Requires improvement

Lincolnshire Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Trust Headquarters - Units 8 & 9
The Point, Lions Way
Sleaford
Lincolnshire
NG34 8GG
Tel: 01522 597979
Website: www.lpft.nhs.uk

Date of inspection visit: 1 - 4 December 2015
Date of publication: 21/04/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP7X3	Trust Headquarters	Peter Hodgkinson Centre - Crisis resolution team Health-based place of safety	LN2 5UA
RP7MB	Sycamore Unit	Crisis resolution team Single point of access	NG31 9DF
PR7LA	Pilgrim Hospital	Crisis resolution team	PE21 9QS
RP7X3	Trust Headquarters	Windsor House - Crisis resolution team	LN11 0NF

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

Summary of findings

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 Lincolnshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Lincolnshire 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?	**Good** 

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We gave an overall rating for mental health crisis services and health-based places of safety as **requires improvement** because:

- Environmental risks in the health based place of safety (HBPoS) identified in our previous monitoring visit and S136 in May 2015 remained. The room was small and only had one door which created a risk that staff would not be able to exit the area quickly if needed. Staff were not able to maintain line of sight observation in all areas. The furniture in the suite was not weighted. This meant that it could be picked up and thrown or used as a barricade. There was nowhere for professionals to talk privately. A new HBPoS was being built to address these concerns at the time of this inspection.
- Some staff we spoke with were mistaken about the point of time that a person was detained under S136 and we observed this in one of the S136 records reviewed. This could result in an incorrect calculation of the period of detention and time the S136 would expire. We raised this as an area for improvement in our previous monitoring visit.
- Staff working in the HBPoS had access to resuscitation equipment, but only 50% had had training in immediate life support.
- People detained under S136 were usually, instead of exceptionally as set out in the MHA Code of Practice, transported to the HBPoS by police rather than by ambulance.
- There was no medicine storage in the HBPoS. Medicines were being stored at 26 degrees celsius in the Boston crisis resolution team which is above the recommended temperature for safe storage of medicines.
- The crisis resolution teams in Louth and Lincoln did not always have rapid access to a psychiatrist when required.
- The crisis resolution teams did not include or have access to the full range of mental health professional backgrounds. There was no occupational therapist or psychologist in any of the teams. There was no social worker in Grantham, Louth or Boston crisis resolution teams.
- Waiting lists for treatment in the integrated care teams, and the lack of a care pathway for people with a personality disorder, had led to the crisis teams experiencing difficulties in discharging people who were ready to move on to other mental health services.
- There was no mental health crisis helpline available.
- Personal safety protocols, including lone working practice, were in place. However, staff often undertook initial assessments alone. Some staff said that they felt unsafe at times and that mobile phone coverage was poor in some areas.
- Staff morale was generally low. Some staff did not feel supported by senior managers and said their concerns were not being addressed.
- Unqualified staff in the single point of access had not had access to specialist training for their role.

However:

- The trust had set safe staffing levels and these were followed in practice.
- Dedicated staffing was in place for the HBPoS.
- Staff undertook risk assessments at initial assessment and updated these regularly.
- Staff completed comprehensive assessments and reviewed these in a timely manner. Interventions included support for housing, employment and benefits. Staff considered people's physical health needs and discussed these at the point of assessment.
- People who used the service were very positive about how staff behaved towards them. Many felt their mental health had improved as a result of the service they received.
- Urgent referrals were seen quickly by skilled professionals. Staff took proactive steps to engage with people who found it difficult or were reluctant to engage with mental health services.
- The introduction of street triage had improved access to services for people with a mental health crisis.
- There was effective team working and staff felt supported by this.

Summary of findings

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

Are services safe?

