the presentation used by the district control nurses and saw that it provided information on the range of mental health services available locally as well as scenarios for police officers to work through during the session.

The trust provided data on the total number of detentions under section 136 from January 2015 to May 2016.

Are services effective?

Requires improvement

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

- 355 people were detained in the six months from January to June 2015
- 320 people were detained in the six months July to December 2015
- 319 people were detained in the five months from January to May 2016

This data showed that the number of detentions under section 136 remained relatively constant in the period. The service explained that whilst the number of detentions remained constant, the number of referrals had continued to increase over the period.

The service employed two harm reduction workers in partnership with a third sector substance misuse service. The harm reduction workers attended assessments in situations where patients presented with signs of drug or alcohol misuse and could refer patients for substance misuse treatments. Both harm reduction workers could access training through both the substance misuse service and through the trust.

Intensive Community Service

We attended a multidisciplinary meeting during the inspection. The service had a daily multidisciplinary meeting. The meeting was well attended by members of the team and included nurses, occupational therapists, a support worker and a psychiatrist who chaired the meeting. The meeting included a discussion of four patients. The meeting had a relaxed tone which allowed all professions to contribute to the discussion. We observed that all staff including the support worker felt able to bring up challenges during the meeting.

The intensive community service worked with the crisis assessment service, community mental health teams, primary care and liaison psychiatry. The service manager told us that the intensive community service had recently sought to improve working relationships between the service and the crisis assessment service and the community mental health teams. Staff in the intensive community service had also recently volunteered to cover the duty desk in the community mental health team to gain a better understanding and improve ties between the two services.

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

Training in the Mental Health Act was mandatory for all staff. Separate modules were available for teams working in patient and community settings. The trust had a target of 90% compliance with mandatory training. The crisis assessment service was required to undertake the inpatient user module of the Mental Health Act training and had a compliance rate of 60% as of February 2016. The intensive community service was required to undertake the community module of the Mental Health Act training and had a compliance rate of 50% as of February 2016.

Staff had an understanding of the principles of the Mental Health Act and the guiding principle of least restriction. We found in care records that consent to treatment and capacity requirements were adhered to. People had their rights under the Mental Health Act explained to them when they were admitted to the section 136 suite, although a recent audit indicated that staff were not routinely documenting this in care notes. The crisis assessment unit, which was purposed for informal patients, had a notice with information for informal patients on their right to leave at any time.

The crisis assessment undertaken an audit of section 136 paperwork in March 2016 which found that 93% of patients admitted had their rights given either verbally or in writing, however 50% were noted in the audit as 'sheet given but not recorded'. The audit stated that 90% of detention forms were fully completed with final outcome including all details on assessor's section. As a result of audit the service produced a three point action plan to address the issues in section 136 documentation. However in May 2016 the service produced a report for the multi-agency meeting which identified there were major gaps in several parts of section 136 paperwork..

The multi-agency report produced for the local members of the crisis care concordat indicates that were significant issues with documentation related to section 136 detentions and assessments. In 994 detentions from January 2016 to May 2016:

- 330 assessments were delayed with the reason documented as 'other' or no reason documented
- 180 did not have the location of the initial place of safety recorded
- 162 of the 174 detentions in a place of safety other than the section 136 suite did not have a reason documented why the section 136 suite was not used.
- 124 did not have the location of the assessment recorded

Are services effective?

Requires improvement

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

- 81 assessments did not have the time from detention to assessment recorded

As an example of impact, by not recording in each case the length of time from detention to assessment the service could not be assured of compliance or seek improvements with its own target of three hours. The target was put in place to ensure that patients do not have to wait for an unreasonable length of time for assessment after they have been detained under section 136.

The crisis assessment service and the intensive community service had posters which advertised the independent mental health advocacy service. Managers described good relationships with the trust's Mental Health Act office who were the central team for administration support and legal advice on the Mental Health Act.

