Outstanding ☆

Rotherham Doncaster and South Humber 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)
RXE00	Trust Headquarters - Doncaster	Mental health crisis services and health-based places of safety	DN4 8QN

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

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

Summary of findings

Where applicable, we have reported on each core service provided by Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

There was a skilled multi-disciplinary team. Some staff were trained as best interest assessors and some had undertaken training in cognitive stimulation therapy, wellness recovery action planning and motivational interviewing. The advanced nurse consultant was a Queen's nurse. The title of Queen's Nurse indicates a commitment to the values of community nursing, high standards of practice, excellent patient-centred care and a continuous process of learning and leadership. Staffing levels and the skill mix within the teams meant the staff on duty were able to meet patients' needs.

We saw a number of excellent examples of proactive work to improve patients' experiences. The teams actively promoted advance decision making so that other people could understand how patients would like to be cared for when they were not well.

In Doncaster, there was a carers' support worker and a wellness action recovery worker. There was an innovative peri-natal mental health service that provided specialist interventions at home to reduce admissions to mother and baby mental health units.

In Rotherham, there was a dedicated service for deaf patients with mental health problems. They worked with children and young people aged 14-18 as well as adults. They supported patients by promoting their deaf identity, to help them live and work as valued members of the deaf and wider communities.

Rotherham and Doncaster operated a new model liaison and diversion service introduced by NHS England. The service supported patients with mental health conditions, substance misuse problems and learning disabilities who were suspected of committing an offence and came into contact with the police. There was also a street triage team working with the police. This team had significantly reduced detentions under section 136 Mental Health Act 1983 (MHA). This year, the street triage team had won the trust's award for partnership working and the Doncaster district police diversity achievement of the year award.

At Great Oaks, the acute care service, including the mental health crisis service, had planned a "perfect week". This was a groundbreaking exercise in mental health services. It focused on organisational development and better patient care, safety and experience.

There was a drive to increase participation in research, such as research into decision making around treatment for patients diagnosed with personality disorders and research into early discharge.

The service had significantly reduced waiting times for mental health assessments for patients with learning disabilities and autism, in line with National Institute for Health and Care Excellence (NICE) guidance.

The referral system enabled patients to access help and support directly when they needed it, 24 hours a day, seven days a week. The mental health crisis services focused on helping patients to be in control of their lives and build their resilience so they could stay in the community and avoid admission to hospital wherever possible. The teams had established positive working relationships with other service providers such as the acute admission wards, GPs and community services and groups. The teams worked with the acute wards and community teams to plan patients' transitions between services in a holistic way. They ensured discharge arrangements were considered from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time.

All but one patient we spoke with told us they had a copy of their care plan and that they had been involved in formulating it. They said staff sought feedback from them about care planning and their views had been included in the care plan. Carers told us that they had been able to ask questions and the staff responded knowledgeably and informatively. The care plans we reviewed and the care we observed showed that patients' individual, cultural and religious beliefs were taken into account and respected. Patients were supported to maintain their social networks and independence in the community.

In all the teams, we saw the staff were kind, caring and compassionate and supportive of patients. When we spoke with patients, they were positive about the support they had been receiving and the kind and caring attitudes of the staff team.

Summary of findings

All the teams were managed well. There was a good governance structure to oversee the operation of the mental health crisis teams. Staff received appraisal and a range of supervision, managers investigated complaints, incidents were reported and investigated, changes were made when they were needed, staff participated in audits and safeguarding and Mental Health Act 1983 procedures were followed.

The staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

The staff we spoke with told us that morale was good. Many staff told us they were proud of the job they did and said they felt well supported in their roles. They felt valued and were positive about their jobs. We saw excellent examples of staff suggestions being implemented.

There was excellent commitment to quality improvement across all the teams and they had developed various services to improve care. However, at the time of the inspection we did not see any formal process for the teams to meet with each other. This meant they may miss opportunities for learning and sharing. We found examples of good or excellent practice in all the teams that could have been shared across the service.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- there were enough competent, skilled staff to ensure patients received safe care and treatment
- patients had prompt access to a psychiatrist when one was required
- there were clear processes to keep patients safe from abuse
- staff had a good understanding of safeguarding and gave it sufficient priority
- staff understood the importance of openness and transparency and their responsibilities in reporting incidents
- managers investigated incidents and took appropriate action
- managers analysed incidents to identify trends
- learning from incidents was shared.

However:

- mandatory training was not easily accessible to all staff.

Are services effective?

Outstanding

We rated effective as outstanding because:

- best practice guidance was embedded within clinical practice
- there was a holistic approach to planning and delivering joined-up care
- staff worked collaboratively to ensure patients had access to a range of therapeutic interventions to support recovery
- plans for moving on reflected patients' circumstances and preferences and were considered from an early stage
- staff were committed to improving quality
- managers encouraged new approaches and there were excellent examples of innovative and proactive work to improve patients' experiences
- there was a strong focus on organisational development and improved patient care, safety and experience
- staff were actively involved in audits and service reviews
- there was proactive work going on to develop research opportunities
- staff development was recognised as essential to ensuring high quality care and progressive methods were being implemented.

Are services caring?

Good

We rated caring as good because:

Summary of findings

- patients and those close to them were positive about the support they had been receiving
- patients were treated with dignity, respect, kindness and compassion
- staff demonstrated a good knowledge and understanding of patients' needs
- staff respected patients' privacy and confidentiality
- patients were involved in planning their own care
- staff supported patients to make decisions about their care
- staff communicated in ways patients could understand
- staff supported patients and those close to them to cope emotionally with their care and treatment
- patients were supported to maintain their independence and their relationships with those close to them.

Are services responsive to people's needs?

Outstanding ☆

We rated responsive as outstanding because:

- patients could access services when they needed to, in a way that suited them
- patients' needs and preferences were integral to planning and delivering care
- staff provided care that was flexible, offered patients choices and ensured continuity
- there was a proactive approach to understanding and meeting the needs of different groups of people and to promoting equality, including people with complex needs or who were vulnerable
- there were innovative approaches to providing cohesive, person-centred care that involved other service providers, particularly for people with multiple and complex needs
- complaints and concerns were reviewed and acted on so that the service improved.

Are services well-led?

Good

We rated well-led as good because:

- the trust's vision and values were embedded
- managers had effective interactions with other senior staff
- quality was sufficiently considered at team meetings
- there was excellent commitment to quality improvement
- there were clear processes for accountability
- there was an effective process to identify, monitor and address risks
- managers and staff understood the duty of candour

Summary of findings

- staff at all levels prioritised safe, high quality, compassionate care and promoted equality and diversity
- staff were proud of their work, they felt valued and supported and morale was good
- we saw excellent examples of proactive, innovative work to improve patients' experiences
- there was a strong focus on continuous learning.

However:

- there was no formal process for the teams to meet with each other to share learning and good practice.

Summary of findings

Information about the service

Rotherham Doncaster and South Humber NHS Foundation Trust provides a range of community based mental health services to adults of working age. This includes mental health crisis services and health-based places of safety. These services operate a 24 hour, 7 day a week service and are open 365 days a year.