Requires improvement

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

- Environmental risks in the HBPoS identified in our previous monitoring visit remained. The room was small and only had one door, which created a risk that staff would not be able to exit the area quickly if needed. Staff were not able to maintain line of sight observation in all areas. The furniture in the suite was not weighted. A new HBPoS was being built to address these concerns at the time of this inspection.
- Staff working in the HBPoS had access to resuscitation equipment but only 50% had had training in immediate life support.
- There was no medicine storage in the HBPoS. Medicines were being stored at 26 degrees celsius in the Boston crisis resolution team which is above the recommended temperature for safe storage of medicines. We raised this with staff on the day we visited.
- Rapid access to a psychiatrist was not always available when required in the crisis resolution teams in Louth and Lincoln.
- Personal safety protocols, including lone working practice were in place. Staff often undertook initial assessments alone, and some said that they felt unsafe at times and that mobile phone coverage was poor in some areas.
- Seventy two per cent of staff in the crisis services and HBPoS were up to date with mandatory training. Sixty two per cent of staff were up to date with safeguarding children training. This was below the trust's target of 95%. The mandatory training list did not include training for safeguarding vulnerable adults.

However:

- The trust had set safe staffing levels for the crisis resolution teams which were followed. Recruitment was in progress for vacancies.
- Risk assessments were undertaken at initial assessment and updated regularly.
- Risk levels for people who used the service were reviewed daily and discussed at handover meetings in order to detect any deterioration in people's health and take prompt action.
- Dedicated staffing was in place for the HBPoS.

Are services effective?

Requires improvement

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

Summary of findings

- The crisis resolution teams did not include or have access to the full range of mental health professional backgrounds. There was no occupational therapist or psychologist in any of the teams. There was no social worker in Grantham, Louth or Boston crisis resolution teams. There was limited medical cover in Lincoln and Louth.
- People who used the service had limited access to psychological therapies.
- Unqualified staff in the single point of access had not had specialist training for their role.
- Some staff we spoke with were mistaken about the point of time that a person was detained under S136 and we observed this in one of the S136 records reviewed. This could result in an incorrect calculation of the period of detention and time the S136 would expire. This was raised as an area for improvement in our monitoring visit of HBPoS and S136 in May 2015.
- People detained under S136 were usually, instead of exceptionally as set out in the MHA Code of Practice, transported to the HBPoS by police rather than by ambulance.
- Training targets of 95% were not being met. Only 66% of staff in the crisis services and HBPoS had received training in applying the MCA.

However:

- Comprehensive assessments were completed in a timely manner. Care plans were individualised, reviewed and updated at each visit. People we spoke with gave us examples of how their individual needs were met.
- Staff considered and discussed people's physical health needs at the point of assessment.
- Interventions included support for housing, employment and benefits and these issues were considered as part of the assessment and care plans.
- Staff in the crisis resolution teams and in the HBPoS were experienced and skilled.
- Team working and inter-agency working were effective in supporting people who used the service.
- Staff were trained in and had a good understanding of the MHA.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated people who used the service with respect; they listened to them and were caring. Staff showed a good understanding of people's individual needs and communicated effectively with them.

Summary of findings

- People who used the service told us they were involved in their care and treatment and were given information about the choices available. Many felt their mental health had improved as a result of the service they received.
- People were involved in their care and treatment and were given information about the choices available.
- Information was available for people who used the service.

However:

- People did not have written information about their plan of care.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Urgent referrals were seen quickly by skilled professionals.
- Proactive steps were taken to engage with people who found it difficult or were reluctant to engage with mental health services. This included re-engaging with people who did not attend their appointments.
- Target times for assessment were set for crisis resolution teams. Each team had agreed criteria for which people would be offered a service.
- Following a referral, people were given a degree of choice in the times of appointments on the first contact by the service.
- People who used the service told us that appointments ran on time and they were kept informed if there were any unavoidable changes.
- The introduction of street triage had improved access to services for people with a mental health crisis.
- A good range of information was available for people in appropriate languages.
- People who used the service knew how to complain.

However:

- Waiting lists for treatment in the integrated care teams and the lack of a care pathway for people with a personality disorder had led to the crisis teams experiencing difficulties in discharging people who were ready to move on to other mental health services.
- There was no mental health crisis helpline available.
- There was nowhere for professionals to talk privately when someone was detained in the HBPoS.

Are services well-led?

Good

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

Summary of findings

- Staff were aware of the trust's values and vision.
- Governance arrangements were in place locally which supported the quality, performance and risk management of the services. Key performance indicators were used to gauge performance.
- Team managers had sufficient authority. They met regularly as a group to discuss performance, address any areas of concern and share good practice.
- Team working was effective and staff felt supported by this.
- Staff felt supported by their immediate managers.