Good practice in applying the Mental Capacity Act

The trust provided a single module of mandatory training which covered the Mental Capacity Act and the Deprivation of Liberty Safeguards. The trust had a target of 90% compliance with mandatory training. The crisis assessment service had a compliance rate of 74% with Mental Capacity Act training and the intensive community service had a compliance rate of 56%. This mean that the trust could not be assured that staff knew how to recognise that patients' rights were upheld.

Staff were aware of the trust policy on the Mental Capacity Act and how to access it on the trust's internal network. The Mental Health Act office provided a central point for advice and administrative support for the Mental Capacity Act.

The immediate plan of care used by the crisis assessment service had a section for staff to consider capacity. The document prompted staff to consider capacity, stating that 'everyone to be presumed capacitous until believed otherwise'. The plan of care reminded staff that 'capacity is assessed on a time and decision specific basis'.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We were able to observe staff during assessments and preparations for home visits. We saw that staff in both the crisis assessment service and the intensive community service were polite patient and that interactions were appropriate and respectful.

Staff were empathetic with patients. In our observation of an assessment, we noted that the staff took time to explain treatment options and potential outcomes and that staff were able to quickly establish a therapeutic relationship. In the handover and multi-disciplinary team meetings staff were professional and non-judgemental and displayed an in-depth knowledge of patients.

We were able to talk to patients of the crisis assessment service. Patients were positive about the staff and told us that staff were kind and caring. Patients in the crisis assessment unit told that they felt safe. We observed the discharge of a patient from the section 136 suite and saw that staff were understanding and worked with the patient to agree practical next steps after discharge including how the patient wanted to travel home.

We were able to current and former patients of the intensive community service. Both groups were positive about the staff. One patient told us that the staff were helpful and had worked in partnership with them to establish the reasons for his crisis and how to prevent it from happening again.

The involvement of people in the care that they receive

Staff in the crisis assessment service gave patients an immediate plan of care after their initial assessment. Staff in the intensive community service gave patients a recovery plan following an initial engagement meeting. In the crisis assessment unit care plans were written by staff overnight and given to patients the next day and staff had made efforts to capture the opinions of patients within the plans.

Both services sought to involve families and carers appropriately. During the initial engagement meeting, staff in the intensive community service brought a welcome pack which included details for carer's support. The immediate plan of care used by the crisis assessment service during an assessment also included a section for carer's support which prompted whether support had been offered and whether it had been accepted. Both the crisis assessment service and the intensive community service had posters which advertised the independent mental health advocacy service.

The service manager of the crisis assessment service told us that the service had historically struggled to get feedback from patients. However the service was trying new approaches to getting patient feedback, including an online survey which allowed patients to provide anonymous feedback. The service had also undertaken a review of the crisis assessment unit in which the feedback of 27 patients was central to the overall evaluation.

The trust recruited staff centrally and then allocated them to work in services. Patients were involved in the central recruitment of staff. The trust confirmed that patients had been involved during recruitment days which included recruitment for staff in the crisis assessment service and the intensive community service.

The intensive community service the team worked collaboratively with volunteers from a MIND led project which encouraged former patients to work within the service to use their experience to support current patients. At the time of inspection the service had five former patients as volunteers. Volunteers received the trust induction and could access additional training. They had supervision sessions and team meetings with the trust's volunteer coordinator and with the volunteer coordinator at Aire Court. We were able to interview one volunteer who was very positive about the project and described how the role had helped with her own recovery and had given her a sense of purpose.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Crisis Assessment Service

The service accepted referrals by telephone, email or letter from three main sources:

- primary care services or other teams within the trust
- patients or carers who could self-refer into the service
- the police.

The single point of access was the central resource for managing all referrals into the crisis assessment service. It was composed of two teams; (1) a team of administrators who received every call to the service and (2) a triage team of clinical staff. The administrative team would undertake an initial screening of all calls. As part of this initial screening the team would identify inappropriate referrals and signpost these to alternative services. When calls involved a clinical decision the team would record the details including the patient's data of birth, postcode, ethnicity and gender. The call would then be transferred to the triage team.