Mental health crisis services carry out short-term work to support patients at home when they are in mental health crisis and to support earlier discharge from hospital. The teams aim to facilitate the early discharge of patients from hospital or prevent patients being admitted to hospital by providing either home- or unit-based support and treatment.

A health-based place of safety is a unit where patients detained under section 136 of the Mental Health Act 1983 are taken by the police for an assessment of their mental health. Section 136 allows for someone who is believed by the police to have a mental disorder and to be in need of immediate care or control to be removed from a public place and taken to a place of safety. This will usually be a health-based place of safety unless there are clear risks, for example risks of violence, that would require the person being taken to a police cell instead. Patients may be detained in a place of safety for a period of up to 72 hours for the purpose of enabling them to be examined by a doctor and assessed by an approved mental health professional, to consider whether compulsory admission to hospital is necessary.

In 2014, the Care Quality Commission carried out a thematic review of health-based places of safety. The trust provided three health-based places of safety, all situated in a mental health hospital. They were managed by the mental health crisis teams. The health-based places of safety were not used for any other purpose. The trust reported there was sufficient provision of health-based places of safety in the three local authority areas it covered. The trust did not apply any exclusion criteria for accepting individuals to the health-based places of safety and all groups of patients, including patients under 16, were able to use the health-based places of safety.

The Care Quality Commission has not inspected the mental health crisis services and the health-based places of safety before.

Our inspection team

Our inspection team was led by:

Chair: Philip Confue, chief executive, Cornwall Partnership NHS Foundation Trust

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Jonathan Hepworth, Care Quality Commission

The team that inspected the mental health crisis services and health-based places of safety included a CQC inspector and three specialist advisors from nursing and social care backgrounds.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out announced visits to the service on 15,16 and 17 September 2015.

We visited the mental health crisis services and the health-based places of safety at:

- Great Oaks hospital in Scunthorpe
- Tickhill Road hospital in Doncaster
- Swallownest Court hospital in Rotherham.

During this inspection we:

- visited three mental health crisis teams and three health-based places of safety and looked at the quality of the environments
- spoke with three patients and four carers and family members
- spoke with the managers of each team
- spoke with 22 other members of staff including:
  - an advanced nurse consultant
  - managers
  - nurses
  - occupational therapists
  - pharmacists
  - psychiatrists
  - support workers
- accompanied staff on four visits to patients at home and observed how they cared for them
- attended and observed one clinical assessment of a patient
- attended and observed two hand-over meetings and one section 136 joint agency meeting
- looked at care and treatment records of 24 patients
- carried out a check of the medication management of the three teams we visited
- looked at a range of policies, procedures and other documents relating to the running of the service
- looked at 12 staff records.

What people who use the provider's services say

We spoke with three patients and four people who cared for patients. They were complimentary about the service they had received, saying the staff were caring and understanding and had helped them become more stable. Patients and the people who cared for them said the staff were respectful, polite and knowledgeable. They were clear about their treatment plans and staff had given them information about their condition.

None of the health-based places of safety were in use during our visit and we were not able to speak with patients who had used them.

Good practice

Patients could self-refer, 24 hours a day, seven days a week, across the service

At Great Oaks, the advanced nurse consultant had recently received the Queen's Nurse award. The title of Queen's Nurse indicates a commitment to the values of community nursing, high standards of practice, excellent patient-centred care and a continuous process of learning and leadership

Summary of findings

There were good examples of partnership working across the service.

At Great Oaks:

- research projects were planned in partnership with the University of Derby and Sheffield Hallam University.

In Doncaster:

- the street triage team had won the trust's award for partnership working and the Doncaster district police diversity achievement of the year award
- the peri-natal service had made links with mother and baby mental health units, child and family services, midwives, health visitors and substance misuse services.

Rotherham and Doncaster operated a liaison and diversion service, in partnership with Together and in collaboration with South Yorkshire Police, criminal justice agencies and local commissioners.

There were excellent examples of developments to improve services for patients.

At Great Oaks:

- the acute care pathway was undertaking a "perfect week" exercise. This involved a whole system approach to the management of admissions and discharges and to review the use of crisis care pathways and respite provisions
- there were multiple levels of supervision
- there was a drive to increase participation in research.

In Doncaster:

- there was a peri-natal mental health service

In Rotherham:

- there was a dedicated service for deaf patients with mental health problems

The street triage team had reduced detentions under section 136 Mental Health Act 1983 (MHA) by 32% in Rotherham and by 23% in Doncaster.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that mandatory training is accessible to all staff.

Rotherham Doncaster and South Humber NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mental health crisis services and health-based places of safety	Trust Headquarters

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 use of the Mental Health Act 1983 (MHA) was not mandatory. However, staff had a good understanding of the application of the MHA and its guiding principles. We were assured by talking with staff that they understood how patients were assessed, cared for and treated in line with the Act and the MHA Code of Practice. They understood the statutory requirements of the MHA.

The mental health crisis service had approved mental health professionals (AMHP) integrated within the teams. This meant that when a person required a MHA assessment, an AMHP was available to arrange assessments within reasonable timescales.

Records we looked at included information about statutory advocacy services and there was information displayed in waiting areas in the team offices.

Staff working in the health-based places of safety understood the statutory requirements of the Mental Health Act (MHA). They had a good understanding of their

responsibilities when patients were brought in by the police under section 136 to ensure they worked within the MHA, the associated Code of Practice and the guiding principles.

There was an inter-agency policy that included all of the areas set out in the Code of Practice for the MHA 1983. The inter-agency group met at least monthly.

When patients were admitted to the health-based places of safety, staff explained their rights to them and repeated them until patients understood their rights. There were effective systems to assess and monitor risks to individual patients who were detained under the MHA. These had been jointly agreed with the police. There was information about statutory advocacy services and other local services available for patients in the section 136 suites.

Mental Capacity Act and Deprivation of Liberty Safeguards

All the teams were fully compliant with Mental Capacity Act training. Staff understood and were compliant with the requirements of the Mental Capacity Act 2005. Staff we spoke with understood that capacity fluctuated and that patients may have capacity to consent to some things but not others, for example, to be able to pay for shopping but not for more complex financial matters. They were able to explain their responsibilities in undertaking capacity assessments and monitoring to ensure patients were able to understand and agree to decisions being made or, if not, that they were made in the best interest of the patient. Patients using the mental health crisis service lived in the community and had a high degree of autonomy and independence to determine aspects of their daily lives.

Staff took steps to enable patients to make decisions about their care and treatment wherever possible. There was good understanding of mental capacity and consent issues. The team at Doncaster actively promoted advance decision making in the form of crisis plans within the wellness recovery action plan. At Rotherham, crisis contingency plans were being introduced for patients who had regular episodes of needing crisis care.

Staff understood the process to follow if a decision was needed about or on behalf of a person lacking mental capacity to consent to proposed interventions. It was clear from the care records we reviewed that staff worked from the premise that patients had mental capacity. Mental capacity assessments were only carried out when there were doubts about the patient's mental capacity.

This meant that patients received appropriate support to help them make specific decisions.

Good

Are services safe?