However:

- Staff morale was generally low following significant organisational change in the trust as a whole. Some staff were very concerned at the future impact of these changes on the availability of services for people who needed them.
- Some staff we spoke with did not feel supported by senior managers and said their concerns were not being addressed.

Summary of findings

Information about the service

The crisis resolution teams aimed to provide a comprehensive assessment of needs, a range of short term treatment and support for people aged 18 and over who were experiencing a serious mental health crisis. The teams provided such services as an alternative to hospital admission. They supported people being discharged from hospital. The teams were based at the Peter Hodgkinson Centre in Lincoln, the Sycamore Unit in Grantham, Pilgrim Hospital in Boston and Windsor House in Louth.

The single point of access provided a first point of contact for people aged 18 and over who wished to access mental health and learning disability services in Lincolnshire. The team provided advice and guidance through a triage process, where the urgency of care required was assessed. The service had recently been restructured to become part of the function of the Grantham crisis resolution team.

A health based place of safety (HBPoS) is a place where someone who may be suffering from a mental health problem can be taken, by the police under section 136 of the Mental Halth Act, in order to be assessed. The HBPoS for people of all ages in Lincolnshire was at the Peter Hodkinson Centre in Lincoln.

We completed a Mental Health Act (MHA) monitoring visit on the HBPoS and the application of S136 MHA in May 2015. We identified a number of areas for improvement. The trust was working through its action plan to meet the areas of improvement and a new health based place of safety was being built at the Peter Hodkinson Centre at the time of this inspection. Examples of improvements made to date were: a new health based place of safety being built at the Peter Hodkinson Centre which could cater for two rather than one person at a time; joint training on mental health issues had been developed and taken place with the police; police officers had shadowed shifts in the HBPoS; and a secure transport provider with a two hour response rate had been contracted to reduce delays.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive of Oxford Health NHS foundation trust.

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

Inspection Manager: Lyn Critchley, Inspection Manager, mental health hospitals, CQC

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

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

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?

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

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

During the inspection visit, the inspection team:

- Visited the crisis resolution teams based at the Peter Hodgkinson Centre in Lincoln, the Sycamore Unit in Grantham, Pilgrim Hospital in Boston and Windsor House in Louth.
- Visited the single point of access based at the Sycamore Unit in Grantham.
- Visited the health based place of safety at the Peter Hodgkinson Centre in Lincoln and the new health based place of safety at that site that was being built at the time of this inspection.
- Spoke with 18 people who used the service and two carers of people who used the service.
- Spoke with 33 staff members; including doctors, nurses, support workers, social workers, managers, administrators and approved mental health professionals.
- Attended and observed four meetings of staff with people who used the service, with the prior permission of those involved.
- Attended and observed two handover meetings.
- Looked at 24 care records of people who used the services.
- Looked at 13 prescription charts for people who used the services.
- Carried out a specific check of the medication management in the teams that we visited.
- Looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider's services say

People were very positive about the treatment and support provided to them and praised the staff. They told us that staff treated them with respect, listened to them and were caring. Many felt their mental health had improved as a result of the service they received. Two people told us they would have killed themselves if the team had not been so responsive and caring.

People said they were involved in their care and treatment and were given information about the choices available. They did not have written information about their plan of care which some said would be helpful for them.

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

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

Good practice

The introduction of street triage had improved access to assessments for people who come to the attention of the police and may have mental health needs. The triage car was staffed by paramedics and qualified mental health professionals from the trust. Information from the trust showed that out of 178 referrals to the triage car in the period from April to October 2015, 59 were resolved with follow up offered, 30 were resolved with no follow up needed, 18 received mental health home treatment, five were detained under S136 MHA and 32 were detained under the MHA.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the identified safety concerns in the current HBPoS are addressed in the new HBPoS being built.
- The trust must ensure that crisis resolution teams include or have access to the full range of mental health professional backgrounds.
- The trust should ensure that rapid access to a psychiatrist is always available when required in a mental health crisis.