The triage team was responsible for making an initial decision on the risks presented by a referral and making a judgement on the timescale and urgency of the response which decided the appropriate service to respond to the referral. The triage team could also contact the patient for further information in non-urgent referrals from primary care and other services. The team also had responsibility for gate-keeping access to all beds on the trust's acute wards and for sourcing and exploring all community alternatives to inpatient admission. Non-urgent referrals would be passed to the trust's community mental health teams. Referrals with high risks which required urgent assessment would be accepted by the crisis assessment service.

The mental health crisis triage team (formally street triage) could be called by the police to conduct an initial assessment a person with mental health issues. In the period February 2015 to January 2016 the police had made over 1,800 referrals to the mental health crisis triage team, an average of 151 referrals per month. In this period:

- 72% of patients were assessed within the target of one hour, with a further 17% seen within one to two hours
- 45% of referrals received assessments face to face, 12% of cases were nurse to police advice and 42% were classed as unspecified contacts
- 56% of assessments were undertaken in patients' homes or other private place, and 28% were undertaken in a public space.

This meant that almost three quarters of referrals received were seen within the target and over half of referrals were seen in an environment which would support the privacy and confidentiality of the patient.

The purpose and impact of this team ensured that people were not detained under section 136 of the Mental Health Act unnecessarily. Data from referrals received by the mental health crisis triage team states that in the three years between January 2013 and January 2016:

- 57% of people were already known to mental health services and were receiving care
- 23% of people were not known to mental health services and did not have any further contact with mental health services after assessment by the mental health crisis triage team
- 8% of people were referred to mental health services after assessment by the mental health crisis triage team
- 2% of people received a further full crisis assessment after initial assessment by the mental health crisis triage team and;
- 1% of people were detained under section 136 of the Mental Health Act after initial assessment by the mental health crisis triage team.

The crisis assessment service was responsible for the assessment of patients who presented with acute needs, as assessed by the single point of access and triage team. This function was distinct from the mental health crisis triage team which was responsible for responding to patients only after they had initial contact primarily with the police.

In the period January 2016 to June 2016 the service received an average of 2260 referrals per month and rejected less than 1% of referrals. Of the referrals requiring assessment:

- 54% of patients were seen within four hours
- 14% of patients were seen within four to eight hours
- 5% of patients were seen within eight-twelve hours
- 11% of patients were seen within 12-24 hours
- 16% of patients were seen after 24 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 assessing team of two clinicians (at least one band six clinician) would complete the gate assessment and functional assessment of the care environment risk assessment and complete an immediate plan of care. The immediate plan of care was a ten point document which covered areas such as the reduction of current risks and a plan to meet immediate needs including physical health. The patient received a crisis plan to avoid and manage current and future episodes of crisis. The service also documented the involvement of carers including whether support for carers had been offered and accepted. Following assessment, patients could be transferred to the intensive community service if the risks cold be managed in the community; admitted directly an acute inpatient ward; referred to primary care services or admitted to the crisis assessment unit for further assessment.

The crisis assessment unit was opened in July 2015. The unit was opened as an extra step in the crisis pathway to provide the crisis assessment service with a resource to assess people over a longer time period for up to 72 hours. The local working instructions for the service described the unit as providing 'the opportunity for further assessment of people in a safe environment [which] allows time and space to explore the current difficulties in more depth'. Just as the mental health crisis triage team had the purpose of reducing unnecessary admission to the section 136 suite, the crisis assessment unit had the purpose of reducing unnecessary or prolonged admission to the acute inpatient wards. Staff told us the unit did this by giving staff within the crisis assessment service more time and a safer environment to assess risks than would be possible in an assessment in the community or in a patient's home.