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

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

Our findings

Mental health crisis services

Safe and clean environment

Interview rooms and clinic rooms used by the mental health crisis teams were clean, well maintained and safe environments. All fixtures, fittings and equipment were clean and in a good state of repair. There was space with comfortable seating for interviewing and meeting individual patients and carers. Some rooms did not have alarms fitted but personal alarms were available and staff were able to raise an alarm if they did not feel safe.

Most of the crisis teams' work involved visiting patients at home to provide an assessment and ongoing care and treatment to support patients through a mental health crisis.

There were effective systems to ensure security and safety. On the days we inspected we were asked to show identification and to sign into and out of the building. There was a lone working policy that set out how the trust ensured safe working practices for staff. Staff were familiar with the policy and understood it. Where there were concerns about risks to staff, they visited patients in pairs or arranged to see them in safer alternative venues. Staff explained what they would do if they were concerned about their safety while on a visit or if someone did not return when they were expected to.

Safe staffing

Managers planned and reviewed the staffing numbers and skill mix to ensure patients received safe care and treatment. Staffing levels and the skill mix within the teams meant the staff on duty were able to meet patients' needs. The out of hours service was managed through a duty system. Staff told us there were sufficient numbers of staff to deliver the care and support that patients needed. They reported manageable caseloads that helped keep patients safe. Staff were able to meet targets, for example, ensuring patients were seen or offered an assessment within four hours of referral.

There were no current vacancies or sickness affecting staffing levels. Sickness within the teams ranged from 3.8%-5.9%; this was in comparison with the national NHS average of 4.7%. Where sickness and short term absences needed to be covered, staff were able to provide cover using a bank system. Managers had planned for vacancies and longer absences and cover was arranged. At Rotherham, one full time equivalent post was filled by agency staff. None of the patients, carers and family members we spoke with reported that they had experienced any cancelled groups or appointments.

Each team included at least one dedicated consultant. This meant patients had prompt access to a psychiatrist when required. There was sufficient medical cover during the day and night. A doctor could attend in an emergency and was available on call out of hours.

The trust provided a programme of mandatory training for staff that included equality and diversity, fire, infection control, safeguarding children, safeguarding adults, health and safety, managing aggression and violence, the Mental Capacity Act and information governance. Managers monitored compliance with mandatory training. Staff compliance with mandatory training requirements ranged from 46% - 73%. At Great Oaks we were told that most mandatory training took place in Doncaster, which was an hour away by car. This meant staff faced difficulties in finding time to spend away from their posts to attend mandatory training. The team had made attempts to overcome these difficulties by arranging for mandatory training to be carried out locally.

Assessing and managing risk to patients and staff

Staff assessed and managed individual risks on an ongoing basis. Staff carried out risk assessments of patients on initial contact and they updated this after each subsequent contact. We reviewed 24 care records and saw that most risk assessments were comprehensive and recorded appropriately. However, at Rotherham, five out of the eight we reviewed had not been updated.

All the services had approved mental health professionals (AMHPs) within the team. This helped ensure assessments carried out under the Mental Health Act 1983 (MHA) occurred in a timely manner. Having AMHPs embedded within crisis services also enhanced the teams' understanding of how staff could manage significant risks using legal powers to bring patients into hospital compulsorily if needed. Patients referred to the teams were

Good

Are services safe?

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

seen within four hours of referral if staff triaged them as needing crisis care. Referrals that staff triaged as urgent were seen within 72 hours and those that were routine were seen within 14 days. There was a standard operating procedure that set out how referrals should be prioritised. There were clear pathways setting out the processes for planned and unplanned Mental Health Act assessments.

The mental health crisis teams worked closely with patients on the adult acute wards to provide intensive home treatment and facilitate early discharge. None of the teams had a waiting list.

Safeguarding arrangements were in place and took account of both adult and children's safeguarding. Staff received training in safeguarding up to level 3 but although compliance in safeguarding children ranged from 63%-80% in Doncaster and Rotherham, figures provided suggested that only 10% - 22% had received training in safeguarding adults. Data the trust provided did not include figures for Great Oaks. We discussed safeguarding with staff. They showed good, comprehensive understanding of safeguarding issues and explained how to make a safeguarding alert. Safeguarding information was displayed in the teams' offices. A safeguarding policy and procedures were available on the trust intranet. We saw evidence in care records that staff attended safeguarding strategy meetings. This assured us of their skills and competence.

There were policies and procedures covering all aspects of medicines management. Clinic rooms were clean and well organised. All medical equipment was monitored and checked every week. Medicines were in date and staff checked stocks every week. We saw completed records of infection control systems. Fridge temperatures were checked daily. Staff explained how to report a medicines incident.

Track record on safety

Staff were encouraged to report all incidents. They had reported 62 incidents between March 2015 and September 2015. Recommendations and learning from incidents reported trust-wide were shared and discussed at weekly team business meetings. We saw documentary evidence of changes made following learning from incidents. For example, an incident relating to delivering medication to patients had been reviewed and practice amended as a result.

Reporting incidents and learning from when things go wrong

There was an incident reporting system in place. This enabled team managers and senior managers to review and grade the severity of incidents. Staff explained how to report an incident. They understood their responsibilities in relation to reporting incidents. Managers analysed incidents to identify any trends and they took appropriate action in response.

Across the teams, staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Staff were de-briefed and supported following serious incidents. Debriefing included input from a psychologist.

Learning from incidents was shared with the teams via trust-wide communications such as a 'patient safety' newsletter. Managers discussed learning and actions in team meetings and individual supervision to ensure lessons were learnt. We saw notes of these meetings confirming this.

Health-based places of safety

Safe and clean environment

The health-based places of safety we visited provided a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983 (MHA). The physical space provided good environments to assess patients and provide safe care. Staff were able to observe all areas at all times, with the exception of the bathroom at Great Oaks. The bathroom door lacked an observation panel and there were ligature points in the bathroom. A ligature point is anything that could be used to attach a ligature for the purpose of strangulation or hanging. There was a ligature risk assessment that set out how this risk was mitigated through staff awareness and care planning for the individual, including clinical risk assessment, observation and controlling patient access to the room. The room was kept locked at all times.

The rooms were clean and well maintained. The furniture was in good condition and suitable for use in a place of safety. The adjacent acute admission wards held emergency equipment, including resuscitation equipment

Good

Are services safe?

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

and oxygen. This was checked daily to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked daily.

Most staff who worked in the health-based places of safety had undertaken training in life support techniques. Compliance with this mandatory training ranged from 74% - 100%. There were alarms available in the suites to summon additional staff if required. Staff said that when the alarm was used staff responded very quickly.

Safe staffing

The health-based places of safety were staffed by nurses from the adjacent acute admission wards when patients were brought to the suite by police. Staff told us that a qualified nurse from the ward would attend and that a member of the mental health crisis team would also attend if possible. Records we reviewed confirmed this.

Staff were clear about their role and function in managing patients in the suite and were able to respond in a timely manner when required.

There was appropriate medical cover available from the trust to ensure that a timely response was available to patients requiring assessment within the units.

Assessing and managing risk to patients and staff

At the health-based places of safety, the designated nurse received the detained patient and contacted an approved mental health professional regarding making arrangements for a MHA assessment. Nursing staff and the police completed an agreed joint risk assessment for the patient. When risk assessments had been conducted for patients and the risks were assessed as too high, the police would stay until the risk had reduced to an acceptable level.