Action the provider SHOULD take to improve

- The trust should ensure that policies, procedure and practice on the use of S136 adhere to the MHA Code of Practice.
- The trust should ensure that medicines are stored at the correct temperature.
- The trust should ensure that people using the crisis services are able to move on to other mental health services when appropriate.
- The trust, with commissioners, should review the need for a mental health crisis helpline.
- The trust should review lone working protocols in the crisis resolution teams to ensure risks to staff are minimised.

Lincolnshire 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 resolution team Health-based place of safety	Peter Hodgkinson Centre
Crisis resolution team Single point of access	The Sycamore Unit
Crisis resolution team	Pilgrim Hospital
Crisis resolution team	Windsor House

Mental Health Act responsibilities

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

Staff received training in the application of the MHA. Information provided by the trust showed that 100% of staff in crisis resolution teams in Boston and Louth, 83% of staff in the team in Grantham, 91% of staff in the team in Lincoln and 83% of staff in the HBPoS had received training on the MHA. Staff we spoke with were knowledgeable about the MHA and Code of Practice.

Relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety in the records we reviewed.

People detained under S136 were given oral and written information about their rights and the process of assessment. People who used the service and approved mental health professionals (AMHP) we spoke with told us that detained people were informed of their rights.

People had access to an independent mental health advocate in crisis resolution teams and in the HBPoS.

Detailed findings

People detained under S136 were usually, instead of exceptionally as set out in the MHA Code of Practice, transported to the HBPoS by police rather than by ambulance.

We completed a Mental Health Act monitoring visit on the HBPoS and the application of S136 MHA in May 2015. We identified a number of areas for improvement. The trust was working through its action plan to meet the areas of improvement. Examples of improvements made to date were: a new health based place of safety being built at the Peter Hodkinson Centre, which could cater for two rather than one person at a time; joint training on mental health issues had been developed and taken place with the police; police officers had shadowed shifts in the HBPoS; and a secure transport provider with a two hour response rate had been contracted to reduce delays.

Some staff we spoke with were mistaken about the point of time that a person was detained under S136 with some believing this was the time when the person arrived at the HBPoS rather than at the emergency department where they had first been taken by the police. We noted that in one S136 record the time of detention had incorrectly been recorded as the time the person arrived at the HBPoS, rather than at the emergency department where they had been treated first. This could result in an incorrect calculation of the period of detention and time the S136 would expire. We had also raised this as an area for improvement in our monitoring visit in May 2015.

Regular meetings took place between the trust, AMHP service and the police to review issues at an operational level. Following our monitoring visit of HBPoS, in May 2015, the ambulance service had been invited to attend to discuss conveyance. A new S136 protocol and memorandum of understanding was out for consultation.

Mental Capacity Act and Deprivation of Liberty Safeguards

Information provided by the trust showed that 66% of staff in the crisis services and HBPoS had received training in applying the Mental Capacity Act (MCA). Eighty eight per cent of staff in the crisis resolution team in Boston, 67% of staff in the team in Louth, 60% of staff in the team in Grantham and 58% of staff in Lincoln had received training in applying the MCA. Fifty per cent of staff in the HBPoS had received training in applying the MCA. The trust's target was 95%. Staff we spoke with were aware of the MCA and the implications this had for their clinical and professional practice.

We looked at 24 care records and found capacity assessments were being completed appropriately.

Requires improvement

Are services safe?

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

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

Our findings

Safe environment

- Interview rooms were fitted with alarms and/or staff had personal pinpoint alarms. Staff said that there was a quick response should an alarm be used. Regular environmental assessments, including ligature risk and fire safety, took place.
- Clinic rooms were available in the crisis resolution teams with the necessary equipment to carry out physical examinations. Equipment was well maintained.
- Posters were displayed on hand washing and hand washing facilities were available. Eighty two per cent of staff in crisis services had had training in hand decontamination.
- Environmental risks in the HBPoS identified in our previous monitoring visit remained. The HBPoS did not meet the Royal College of Psychiatrists' guidelines (April 2013). The room was small and only had one door which created a risk that staff would not be able to exit the area quickly if needed. There had been an incident where an approved mental health professional had been unable to leave the room urgently when the detained person became very violent. Staff were not able to maintain line of sight observation in all areas. The furniture in the suite was not weighted. A new HBPoS was being built to address these concerns.
- Staff working in the HBPoS had access to resuscitation equipment but only 50% had had training in immediate life support.