The crisis assessment unit had 185 admissions in the period January 2016 to June 2016 with an average length of stay in this period of 55 hours. We requested data about where who had been admitted to the crisis assessment unit were discharged. We requested this data to evidence whether the crisis assessment unit was having a positive impact on patients by reducing the number of subsequent admissions to acute inpatient wards after initial admission to the unit. Of the 185 admissions:

- 55% were discharged to the intensive community services
- 26% were transferred to one of the trust's acute inpatient wards
- 10% were discharged directly to a community mental health team
- 6% were transferred to another provider's inpatient ward
- 4% were transferred to other locations

As only one third of admissions to the crisis assessment unit resulted in a subsequent admission to an inpatient ward it should be possible to conclude that the unit was having a positive impact in reducing inpatient admissions for people presenting in a state of mental crisis. However, this data does not factor the impact of admissions to the unit which were outside the statement of purpose of providing extended assessment. As an example, from November 2015 to May 2016 30 admissions to the unit were for the purpose of providing overnight support for patients receiving treatment from the intensive community services. As these patients would be counted as an admission, and discharged back to the service the following day, these admissions would naturally impact on the overall outcome figures.

The crisis assessment service assessed 994 people detained under section 136 of the Mental Health Act in the period January 2015 to June 2016. Of the 994 people:

- 611 were admitted first to the section 136 suite, an average of 48 admissions per month.
- 115 were admitted first to an alternative place of safety which included the emergency departments of Leeds General Infirmary and St. James University Hospital, other medical wards,
- 88 were taken first to police stations as a place of safety.
- 180 did not have the location of the first place of safety recorded.

The crisis assessment service undertook assessments of people detained under section 136 of the Mental Health Act (1983) primarily in the section 136 suite. Of the 994 people:

- 816 were assessed in the section 136 suite at the Becklin Centre
- 54 were assessed in an alternative place of safety including 25 in a police station
- 124 did not have the location of the assessment recorded.

The service had a waiting time target of three hours for assessments. Compliance with this target was:

- 44% (437 assessments) within one to three hours

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- 21% (207 assessments) within four to six hours
- 12% (122 assessments) within seven to nine hours
- 11% (112 assessments) within 10-24 hours
- 4% (35 assessments) after 24 hours
- 8% (81 assessments) did not have the time from detention to assessment recorded

The service documented in some cases the reasons for the delay in assessments following detention which included:

- 100 assessments delayed due to alcohol intoxication
- 46 assessments delayed due to delays with the approved mental health practitioner
- 55 assessments delayed due to delays with the section 12 approved doctor
- 51 assessments delayed due to the patient requiring medical attention

Five hundred and fifty one assessments were undertaken after the three hour target (56%). Of the 551 delayed assessments, 330 assessments (60%) had the reasons documented as 'other' or had no reason for the delay documented. Without clear documentation for the reasons for delays to assessments it was not clear how the service would be able to improve compliance with the three hour target.

Of the 994 people detained under section 136 of the Mental Health Act, 290 people (29%) were then admitted into an inpatient ward. 429 (43%) were referred to a mental health service in the community and 275 (28%) were discharged to their GP or without follow up. This can be regarded as positive, as one of the purposes of detention under section 136 is to ascertain whether detention and admission to an inpatient ward under the Mental Health Act is necessary, and the service was able to discharge two thirds of patients without further admission.

The crisis assessment service was responsible for supporting the section 136 suite for children and young people when a young person was admitted. The service would provide nursing and approved mental health professional cover, with consultant cover provided by Leeds Community Health Trust's community mental health service for children and adolescents. Whilst staff described excellent working relationships between the two trusts in relation to the section 136 suite, the staff of the crisis assessment service did not have access to patient records held by the community mental health service for children and adolescents. Staff told us that the suite was very rarely used. Data submitted by the trust showed that in the period July 2015 to June 2016 the suite was used for 17 patients, an average of three patients in any two month period.

Intensive Community Service

The intensive community service received referrals mainly from the crisis assessment service, although other sources for referral included primary care services, community mental health teams and inpatient wards. The service was regarded as the primary alternative to admission to an inpatient ward for people experiencing crisis or associated medium to high risks due to acute changes in their mental health. It provided appointments and interventions from 8am to 9pm, seven days a week. If a patient's mental health suddenly deteriorated outside these hours then they were directed to contact the crisis assessment service.

The service had a wide referral criteria and the service manager told us that almost all referrals were accepted. The referral criteria for the service was:

- Adults, over 18 years of age, across the whole age spectrum.
- People with acute mental health needs requiring intensive intervention that otherwise would require hospital admission.
- Patients who, with intensive intervention could have early discharge from hospital.
- Patients requiring short periods of intensively supported leave in order to facilitate early discharge.