Staff who worked in the health-based places of safety were required to undertake training on managing violence and aggression every year. Training comprised four modules. In the last year, compliance among the mental health crisis teams ranged from 14% - 60%. Ward staff compliance ranged from 34% - 100%. We discussed this with staff. They explained how they would manage incidents of violence and aggression, which assured us of their skills. They were familiar with de-escalation techniques and told us that they used these in the first instance and would only use restraint as a last resort.

Staff working in the health-based places of safety had received training in safeguarding vulnerable adults and children with compliance of 50% in safeguarding adults and ranging from 63% - 80% in safeguarding children. We discussed safeguarding with staff. They showed good understanding of safeguarding issues and explained how to make a safeguarding alert.

Track record on safety

In the last six months, five incidents had been reported in relation to the health-based places of safety, all of which resulted in minor or no harm.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. Managers reviewed all incidents and sent them on to the trust's clinical governance team who maintained oversight. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.

Learning from incidents was also circulated trust-wide via a newsletter.

Are services effective?

Outstanding ☆

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

Mental health crisis services

Assessment of needs and planning of care

We looked at the care records of 24 patients. Records were stored electronically and access was protected.

The mental health crisis teams had several functions. They provided a single point of access for patients referred into mental health services. They acted as gatekeepers for admissions into hospital, they offered a crisis service and a home treatment service providing short term interventions for patients experiencing a mental health crisis. They had developed other services within the teams, such as a peri-natal mental health service, a service for deaf patients with mental health problems, a liaison and diversion service and a street triage team.

Across all the teams, staff triaged all referrals and prioritised patients according to whether they were in need of crisis, urgent or routine care. Staff completed assessments quickly. They assessed patients in crisis within four hours and urgent referrals within 72 hours. They assessed routine referrals within 14 days. All the teams held daily meetings where they discussed patients' care and the support they required. We observed these meetings taking place at two of the services we inspected.

Following referral, staff carried out an initial assessment that included a risk assessment and consideration of patients' social, cultural, physical and psychological needs and preferences. The assessments focused on patients' strengths, self-awareness and support systems, in line with recovery approaches. The teams used standard assessment tools such as the Generalised Anxiety Disorder Assessment 7, Patient Health Questionnaire 9, Addenbrooke's Cognitive Examination 111 and the Short Warwick-Edinburgh Mental Wellbeing Scale. At Doncaster, we saw a checklist being used to ensure all tasks were completed. Staff could access patients' GP records from the electronic system for previous medical history.

With the patient, staff developed a care plan. The records we reviewed were up to date. The care plans were centred on the patient's needs as identified by themselves. They demonstrated knowledge of current, evidence-based practice. They were solution focused and there was evidence of referral to other services such as community services, admission to hospital or discharge to primary care based on the patient's needs. Some patients had developed a crisis plan as part of their wellness recovery action plan.

Discharge plans were included in care planning and action plans from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time. All but one of the patients and carers we spoke with were aware of plans for discharge from the mental health crisis service. One said they had been signposted to the trust's recovery college for longer term care.

Best practice in treatment and care

All the teams we inspected implemented best practice guidance within their clinical practice. They offered a range of short term interventions. Staff we spoke with described the interventions they used to assist patients with managing crises and distress and to support their recovery, including cognitive stimulation therapy, anxiety management and wellness recovery action plans. Support workers assisted patients with practical issues.

We reviewed supervision records and they confirmed the teams were using National Institute for Health and Care Excellence (NICE) guidelines in relation to risk management, depression, anxiety and personality disorder.

Patients' physical health needs were considered alongside their mental health needs. The teams had a dedicated member of staff who carried out physical health checks. The care records we reviewed included physical health assessments and staff had access to GP records via the electronic system.

There were clear criteria for patients to be offered a service. Staff assessed all patients using a clustering tool and referred them into the appropriate care pathway.

There were excellent examples of proactive work to enable patients to avoid being admitted to hospital.

In Doncaster, a peri-natal mental health service had been set up by a staff member with a particular interest in this field. The aim was to reduce admissions to mother and baby mental health units by providing specialist interventions at home. The service had not been evaluated as yet but early indications were positive. Eight women had been treated and, of these, one who would have required admission to hospital had been able to stay at home.

Are services effective?

Outstanding ☆

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

The teams actively promoted advance decision making. There was a carers' support worker and a wellness action recovery worker who supported patients to develop wellness recovery action plans (WRAP). WRAP is an evidence-based practice that anyone can use to help them recover and stay well. Patients can plan ahead to maintain their mental wellbeing. It includes sections on things that make patients feel unwell, early warning signs, a crisis plan that tells other people how the patient would like to be cared for when they are not well and a plan for reducing support as they recover from crisis and take back responsibility for their own care. The WRAP worker helped patients to make these plans and supported other staff to use WRAP.

In Rotherham, crisis contingency plans were being introduced for patients who had regular episodes of needing crisis care.

There was a dedicated service for deaf patients with mental health problems. One member of the team was a member of the NHS England clinical reference group for mental health and deafness, which sets standards for deaf services. As part of this, the team had been involved in developing a national recovery package, 'All about me', for the deaf community. This will form a commissioning for quality and innovation target for specialised services and be used to enhance the care given.

A street triage service was launched in Rotherham and Doncaster in January 2014. Street triage involves mental health practitioners providing on the spot support to police officers who are dealing with patients who appear to be in immediate need of mental health support. Successful street triage results in better assessment of situations, more effective use of police resources and quicker access to appropriate mental health support for patients in crisis. The project had been evaluated after six months and at the end of 2014. It found that there were significant reductions in the use of section 136, hospital admissions and use of police resources. The street triage team had reduced detentions under section 136 Mental Health Act 1983 (MHA) by 32% in Rotherham and by 23% in Doncaster. Another significant finding was the higher number of interventions undertaken by the street triage team. The number of interventions was 226% higher than the number of section 136 assessments undertaken within the same operational hours during the previous year. Even though this was partly due to the fact that the street triage team's remit was wider than simply undertaking section 136 assessments, it demonstrates the additional benefit of this partnership work for patients with mental health needs. Additionally, fewer patients were admitted through street triage interventions than were admitted informally and under the MHA through section 136 detentions. In Rotherham, 30% fewer patients were admitted following a street triage intervention and 17% fewer in Doncaster. The evaluation found that, given the wider remit of street triage, this was to be expected but it raised the question as to whether the section 136 process alone increased the risk of an admission.

Police data showed that 75% of the street triage team's interventions had enabled police officers to resume other duties in a timelier manner.

The street triage team had won the trust's 2015 award for partnership working and the Doncaster district police diversity achievement of the year award.

Rotherham and Doncaster operated a liaison and diversion service, in partnership with Together and in collaboration with South Yorkshire Police, criminal justice agencies and local commissioners. The service supported patients with mental health conditions, substance misuse problems and learning disabilities who were suspected of committing an offence and came into contact with the police. Patients had an assessment of their health needs, including mental health. This was shared with police and the courts to help ensure decisions made about charging and sentencing take their health needs into consideration an individual's health needs. It also meant treatment was given sooner, which would help stop re-offending.