Safe staffing

- The trust had estimated the number and grades of staff required for the crisis resolution teams and HBPoS. Information provided by the trust showed that the crisis resolution team in Lincoln had 29 substantive staff, Boston had 19, Grantham had 13 and Louth had 10. The HBPoS had 8 regular staff.
- Managers told us they were able to allocate additional staff if more staff were required for some shifts. Staff told us they could respond promptly to the needs of the people who used the service but some said that they needed more staff to meet high levels of demand, particularly in Lincoln.
- Recruitment for vacant posts was under way. Information provided by the trust showed that the crisis resolution team in Lincoln had 13% vacancies with one person leaving in the last 12 months. Sickness rates in the team were 6%. The team in Boston had 8% vacancies with three people leaving in the last 12 months. Sickness rates were 7%. The team in Grantham had 3% vacancies with one person leaving in the last 12 months. Sickness rates were 3%. The team in Louth had 13% vacancies with no one leaving in the last 12 months. Sickness rates were 13%. The HBPoS had no vacancies with no one leaving in the last 12 months. Sickness rates were 1%.
- Cover arrangements for sickness, leave and vacant non-medical posts ensured patient safety. We reviewed the staff rotas for the weeks prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the trust as safe. Bank staff and overtime for existing staff in the teams were mainly used to cover any vacant shifts.
- Rapid access to a psychiatrist was not always available when required in the crisis resolution teams. People using the service in Boston and Grantham were able to see a psychiatrist the same day if needed. In Louth access to a psychiatrist was only on three days per week. In Lincoln there was a full time speciality doctor but the consultant psychiatrist post was vacant. Staff told us that this meant that at times people had to wait two to three days to see a psychiatrist.
- Caseloads were reassessed weekly in team meetings. Workloads for staff were increased as they were also providing assessments for people who presented with a mental health need in the emergency departments of the local acute hospitals. New services for people presenting in emergency departments were being introduced by the trust. We observed that staff were also taking telephone calls from members of the public and other health professionals which were not always relevant to a crisis resolution team but did need a response. This was particularly evident on Lincoln. Staff told us that this was because there was no crisis help line available for people to use and because general practitioners often referred directly to crisis resolution teams rather that referring through single point of access.

Requires improvement

Are services safe?

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

- Staff received mandatory training such as risk assessment, medicine management and physical restraint and breakaway. Information provided by the trust showed that 72% of staff in crisis services and HBPoS were up to date with all mandatory training. The trust's target was 95%.

Assessing and managing risk to patients and staff

- The 24 case records we reviewed showed that staff had undertaken a risk assessment at the initial assessment, then reviewed and updated this when required. Most of the risk assessments used the trust's new clinical risk assessment framework. Care plans were in place to address the identified risks.
- Risk levels for people who used the service were reviewed daily and discussed at handover meetings in order to detect sudden deterioration in people's health and take prompt action. Staff demonstrated a good understanding of the needs and assessed risks of people who used the service.
- Personal safety protocols, including lone working practice, were in place. Some staff had been issued with skyguard electronic devices but these were not being used consistently. Staff often undertook initial assessments alone, and some staff said that they felt unsafe at times and that mobile phone coverage was poor in some areas.
- Staff we spoke with knew how to recognise and report a safeguarding concern. Each crisis resolution team had identified safeguarding champions. Sixty two per cent of staff were up to date with the mandatory training on safeguarding children. Managers told us they were unable to book staff onto courses in a timely way as there were none available. The mandatory training list did not include training for safeguarding vulnerable adults.
- Our review of 13 prescription charts showed that medicines were dispensed safely. The temperature which medicines were being stored at was monitored. This showed that medicines were being stored at 26 degrees celsius in the Boston crisis resolution team which is above the recommended temperature for safe storage of medicines. We raised this with staff on the day we visited.
- There was no medicine storage in the HBPoS as recommended in the Royal College of Psychiatrists' guidelines (April 2013).