From 1 July 2015 to 30 June 2016 the service received 707 referrals. Over 95% of the referrals came from other services within the trust which included the crisis assessment service and the community mental health teams.

From January 2016 to June 2016:

- 331 referrals were received by the service
- 55 referrals were received on average each month.
- 29 referrals (9%) were rejected
- 317 referrals were discharged
- 62% of referrals were discharged to community mental health teams
- 4% of referrals were discharged to primary care services

Initial data from the trust indicated that the service had discharged 409 patients however the service clarified that this data included a planned migration of figures from a clinic that was not within the remit of the intensive

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community service; 317 discharges represents the figures without this clinic in the January 2016 to June 2016 time period. Rejected referrals represented referrals that did not meet the criteria for the service or referrals received without up to date clinical information and risk assessment.

Referrals to the service had to include a risk assessment completed by the referrer which included a crisis plan, a recommendation for either home-based or unit-based treatment and instructions for the service on how to respond if the patient did not attend an appointment or engage with the service.

Once a service accepted a referral the staff would undertake an 'initial engagement' meeting with the patient. The initial engagement meeting could take place in the patient's home, in one of the units used as team bases or in another agreed venue. The engagement meeting allowed the service to develop a recovery care plan with the patient.

The service operated a three tier – red/amber/green – model for categorising both risks and the intensity and frequency of interventions. All patients joining the service would be first categorised as 'red'. The red category meant that the patient had the highest level of need, the greatest risks and the most frequent interventions. Patients would be reviewed by the multidisciplinary team on a daily basis and would receive daily interventions from staff in the service. As the service did not provide support 24 hours a day, if a patient in the red category required overnight support then the service used the crisis assessment service to admit the patient for an overnight stay in the crisis assessment unit. This additional function was not part of the stated purpose of the crisis assessment unit. As patients in this case required support and not assessment it had the potential to impact on patients who would have benefitted from an extended assessment which would in turn have reduced an unnecessary inpatient admission.

When the service assessed that the intensity of symptoms and risks had reduced, then the patient would be re-categorised as 'amber'. Patients in the amber category would be reviewed up to every two days by the multi-disciplinary team. Although there was an understanding from staff that patients might escalate back into the red category, the focus of the amber category was to stabilise recovery. The amber category also included initial formulation on transfer and discharge planning.

Once recovery had stabilised the patient would progress to the green category. Staff told us that the purpose of the service was to deliver intensive interventions over a short period which reduced risks and stabilised recovery to a level where less intensive treatment options could be provided by other services. Whilst there was no target, in the period January 2016 to June 2016 the average time from initial engagement to discharge was 29 days. The average length of time in treatment in treatment in the community mental health teams for the same locality was 309 days. Both staff and the written local working instructions told us that the majority of patients were transferred to the care programme approach care coordinator within the trust's community mental health team for adults. Data from the service showed that on 4% of patients were discharged straight to primary care services.

The facilities promote recovery, comfort, dignity and confidentiality

Crisis Assessment Service

The crisis assessment service operated from a newly refurbished area within the Becklin centre which included the section 136 suites for adults and for children and the crisis assessment unit. The service had one clinic room for both suites and the crisis assessment unit.

The section 136 suite for adults consisted of:

- four individual bedrooms
- two shower rooms which also had toilet facilities
- a nurse's office
- a kitchen for staff to prepare basic meals.

The suite did not have a separate interview room for patients. There were no facilities for access to private outside space, other than the unenclosed hospital grounds. There were no facilities for access to quiet areas other than patient bedrooms, and no facilities for patients to make a phone call in private.

There were no restrictions on patients in the crisis assessment unit having their own mobile phones. There was no enclosed outside space although they could access the hospital grounds with staff. The unit did not have an activity programme because the unit was purposed for assessment and not treatment. Patients could access the gym within the Becklin Centre.

Are services responsive to people's needs?