The project had a steering group that met every month. We reviewed minutes of these meetings and saw discussion of strategy and priorities for the service. There were no exclusion criteria and the service took referrals relating to all groups, including children and young people. We saw notes of discussion about working with this group, such as whether a parent or appropriate adult should be contacted when a referral was received.

Services such as this are being introduced as part of a wider initiative by NHS England and other departments including Public Health England, the Home Office and the Ministry of Justice to test out a new model in liaison and

Are services effective?

Outstanding ☆

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diversion services to ensure the quality of services is consistent across England. The new model will be independently evaluated to inform a business case for services to cover all of the English population by 2017-18.

At Great Oaks, there was a drive to improve participation in research. Staff told us about planned projects, such as research into decision making around treatment for patients diagnosed with personality disorders, in partnership with the University of Derby. Staff had also planned research into early discharge, to be carried out jointly with Sheffield Hallam University. We saw that these had been given ethics approval and funding applications had been made.

A "perfect week" exercise was planned and three more research projects were expected to be identified following this. This was a groundbreaking exercise led by the advanced nurse consultant. It is usually used in acute hospitals and has not been used in mental health services before. It focuses on organisational development and improved patient care, safety and experience.

One patient told us they had been given a crisis card. Crisis cards are designed to be carried in a pocket or wallet and should contain information about what to do and who to contact when someone is experiencing a crisis. They can be useful if patients have difficulties communicating when they are experiencing a crisis, for example if they suffer from anxiety.

We saw several instances of staff being involved in audits. For example, they had undertaken an equality impact assessment of the service for deaf patients with mental health problems and they were involved in evaluating the street triage service. The section 136 multi-agency group met every month and their discussions included reviewing performance indicators, such as three-hour wait times, the number of times section 136 was used and outcomes following admission. The peri-natal mental health service had not been evaluated but we saw evidence of discussion with commissioners relating to outcome measures.

We noted in team meeting minutes that staff had undertaken reviews. For example, a clinical risk assessment review had been carried out. A risk log had been set up for staff to complete if there were issues that presented a risk to patient safety.

Skilled staff to deliver care

The mental health crisis service had access to a range of mental health disciplines required to care for patients. There was an effective multi-disciplinary structure that included input from mental health nurses, support workers, social workers, approved mental health professionals (AMHPs), occupational therapists, administrative support and doctors.

The staff were all trained in the skills needed for crisis care, assessment and home treatment. This meant they could provide safe cover across all areas the teams worked in.

Staff received training to support them in their roles. The training records we saw showed that staff had accessed a range of training so they were able to meet the needs of patients who used the service. We saw discussion about additional training noted in supervision records and managers encouraged staff to develop skills in specialist areas. Some staff were trained as best interest assessors and some had undertaken training in cognitive stimulation therapy, wellness recovery action planning and motivational interviewing. At Doncaster, a member of staff was trained in helping patients develop wellness recovery action plans and was beginning to roll this out among other staff.

Staff were supported to deliver effective care by means of supervision and appraisal of their work performance, to identify additional training requirements and manage performance. Staff had an annual appraisal that included setting objectives for personal development. The appraisal records we saw confirmed this. All the staff had had an appraisal in the last 12 months.

Staff received clinical and managerial supervision every two months. Staff wellbeing and performance issues were also discussed. All staff supervision was up to date. They said they found supervision valuable. The records we reviewed were all up to date.

At Great Oaks, there were additional levels of supervision, set up after asking staff how they would like to receive supervision. Staff had said they would like supervision to be part educational and part casework focused.

Group supervision sessions took place every two weeks. Staff brought complex or challenging clinical issues to discuss and explored ways to improve the service they provided.

Are services effective?

Outstanding ☆

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Teaching sessions also took place every two weeks. Following a service evaluation, these sessions looked at skill sets and provided support for staff to develop their practice.

There was also a monthly forum that was open to all levels of staff, including clinical, medical and administrative staff. These sessions looked at how different levels of the service functioned. Guest speakers were invited, such as a commissioner and the trust solicitor. The sessions were non-hierarchical, offering the same level of validity to all staff attending and provided an opportunity for systemic learning about how issues could be dealt with. There were plans to use video conferencing to open up opportunities for more staff to participate.

Workshop dates were also available to enhance staff skills in areas such as personality disorder and autism spectrum conditions.

All the staff we spoke with were knowledgeable and committed to providing high quality and responsive crisis care.

This model of supervision had been set up by the advanced nurse consultant, who had recently received the Queen's Nurse award. The title of Queen's Nurse indicates a commitment to the values of community nursing, high standards of practice, excellent patient-centred care and a continuous process of learning and leadership.

Staff and managers discussed performance in individual supervision sessions. We saw evidence of this in the records we looked at. Managers told us they felt well supported in dealing with poor performance.

Multi-disciplinary and inter-agency team work

The teams included and had access to a range of disciplines to support patients. This included managers, nursing staff, pharmacists, psychiatrists, psychologists, social workers, support workers and allied health professionals such as occupational therapists. They provided a range of therapeutic interventions to support patients' recovery in line with best practice guidance. Staff we spoke with recognised the benefit of close working with allied professionals.

The mental health crisis services held daily MDT meetings to review the mental health of the patients. Ward staff were included in these meetings.

The mental health crisis services had established positive working relationships with other service providers such as the acute admission wards, GPs and community services and groups. The teams worked with the acute wards and community teams to plan patients' transitions between services in a holistic way.

We reviewed minutes of team meetings that took place every month. Discussion included such issues as team performance, training, safeguarding, trust safety alerts and communications, outcomes measurement and the duty of candour.

Adherence to the MHA and the MHA Code of Practice

Training in the use of the Mental Health Act 1983 (MHA) was not mandatory. However, staff had a good understanding of the application of the MHA and its guiding principles. We were assured by talking with staff that they understood how patients were assessed, cared for and treated in line with the Act and the MHA Code of Practice. Staff understood the statutory requirements of the MHA.

The mental health crisis services had approved mental health professionals (AMHP) integrated within all the teams. This meant that when a person required a MHA assessment, an AMHP was available to arrange assessments within reasonable timescales.

Records we looked at included information about statutory advocacy services and there was information displayed in waiting areas in the team offices.

Good practice in applying the MCA

All the teams were fully compliant with Mental Capacity Act training. The staff understood and were compliant with the requirements of the Mental Capacity Act 2005 (MCA). Staff we spoke with understood that capacity fluctuated and that patients may have capacity to consent to some things but not others, for example, to be able to pay for shopping but not for more complex financial matters. Patients using the mental health crisis service lived in the community and had a high degree of autonomy and independence to determine aspects of their daily lives.

Staff took steps to enable patients to make decisions about their care and treatment wherever possible. There was good understanding of mental capacity and consent issues. The team at Doncaster actively promoted advance

Are services effective?

Outstanding ☆

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decision making in the form of crisis plans within the wellness recovery action plan and at Rotherham, crisis contingency plans were being introduced for patients who had regular episodes of needing crisis care.