Track record on safety

- Information provided by the trust showed there had been 15 serious incidents in the period from 1 April 2014 to 31 March 2015 relating to the crisis resolution teams. The findings from the reviews of these incidents had been used to improve safety. One example involved introducing a protocol to be followed by staff when people did not attend or were not available for their appointment. Another example was a protocol to be used when discharging someone to ensure all relevant people were able to give their input into assessing any risks associated with this.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and were able to describe what should be reported.
- Team meetings were used to discuss feedback from incidents. Learning from serious incidents had been shared across the four crisis resolution teams.
- Staff told us that they were de-briefed and supported after a serious incident.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- Comprehensive assessments were completed in a timely manner. We looked at 24 care records for people who used the service. We saw that assessments considered all aspects of the person's circumstances. Care plans were individualised, short term, reviewed and updated at each visit. People we spoke with gave us examples of how their individual needs were met.
- All information needed to deliver care was recorded on an electronic record system that operated across the trust. All staff involved in a person's care could access the system.

Best practice in treatment and care

- Staff conducted regular audits to ensure NICE guidance was followed when prescribing medication.
- People who used the service had limited access to psychological therapies as there was no psychology input into any of the crisis resolution teams. An 'emotional first-aid group' for people experiencing a mental health crisis had been developed and run by one crisis resolution team. Learning from this had been shared across the crisis resolution teams and the group was offered in other teams as a result. We spoke with people who had attended the group who gave very positive feedback about the group and how it had helped them.
- Our review of 24 records showed that people's physical health needs were considered and discussed at the point of assessment.
- Interventions included support for housing, employment and benefits and these issues were considered as part of the assessment and care plans.
- Some clinical staff were participating in clinical audit, such as the quality of risk assessments and seven day follow up after discharge.

Skilled staff to deliver care

- The crisis resolution teams did not include or have access to the full range of mental health professional backgrounds. There was no occupational therapist or psychologist in any of the teams. There was no social worker in Grantham, Louth or Boston crisis resolution teams. There was limited medical cover in Lincoln and Louth.
- Staff in the crisis resolution teams and in the HBPoS were experienced and qualified.
- Staff in the single point of access had not had access to specialist training for their role.Suicide prevention training was planned for January 2016. The restructuring of the single point of access, to become part of the function of the Grantham crisis resolution team, meant that qualified experienced staff in the crisis resolution team were able to mentor and provide ad hoc supervision for single point of access staff.
- New staff had a period of induction before being included in the staff numbers on a shift. This included a period of shadowing experienced staff.
- Staff were regularly supervised. We spoke with 33 staff who told us they had regular managerial supervision. All felt that there was good ad hoc supervision on a daily basis during the shift and in handover meetings. There were limited reflective practice opportunities in Lincoln, Louth and Grantham crisis resolution teams.
- Most staff had had an appraisal in the last 12 months. Information from the trust showed that 100% of staff in Louth, 92% in Grantham, 90% in Lincoln, 63% in Boston crisis resolution teams and 100% of staff in HBPoS had had an appraisal in the last 12 months.

Multidisciplinary and inter-agency team work

- Staff told us team working was effective within the service, although this was not fully multi-disciplinary because of the lack of some disciplines in the teams.
- We observed three handover meetings, and found they were effective in sharing information about people and reviewing risks and progress in delivering their plan of care.
- There were good working links with the inpatient wards and integrated care teams. Weekly interface meetings were used to good effect to discuss the progress and care pathway for individuals who used the services.

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.

- We saw effective inter-agency working in assessing and supporting those people detained under S136 at the HBPoS. Staff reported good working relationships with the police and local AMHPs.