Good

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The locked door between the female section of the corridor and the section 136 suite had a glass panel which was approximately two thirds obscured with an opaque film. Staff told us that the panel was not fully obscured so that staff on the crisis assessment unit could see into the section 136 suite when they were responding to incidents. However, it also meant that patients in the crisis assessment unit could potentially see and hear patients on the section 136 suite as they were being admitted in a state of crisis. This impacted on the privacy and dignity of patients in the section 136 suite. We raised this with the trust and on our return visit the service had added an additional screen to the door which, whilst reducing the vision through the panel further, had still left a gap through which people could see into the section 136 suite.

The office for nursing staff was in the female section of the corridor of the crisis assessment unit. During our first visit to the crisis assessment unit we noticed that the door between the male and female sections of the corridor was left open. Staff told us this was for ease of access and so male patients could access the staff in the nurse's office. However it meant that there was potential for male patients to be in the female section of the corridor as female patients accessed the toilet and shower facilities. This was raised during feedback to the trust senior management on the final day of the inspection.

A wall divided one bedroom on the crisis assessment unit and a bedroom on the section 136 suite. Staff told us that there had been occasions where patients in the crisis in the section 136 suite had disturbed female patients in the crisis assessment unit by banging on the dividing wall.

Intensive Community Service

The intensive community service operated from Aire Court, a community facility. Aire Court was shared with the trust's community mental health teams for adults, although apart from a shared waiting area, the service had a designated space within the building.

The service had a number of interview rooms as well as a large kitchen and dining area. Staff told us that they felt there was an adequate number of rooms to conduct interviews and undertake group work. All areas of the building were clean and generally the décor and furnishings were well-maintained and of a high standard. The service manager told us that there was a process for reporting maintenance issues to the trust's estates department.

Until March 2016 the unit had been used extensively for group work with patients. Team meeting minutes from April 2016 indicated that the service adopted a new referral criteria which had significantly decreased the number of patients requiring unit-based treatment. This was reflected in the data from the service which indicated that the average unit-based contacts dropped from an average of 268 per month during the period January to March 2016 to 74 per month during the period April to June 2016.

Meeting the needs of all people who use the service

The crisis care concordat states that health based places of safety should not refuse to admit a person in a state of mental health crisis because the person shows signs of intoxication or drug misuse. The crisis assessment service did not exclude people on the basis that they had used alcohol or drugs. Data from the service indicated that a police station had been used as a place of safety for intoxicated people only twice from January 2015 to May 2016 whereas the section 136 suite had been the place of assessment for 22 intoxicated people.

Catering in the crisis assessment unit and the section 136 suite was provided through a service level agreement with Interserve, a private business support organisation. We reviewed the menu for a one week period and saw that there were several options available for patients including vegetarian options. Healthy meal choices were clearly marked on the menu.

Both the crisis assessment service and the intensive community service operated from facilities that were compliant with the Disability Discrimination Act 2005. In both services the patient designated areas were on the ground floor and were wheelchair accessible. Both services had a range of leaflets available which covered treatment options, legal rights and how to complain. The intensive community service was having issues procuring leaflets in languages other than English. Staff offered different explanations for this with some suggesting it was a trust wide issue and others stating it was related to the uncertainty surrounding the future of the service.

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Good

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Both services had access to interpreters for other languages including sign language. The service manager in the intensive community service told us that there had been issues with the interpreter service including occasions where the interpreter had failed to turn up for appointments.

Listening to and learning from concerns and complaints

The crisis assessment service received 18 complaints between April 2015 and March 2016. Six complaints were fully or partially upheld. None of the 18 complaints were referred to the parliamentary and health service ombudsman.

The intensive community service received three complaints between April 2015 and March 2016. Only one of the complaints was partially upheld. None of the three complaints were referred to the parliamentary and health service ombudsman.

Both services had information displayed on how patients and patients could complain. The trust had a patient advice and liaison service which investigated complaints and supported the complaints process. Staff and managers explained that feedback from complaints followed a similar process to feedback from incidents, with discussion in individual supervision and in team meetings.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

In April 2016 the trust launched a consultation process with staff, patients and other partners to determine a new statement of vision and values. During this inspection the trust was guided by a mission statement of a shared purpose, ambition and values.