Staff understood the process to follow if a decision was needed about or on behalf of a person lacking mental capacity to consent to proposed interventions. It was clear from our discussions with staff and the care records we reviewed that staff worked from the premise that patients had mental capacity. Mental capacity assessments were only carried out when there were doubts about the patient's mental capacity.

This meant that patients received appropriate support to help them make specific decisions.

Health-based places of safety

Assessment of needs and planning of care

A comprehensive assessment and physical health check was undertaken when patients were brought to the section 136 suites by the police. Physical health checks were usually carried out by a paramedic who conveyed the person to the health-based places of safety or by nursing staff on arrival if the person was conveyed by the police. This meant that patients had baseline physical assessments before or on admission to the health-based places of safety.

Staff kept electronic records so information about patients already known to the service was available at the point of admission. They also had access to GP records via the electronic system. This meant that information was readily available so staff could assess patients and make appropriate decisions.

The trust's target time for starting a MHA assessment for patients brought to the place of safety was three hours. The MHA Code of Practice at paragraph 16.47 states "…it is good practice for the doctor and AMHP to attend within three hours; this is in accordance with best practice recommendations made by the Royal College of Psychiatrists." During the last six months, out of 86 admissions reviewed, 76 assessments started within this time period. Of the 10 that did not, all but one was started within eight hours. All took place well within the 72 hour limit on detention provided by the MHA. The delays in carrying out MHA assessments occurred most frequently because there were clinical grounds for delaying the assessment; for example, intoxication.

Best practice in treatment and care

Patients assessed in the health-based places of safety were given information about the powers and responsibilities devolved under section 136. Staff also explained this. Staff repeated explanations until patients understood. This ensured that patients understood where they were, the assessment process and what their rights were. Information leaflets about the service were available in the suite. An information pack was being developed and the meeting minutes we reviewed confirmed this.

Skilled staff to deliver care

The health-based places of safety were next to the acute admissions wards or the psychiatric intensive care units. Qualified staff from these units co-ordinated admissions to the health-based places of safety and received the detained patient. Additional staff could be called to assist where necessary. Staff from the crisis teams also attended.

The staff we spoke with explained their roles and responsibilities under section 136.

Staff had access to a checklist of actions to be completed when someone was admitted to the health-based places of safety.

Multi-disciplinary and inter-agency team work

There was a joint agency policy in place for the implementation of section 136 of the MHA that had been agreed by the trust, local commissioners, police forces and ambulance service.

Monthly multi-agency monitoring meetings were well established to oversee the operation of section 136 and the use of the health-based places of safety. Attendance at the monitoring meetings was good with representatives from all agencies. We attended one of these meetings during the inspection and we reviewed minutes from the last three meetings for each team. The analysis of incident data and areas for improvement were routinely discussed in these monitoring meetings. The outcomes of all admissions were discussed plus, for example, meeting the three hour target for initiating a MHA assessment, police waiting times, the numbers of patients seen by the street triage team and improvements in the arrangements for conveyance and assessment when patients were brought in under section 136.

There were good links with the police in the operation of section 136. Good working relationships were evident at a strategic and operational level.

Are services effective?

Outstanding ☆

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 found there were local arrangements in place to ensure proper risk assessment before joint decisions were made about the police officers leaving patients in the health-based places of safety.

Staff working at the health-based places of safety described good working relationships between the agencies. The approved mental health professionals (AMHPs) we spoke with told us the staff working in the health-based places of safety were effective, made referrals appropriately and communicated information. This helped to ensure assessments were completed in a timely manner and delays minimised.

Adherence to the MHA and the MHA Code of Practice

Staff understood the statutory requirements of the Mental Health Act (MHA). They had a good understanding of their responsibilities when patients were brought in by the police under section 136 to ensure they worked within the MHA, the associated Code of Practice and the guiding principles.

There was an inter-agency policy that included all of the areas set out in the Code of Practice for the MHA 1983. The inter-agency group met at least monthly.

When patients were admitted to the health-based places of safety, staff explained their rights to them and repeated them until patients understood their rights. There were effective systems to assess and monitor risks to individual patients who were detained under the MHA. These had been jointly agreed with the police. There was information about statutory advocacy services and other local services available for patients in the section 136 suites.

Good practice in applying the MCA

Compliance with mandatory MCA training was 100%. Staff we spoke with understood that capacity fluctuated and that patients may have capacity to consent to some things but not others. They were able to explain their responsibilities in undertaking capacity assessments and continuous monitoring to ensure patients were able to understand and agree to decisions being made or if not that they were made in the best interest of the person.

Good

Are services caring?

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

Our findings

Mental health crisis services

Kindness, dignity, respect and support

In all the teams, we observed the staff to be kind, caring and compassionate and supportive of patients. All the staff we observed demonstrated this. When we spoke with patients, they were positive about the support they had been receiving and the kind and caring attitudes of the staff team. However, one patient said they had seen several different members of staff. This had caused them difficulty as they had felt uncomfortable talking to unfamiliar people.

Staff demonstrated a good knowledge and understanding of patients. When we accompanied staff visiting patients, it was clear that they had a good understanding of their needs.

All the staff teams maintained patients' confidentiality at all times. When we accompanied staff on home visits the staff members asked if the patient was happy for a Care Quality Commission team member to be present prior to the visit. All staff we spoke with were aware of the need to ensure confidential information was kept securely. Staff access to electronic case notes was protected.

The involvement of people in the care that they receive

When we accompanied staff on home visits, we saw that patients had copies of their care plans. All but one patient told us they had a copy of their care plan and that they had been involved in writing it. They said staff sought feedback from them about care planning and their views had been included in the care plan. One person said staff had listened to their anxieties about aspects of their treatment such as the side effects of medication. Patients told us that staff had given them useful information about their condition and symptoms. Carers told us that they had been able to ask questions and the staff responded knowledgeably and informatively. Two said staff had provided specific information, advice and support to them as a carer. Staff routinely looked out for stress in carers. We saw a "carers' burden" assessment tool being used.

The records we looked at contained personalised, holistic care plans. The support offered was flexible depending on the patient's needs. For example, some patients received visits several times a day. Patients' family, friends and advocates were involved in their care if the patient wished. Patients were able to decide who should be involved in their care and to what degree.

Patients and their families and carers were also given information about complaints, advocacy information, support groups and self-help groups and literature to promote independence and learning.

Health-based places of safety

Kindness, dignity, respect and support

The staff at each of the units explained how they would try and support patients in a kind and considerate manner.

Managers and staff that we spoke with were enthusiastic about the use of health-based places of safety and the improvements that were associated with the street triage initiatives.

The involvement of people in the care that they receive

Advocacy services were available for patients to access from the health-based places of safety.

Staff explained patients' rights to them routinely whilst they were detained.

Patients had access to information in different languages and formats. Interpreting services were also available if necessary.

Feedback about patients' experiences was not routinely requested during or after being cared for in the health-based places of safety.

Are services responsive to people's needs?

Outstanding ☆

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

Our findings

Mental health crisis services

Access and discharge

The referral system enabled anyone to refer into the service, including self-referrals from patients or their carers. This meant that patients were empowered to access help and support directly when they needed it, 24 hours a day, seven days a week. Access to crisis care was not delayed, for example, by having to access it through the accident and emergency department. In addition, the mental health crisis services took referrals from inpatient wards, the different functions of the community mental health teams, community based services such as GPs and other organisations they had developed links with.