Adherence to the MHA and the MHA Code of Practice

- Staff received training in the application of the MHA. Information provided by the trust showed that 100% of staff in crisis resolution teams in Boston and Louth, 83% of staff in the team in Grantham, 91% of staff in the team in Lincoln and 83% of staff in the HBPoS had received training on the MHA. Staff we spoke with were knowledgeable about the MHA and Code of Practice.
- Relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety in those records we reviewed.
- People detained under S136 were given oral and written information about their rights and the process of assessment. People who used the service and approved mental health professionals (AMHP) we spoke with told us that detained people were informed of their rights.
- People had access to an independent mental health advocate (IMHA) in crisis resolution teams and in the HBPoS.
- People detained under S136 were usually, instead of exceptionally as set out in the MHA Code of Practice, transported to the HBPoS by police rather than by ambulance.
- We completed a Mental Health Act (MHA) monitoring visit on the HBPoS and the application of S136 MHA in May 2015. We identified a number of areas for improvement. The trust was still working through its action plan to meet the areas of improvement.Examples of improvements made to date were: a new health based place of safety being built at the Peter Hodkinson Centre which could cater for two rather than one person at a time; joint training on mental health issues had been developed and taken place with the police; police officers had shadowed shifts in the HBPoS; and a secure transport provider with a two hour response rate had been contracted to reduce delays.
- Some staff we spoke with were mistaken about the point of time that a person was detained under S136, with some believing this was the time when the person arrived at the HBPoS rather than at the emergency department where they had first been taken by the police. We noted that in one S136 record the time of detention had incorrectly been recorded as the time the person arrived at the HBPoS rather than at the emergency department where they had been treated first. This could result in an incorrect calculation of the period of detention and time the S136 would expire. We raised this as an area for improvement in our monitoring visit in May 2015.
- Regular meetings took place between the trust, AMHP service and the police to review issues at an operational level. Following our monitoring visit of HBPoS, in May 2015, the ambulance service had been invited to attend to discuss conveyance. A new S136 protocol and memorandum of understanding was out for consultation at the time of the inspection.

Good practice in applying the MCA

- The training targets of 95% were not being met. Information provided by the trust showed that 66% of staff in the crisis services and HBPoS had received training in applying the MCA. Eighty eight per cent of staff in the crisis resolution team in Boston, 67% of staff in the team in Louth, 60% of staff in the team in Grantham and 58% of staff in Lincoln had received training in applying the MCA. Fifty per cent of staff in the HBPoS had received training in applying the MCA. Staff we spoke with were aware of the MCA and the implications this had for their clinical and professional practice.
- We looked at 24 care records and found capacity assessments were being completed appropriately.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and compassion

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

The involvement of people in the care they receive

- People who used the service told us they were involved in their care and treatment and were given information about the choices available. Many felt their mental health had improved as a result of the service they received. Two people told us they would have killed themselves if the team had not been so responsive and caring.
- People were encouraged to involve relatives and friends in care planning if they wished. This was reflected in the care records we looked at. People did not have written information about their plan of care, which some said would be helpful for them.
- Information was available for people who used the service on, for example, access to advocacy. A comprehensive information pack had been developed for people who used the service and their carers in Grantham and Boston, and was being shared across all four crisis resolution teams.

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, discharge and transfer

- Target times for assessment were set for crisis resolution teams. Each team had agreed criteria for which people would be offered a service.
- Urgent referrals were seen quickly by skilled professionals in all the teams we visited, although rapid access to a psychiatrist was not always available when required in Lincoln and Louth. Non-urgent referrals were seen within an acceptable time.
- We observed that people were given a degree of choice in the times of appointments on the first contact by the service following a referral.
- The crisis resolution teams took a proactive approach to engaging with people who found it difficult or were reluctant to engage with mental health services. This included re-engaging with people who did not attend (DNA) their appointments. Protocols had been developed using learning from a serious incident and had been implemented across the four crisis resolution teams.
- We spoke with 18 people who used the service and two carers. People told us that appointments ran on time and they were kept informed if there were any unavoidable changes. Some told us they saw different members of staff due to the nature of the service but felt that they all knew and understood their needs and that this was not a barrier to their treatment and support.
- Waiting lists for treatment in the integrated teams, such as 56 days in Grantham, and the lack of a care pathway for people with a personality disorder had led to the crisis teams experiencing difficulties in discharging people who were ready to move onto other mental health services.
- There was no mental health crisis helpline available. Staff told us that crisis plans for people using other mental health services provided by the trust often included the crisis resolution team's phone number as no other was available. They said at times they had to deal with many calls from people who did not need the crisis service but needed someone to talk to, and that this impacted on their ability to respond to people needing the crisis resolution team. The Lincolnshire mental health crisis care concordat action plan contains an action to scope the provision of a free 24/7 helpline number for people in mental health crisis.
- The introduction of street triage had improved access to assessments for people who come to the attention of the police and may have mental health needs. The triage car was staffed by paramedics and qualified mental health professionals from the trust. Information from the trust showed that out of 178 referrals to the triage car in the period from April to October 2015, 59 were resolved with follow up offered, 30 were resolved with no follow up needed, 18 received mental health home treatment, five were detained under S136 MHA and 32 were detained under the MHA.