The purpose of the trust was 'improving health, improving lives'. The stated ambition of the trust was 'working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives'.

The six values of the trust were:

- respect and dignity
- commitment to quality of care
- working together
- improving lives
- compassion
- everyone counts.

Staff awareness of the current purpose, ambition and values was limited. Two members of staff were able to identify one or more of the values. The trust stated that the values represented 'what was important' to the trust, however as so few staff were had any awareness of the values it was difficult to see how they had any impact on how staff undertook their work.

Staff knew and were positive about local managers. Service managers told us that they felt well supported by their immediate line managers and that they felt they had enough authority to do their job successfully. The intensive community service was due for review as part of the trust's wider review of its community mental health services. Staff expressed uncertainty about the future of the service and told us that this had affected morale in the team.

Good governance

We found several issues with governance systems and processes.

During the inspection the inspection team made 65 requests in total for additional written evidence from the crisis assessment service and the intensive community service. An additional evidence request forms part of the evidence base used to inform the report. Trusts and services are given 48 hours to meet each request. Over half of the requests made to the service failed to meet this target with most taking over a week to be returned to the inspection team. The length of time to complete each request led to the conclusion that data was either not routinely collected and monitored or was not readily accessible to managers.

The crisis assessment service was a member of the crisis care concordat and a partner in the local interagency crisis protocol. We asked the service to provide data on the method of conveyance to the section 136 suite which was provided eight days after the request. It showed that from 1 January 2016 to 30 June 2016, 222 of conveyances were in a police vehicle, 22 were in an ambulance, 5 were in other vehicles and 18 were not recorded. This data was not included in any of the reports submitted by the service to the multi-agency meeting from January 2015 to May 2016. As the service was not regularly sharing this information it was not clear how the members of the multi-agency meeting would be able to seek improvements.

The trust compliance target for mandatory training was 90%. The crisis assessment service achieved an average of 85% compliance and the intensive community service achieved an average of 77% compliance. The data from the trust indicated that both services had a significantly lower compliance in seven modules of mandatory training.

The trust compliance target for appraisals was 90%. By May 2016 the crisis assessment service had achieved 59% compliance and the intensive community service had achieved 52%.

The trust's supervision policy distinguished between management and clinical supervision and set a minimum requirement for staff to undertake both at least once every two months. The intensive community service stated it had achieved 67% compliance with clinical supervision. The crisis assessment service stated that it had achieved 97% with clinical supervision. Team meeting minutes from the crisis assessment service demonstrated that the service was not routinely monitoring clinical supervision compliance. Staff were asked in April 2016 to self-declare how many clinical supervision sessions they had received as part of the service's preparation for inspection. The intensive community service's compliance with management supervision could not be clearly discerned

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from the data provided by the trust. The crisis assessment service's compliance met the required standard but the data showed that sessions were regularly lower than the number expected.

The crisis assessment service had undertaken audits of the environment, ligature risks and compliance with documentation standards for the section 136 suite. In March 2016 the service had also completed audits which reviewed the impact and performance of the district control nurses, the mental health crisis triage team, the harm reduction workers project, and the crisis assessment unit. The intensive community service had undertaken audits of the environment and ligature risks and one clinical audit of service provision which looked at Driver and Vehicle Licensing Agency advice given during admission to the service.

Staff knew how to report incidents and both services facilitated staff meetings were feedback from incidents was discussed. Staff were aware of safeguarding procedures and both services met compliance targets for mandatory training in safeguarding adults. Neither service met compliance targets for safeguarding children level three training.

Both services routinely collected data on key performance indicators. The intensive community service collected data on referrals received, rejected and discharged; on contact method (face-to-face / telephone) and location (home based, community based or unit based); and on completion of data capture standards. Although the service collected data on these and other key performance indicators, the service had no targets to measure and benchmark performance or to identify areas of concern.

The crisis assessment service routinely collected similar data on key performance indicators, and additional indicators including:

- waiting times for assessment by the crisis assessment service
- waiting times for assessment in the section 136 suite with a target of three hours.