All the teams had developed links with organisations and groups in the community so that they knew how to make a referral, particularly groups that may be hard to reach, for example, BME communities, the Eastern European Roma community, substance misuse services, domestic abuse support services and local organisations for homeless patients.

Staff visited patients in their homes or they could attend the team offices, dependent upon their needs and level of risk. Staff also supported patients by telephone or an agreed level of contact.

The teams acted as gatekeepers for inpatient beds. During 2014-2015 they acted as gatekeepers for 98.4% of admissions. From April to August 2015 they had acted as gatekeepers for 100% of admissions. "Gatekeeping" means that nobody is admitted into hospital unless the team has agreed there is no alternative. This is in line with the "least restrictive" principle of the Mental Health Act 1983 (MHA) Code of Practice. The only admissions the teams did not gatekeep were transfers into the trust of patients who had been admitted to beds outside the trust's area and those admitted by approved mental health professionals under section 136.

The mental health crisis services worked within the principles of the recovery model. This meant they focused on helping patients to be in control of their lives and build their resilience so that they could stay in the community and avoid admission to hospital wherever possible. The home treatment function of the teams also enabled some patients to be discharged from hospital early by offering intensive support during the transition from hospital back to the community. This helped to reduce the risk of them relapsing during their recovery. This meant that the teams ensured patients did not stay in hospital longer than necessary and promoted patients' early discharge.

The teams ensured discharge arrangements were considered from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time. They had regular daily contact with the acute wards to identify patients who may be appropriate for early discharge with support from the team. This included providing support to patients during periods of leave from the ward.

The facilities promote recovery, comfort, dignity and confidentiality

Staff were committed to providing care that promoted patients' privacy and dignity. Care focused on patients' holistic needs and not just on treating their mental distress or illness. For example, the records we reviewed showed staff supported patients to consider issues of money and benefits, family issues, life events and vocational and educational opportunities. This meant that patients who used services were enabled to participate in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to.

We observed staff assessing and providing crisis care and saw patients were treated with dignity and respect throughout the interventions.

Meeting the needs of all people who use the service

The service had access to interpreting services that assisted them to support patients. Information leaflets were available in a range of languages and formats including CD, audiotape and Braille.

The care plans we reviewed and the care we observed showed that patients' individual, cultural and religious beliefs were taken into account and respected. Patients were supported to maintain their social networks and independence in the community.

We saw excellent examples of proactive work to improve patients' experiences and keep them out of hospital.

At Great Oaks, the acute care service, including the mental health crisis service, had planned a "perfect week", beginning on 5 October 2015. This was a groundbreaking

Are services responsive to people's needs?

Outstanding ☆

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

exercise led by the advanced nurse consultant. "Perfect week" is usually used in acute hospitals and has not been used in mental health services before. It is an inititiative designed by NHS England's Urgent & Emergency Care Intensive Support Team that aims to change behaviour and let services identify where they can work better. It focuses on organisational development and improved patient care, safety and experience. It involves a whole system approach to the management of admissions and discharges in to the ward beds and was adapted to review the use of crisis care pathways and respite provisions. The week allows staff to work together and test changes that can improve the way patients move through the system or to better understand why delays happen. We saw details of a presentation made to staff about the exercise and consequent discussions. Funding had been secured to support the week; for example, to be used to provide crisis beds or other placements. There was engagement at all levels of the trust. The trust board assumed "gold command" for the week, so that decisions that would usually be made by commissioners could be made in-house. Decision making responsibilities were also allocated at service level so that permissions need not be sought from senior management. The service expected to identify three research projects and to develop three business cases for improvements in the patient journey following the "perfect week" exercise. It was also expected that once staff had experience of decision making at service level, without having to seek permission from more senior staff, they would have the confidence to continue to do so, thus providing quicker, more seamless services for patients.

The service carried out mental health assessments for patients with learning disabilities and autism, using the Diagnostic Interview for Social and Communication Disorders and the Autism Diagnostic Observation Schedule. This work had reduced waiting times for assessment from two years in 2012 to four to eight weeks. This is in line with NICE guidance, which recommends 12 weeks.

There were multiple levels of supervision, teaching sessions and workshops to enhance staff skills in areas such as personality disorder and autism spectrum conditions.

In Doncaster, a peri-natal mental health service had been set up by a staff member with a particular interest in this field. In March 2015, funding had been secured to run a 12 month pilot. The pilot began in at the end of April 2015. The aim was to reduce admissions to mother and baby mental health units by providing specialist interventions at home. The service made links with mother and baby mental health units, child and family services, midwives, health visitors and substance misuse services. All these services had met to develop a care pathway into mental health services. A consultant psychiatrist sat in the ante-natal clinic once a week and took referrals from midwives. The peri-natal functional analysis of care environments (FACE) risk profiling module had been purchased to support the work. Staff in each service had been trained to use the module and to train others to use it. Referral criteria had been developed and the team was working on a specialist self-help pack. A launch event was being planned. The service had not been evaluated as yet but we saw evidence of discussion with commissioners relating to outcome measures. We reviewed minutes of a steering group that met monthly to decide on strategy and priorities for the services.

In Rotherham, there was a dedicated service for deaf patients with mental health problems. The John Denmark unit in Manchester had formerly provided a monthly clinic but the service had identified a need for more immediate and long-term input. The team consisted of staff with experience of working with members of the deaf community with mental health problems. All the staff could sign in British sign language (BSL). They also used, for example, BSL interpreters, text messaging, email and SMS to communicate with patients. The service focused on supporting deaf patients with severe mental health problems and improving services and access for deaf patients with common mental health problems across South Yorkshire. They worked with children and young people aged 14-18 as well as adults. The team had undertaken an equality impact assessment. Following this, they had created an equality delivery strategy that outlined what should be provided in relation to each goal and outcome. The staff were not available for us to speak with but it was clear from the documents and records we reviewed that they had an excellent understanding of the needs of the deaf community. They supported patients by promoting their deaf identity, to help them feel better about themselves and to live and work as a valued member of the deaf and wider communities.

Are services responsive to people's needs?

Outstanding ☆

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

Listening to and learning from concerns and complaints

Patients and carers we spoke with told us staff had given them information about how to complain or raise a concern. We saw that complaints were well managed. Patients received written information about making complaints and they knew how to raise concerns. They could do this electronically if they wished.

Complaints within each service were looked into and responded to. In the last 12 months, patients had raised 18 complaints. We found evidence that managers had taken appropriate action in response to complaints they had received.

Complaints and concerns that patients had raised were discussed routinely at the weekly team meetings and in supervision, or at the daily multi-disciplinary team meeting if necessary.

Health-based places of safety

Access and discharge

The development of the health-based places of safety and joint working arrangements with the police had reduced the numbers of patients being detained under section 136 Mental Health Act 1983 (MHA).

The arrangements and availability of staff meant the police were able to hand patients over to health staff within an appropriate timescale.