The facilities promote recovery, comfort, dignity and confidentiality

- The crisis resolution teams had facilities to see people in their premises. Interview rooms had adequate soundproofing.
- There was nowhere for professionals to talk privately when someone was detained in the HBPoS. The entrance and office area was very small and the detained person could hear any conversation taking place.
- Information on local services and patients' rights were available in all services we visited, including the HBPoS.

Meeting the needs of all people who use the service

- Adjustments were made for people requiring disabled access.
- Staff had access to translation services and interpreters to help assess and provide for the needs of people using the service.
- Information leaflets were available in languages spoken by the people who used the service.

Listening to and learning from concerns and complaints

- Information was available for people who used the service on how to complain or raise a concern. Such information was displayed in all services we visited and in information packs. Most people we spoke with said they had seen information on how to complain and all knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them.
- In the period 1 August 2015 to 30 November 2015 Boston crisis resolution team received three complaints,

Are services responsive to people's needs?

Good

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

one of which was upheld. Grantham team received four complaints, one of which was upheld. Lincoln team received five complaints, one of which was upheld and one of which was ongoing. Louth team received one complaint, which was ongoing.

- Staff told us they tried to address people's concerns informally as they arose. Staff we spoke with were aware of the formal complaints process

Are services well-led?

Good

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

Our findings

Vision and values

- Staff we spoke with were aware of the trust's values and vision. These were displayed in the services we visited.
- Staff told us they had regular contact with their immediate managers and occasional contact with more senior managers.

Good governance

- Governance arrangements were in place locally which supported the quality, performance and risk management of the services. Staff were being supervised and most had been appraised. Incidents were reported and staff had learned from these. Overall, the trust's target of 95% of staff being up to date with mandatory training had not been achieved. Managers were aware of this and had plans in place to address this with individual staff where appropriate.
- Key performance indicators and other indicators were used to gauge the performance of the crisis resolution teams.
- Team managers told us that they had sufficient authority and administrative support to manage the service effectively. They met regularly as a group to discuss performance, address any areas of concern and share good practice. They also said that where they had concerns they could raise them.
- Staff confirmed they could submit items to the risk register.

Leadership, morale and staff engagement

- All staff we spoke with were very positive about team working and the mutual support they gave one another. They felt supported by their immediate managers who they said would get involved in daily clinical practice if needed.
- Staff we spoke with knew how to use the whistleblowing process.
- Staff morale was generally low following significant organisational changes in the trust as a whole. Some staff were very concerned at the future impact of these changes on the availability of services for people who needed them.
- Some staff we spoke with did not feel supported by senior managers and said their concerns, such as lone working and the lack of a crisis helpline, were not being addressed.

Commitment to quality improvement and innovation

- The Grantham crisis resolution team was taking part in the Royal College of Psychiatrists' home treatment accreditation scheme . Their peer review had taken place on 20 November 2015 and the team had just received its draft report on this at the time of the inspection.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The trust did not protect patients from the risks associated with unsafe or unsuitable premises by means of suitable design and layout.** • **Environmental risks in the HBPoS identified in our previous monitoring visit remained. The room was small and only had one door, which created a risk that staff would not be able to exit the area quickly if needed. Staff were not able to maintain line of sight observation in all areas. The furniture in the suite was not weighted. There was no medicine storage.** **This was in breach of regulations 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The trust did not deploy sufficient numbers of suitable qualified, competent, skilled and experienced staff to make sure they could meet people's care and treatment needs.** • The crisis resolution teams did not include or have access to the full range of mental health professional backgrounds. There was no occupational therapist or psychologist in any of the teams. There was no social worker in Grantham, Louth or Boston crisis resolution teams. Rapid access to a psychiatrist was not always available when required in the crisis resolution teams in Louth and Lincoln.

This section is primarily information for the provider

Requirement notices

This was in breach of regulations 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.