The crisis assessment unit separately collected data on key performance indicators including:

- admissions, discharges and readmissions
- occupancy rates
- average length of stay.

Information leaflets stated that the length of stay for the crisis assessment unit was up to 72 hours. Staff told us that this was an aspiration and not a formal target. As such the crisis assessment unit did not have any formal targets for key performance indicators.

Governance systems did not support the staff of the crisis assessment service to operate the crisis assessment unit for its stated purpose. This meant that the crisis assessment unit was admitting patients for reasons other than its stated purpose of providing extended assessments for people experiencing acute and complex mental health crisis. The unit was not intended and was not suitable for lengths of stay significantly above 72 hours. The unit was taking admissions due to bed management and other issues for which it was not suitable.

Service managers were able enter items on the local risk register and could describe the process for escalating risks to the trust risk register.

Leadership, morale and staff engagement

The crisis assessment service had an 18% vacancy rate for qualified nurses and 19% for nursing assistants was significantly higher than the trust's average vacancy rate. The sickness rate was 1% over the trust's average sickness rate. The service had a low turnover rate, with 5% of staff leaving in the last 12 months.

The intensive community service had a lower average vacancy rate, lower qualified nurse vacancy rate and lower nursing assistant vacancy rate than the trust's average vacancy rate. The sickness rate was lower than the trust's average sickness rate. The service had a high turnover rate, with 15% of staff leaving in the last 12 months.

There were no reported incidents of bullying and/or harassment. In June 2016 the trust had implemented a 'freedom to speak up: raising concerns (whistleblowing) procedure' which stated that staff had a duty to raise concerns if and when they had them. Staff told us that they felt they could raise concerns without fear of victimisation. Team meeting minutes for both services documented how staff were encouraged to engage with the inspection team during the inspection. However, one set of minutes did state that 'the CQC visit is not to be used as a platform for negativity, but should be used to celebrate and promote the positive things about our service' which could be seen as encouraging staff to withhold concerns.

Are services well-led?

Requires improvement

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.

We found that staff morale in both teams was mixed. Whilst all staff were positive about their local managers, we heard that staff felt pressured by their workload. Staff in the crisis assessment service told us that the high vacancy rate and the high number of staff on maternity leave had increased the pressure faced by the team.

Commitment to quality improvement and innovation

The crisis assessment service had piloted several approaches to reduce unnecessary or prolonged inpatient user admissions including:

- the district control nurses who worked within the police control centre with the aim of reducing police interventions in situations where interventions by mental healthcare professionals was more appropriate
- the mental health crisis triage team who assessed people in the community to help police officers make a clinically informed judgement on whether a section 136 admission was necessary and appropriate
- the crisis assessment unit which when used for its primary purpose allowed the crisis assessment service to undertake an extended assessment in a safe space, with the aim of allowing a more informed decision on whether an inpatient user admission was necessary and appropriate
- the harm reduction workers who provided more timely access to local substance misuse services and initial support for people waiting for support with substance misuse.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not met** The trust was not ensuring that the care and treatment of service users was appropriate and met their needs because: The crisis assessment unit was not being used in all admissions for the stated purpose of providing services for adults experiencing acute and complex mental health crises that required a period of assessment of up to 72 hours. This was a breach of Regulation 9(1)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not met** The trust did not have effective governance systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services) because: The crisis assessment service was not fully completing section 136 detention documentation for all patients. The crisis assessment service did not routinely share all data with other agencies on the method of conveyance to the health based place of safety. The crisis assessment service and the intensive community service were not able to share relevant information with the Care Quality Commission in a timely manner.

This section is primarily information for the provider

Requirement notices

This was a breach of a Regulation 17(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not met** The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the care and treatment needs of people using the service because: Staff in the crisis assessment service and the intensive community service did not receive an annual appraisal. The overall compliance rate for mandatory training was below the requirement in the crisis assessment service and the intensive community service. Eight modules were below 75% compliance in the crisis assessment service and the intensive community service. This was a breach of Regulation 18(2)(a)