Patients in the health-based places of safety were seen quickly, well within the 72 hour limit on detention provided by the MHA but not always within the target time of three hours the trust had set for beginning the MHA assessment. The MHA Code of Practice at paragraph 16.47 states "…it is good practice for the doctor and AMHP to attend within three hours; this is in accordance with best practice recommendations made by the Royal College of Psychiatrists." Delays occurred most frequently because there were clinical grounds for delaying the assessment, for example, intoxication.

The trust collected data from the health-based places of safety to monitor the service. This included information about gender and ethnicity but not age, disability and other protected characteristics. Data was also collected on the outcome of the assessment, the number of patients transferred between places of safety and delays in initiating a MHA assessment for patients brought to the place of safety but not how many times patients were turned away from the place of safety or the reason why patients were turned away.

The facilities promote recovery, comfort, dignity and confidentiality

The environments provided a dignified environment for the assessment of patients detained under section 136. There was a separate entrance for police to bring patients into the suites, which helped maintain patients' safety, dignity and confidentiality. The suites provided clean, comfortable areas to carry out assessments, including separate toilet and bathroom areas, appropriate furniture and comfortable chairs. All had a bed or a sofa available so where there were delays in assessments patients could make themselves comfortable. A clock was visible from all rooms and there was 24 hour access to food and drinks.

There were separate areas for staff to meet and discuss the assessment.

The trust was aware of the possibility of there being more than one person requiring the facility at any given time. We were told that a second person detained under section 136 MHA would be conveyed to another suite within the trust. However, this occurred on an infrequent basis and there had been only one instance of this in the last six months.

Meeting the needs of all people who use the service

Skilled staff from services across the trust could be called on for advice when necessary, for example, if young patients or patients with learning disabilities or autism were admitted for section 136 assessments.

Staff confirmed that they had access to translation services and interpreters where required. A range of patient information was available for patients admitted to the health-based places of safety. When patients were admitted to the health-based places of safety, staff explained the powers and responsibilities devolved under section 136 of the MHA.

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to patients who were assessed in the health-based places of safety. During the last 12 months there had been no complaints received from patients detained under section 136.

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

Mental health crisis services

Vision and values

The trust had adopted a vision of 'leading the way with care', based on six values intended to ensure staff provided services that were passionate, reliable, caring and safe, empowering and supportive of staff, progressive, open, transparent and valued.

The vision and values were displayed on posters and leaflets around the premises. Our discussions with staff and our observations of care being delivered assured us that the vision and values were embedded in the service and in individual practice.

Managers in all teams explained the team objectives. Staff across the teams told us their priority was preventing admission and facilitating patients returning to the community.

Good governance

Staff told us they had regular contact with their senior management team. They explained the leadership and management structures in their service and they knew who the senior managers in the trust were.

We found all the teams were well managed locally. Staff were clear about their roles and they understood the management structure. Staff were appraised and supervised, complaints were investigated, incidents were reported and investigated, changes were made where needed, staff participated in audits, and safeguarding and Mental Health Act (MHA) 1983 procedures were followed. However, compliance with mandatory training was low.

Staff could submit items to be included on the risk register and they explained how they would do this. We noted in team meeting minutes that staff had undertaken reviews; for example, a clinical risk assessment review had been carried out. A risk log had been set up for staff to complete if there were issues that presented a risk to patient safety.

Across the teams, staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Staff supervision was carried out at least every two months, in line with the trust policy. Staff records contained a supervision contract that set out both staff and trust expectations of supervision. Staff told us they had been supervised and appraised by their line managers and that they were supported by them as well as by their peers. We looked at records that supported this. The records we reviewed were all up to date although the supervision matrix provided by the trust showed slippage of two to four weeks for all 18 staff at Great Oaks and 19 out of 30 staff at Doncaster.

Staff were responsible for ensuring their training was up to date but managers also monitored compliance. We reviewed the training matrix for all the teams we visited and the overall rates for completing mandatory training were low, ranging from 46% - 73%. However, throughout our inspection we discussed various issues with staff, such as safeguarding, mental capacity and dealing with violence and aggression, and we reviewed care records and supervision notes. We were assured that staff were competent and had the skills necessary to enable them to carry out their roles.

All the teams held weekly team meetings where service level performance and trust-wide issues were discussed. The trust had a good governance structure to oversee the operation of the mental health crisis teams. The team managers reported to the trust's clinical governance teams every month. Managers told us they had sufficient autonomy to carry out their role and they felt supported by their managers.

Leadership, morale and staff engagement

All the staff we spoke with were complimentary about the support and involvement of their line manager and more senior management. We did see minutes of meetings at which some staff had said they felt unable to raise concerns with their manager for fear of reprisals and that morale was low. However, the staff we spoke with told us that morale was good. Many staff told us they were proud of the job they did and said they felt well supported in their roles. They felt valued and were positive about their jobs. Staff told us they felt empowered to raise any issues and promote service development and initiatives. They showed a clear commitment to providing the quality care that

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Good

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individuals needed. Staff felt well managed locally and had high job satisfaction. They understood the trust whistleblowing policy and told us they felt able to raise concerns without fear of victimisation.

Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers. Records we reviewed confirmed this. We also saw excellent examples of staff suggestions being implemented; for example, at Doncaster a peri-natal mental health service had been set up by a staff member with a particular interest in this field. In March 2015, funding had been secured to run a 12 month pilot.

Commitment to quality improvement and innovation

Two patients said that, on discharge, they had had the opportunity to provide feedback. They said they had been given copy of a feedback questionnaire to complete. The service used the trust's 'your opinion counts' questionnaire to gather feedback from patients. This incorporated the "friends and family" test. We saw that the trust shared comments with staff via its newsletter "trust matters".

A quarterly staff survey was also carried out.

There was excellent commitment to quality improvement across all the teams; for example, in Doncaster, a peri-natal mental health service had been set up and patients were being helped to develop wellness recovery action plans. In Rotherham, there was a dedicated service for deaf patients with mental health problems and crisis contingency plans were being introduced for patients who had regular episodes of needing crisis care. Rotherham and Doncaster had a liaison and diversion service and a street triage team.

At Great Oaks, the service had significantly reduced waiting times for mental health assessments for patients with learning disability and autism. There were multiple levels of supervision that helped staff develop and a drive to increase participation in research. Staff told us about planned projects, such as research into decision making around treatment for patients diagnosed with personality disorders, in partnership with the University of Derby. Staff had also planned research into early discharge, to be carried out jointly with Sheffield Hallam University. We saw that these had been given ethics approval and funding applications had been made.

We saw details of a 'perfect week' planned to take place across the acute care pathway, including the mental health crisis service. "Perfect week" is an initiative that aims to change behaviour and let services identify where they can work better. Planning involved staff reviewing services and identifying gaps.

The service expected to identify three research projects and to develop three business cases for improvements in the patient journey following the "perfect week" exercise. It was also expected that once staff had experience of decision making at service level, without having to seek permission from more senior staff, they would have the confidence to continue to do so, thus providing quicker, more seamless services for patients.

However, at the time of the inspection there was no formal process for the teams to meet with each other. This meant they may miss opportunities for learning and sharing. We found examples of good or excellent practice in individual teams that could have been shared across the service.

Health-based places of safety

Vision and values

There was a joint agency protocol in place for the implementation of section 136 of the MHA. This had been jointly agreed by the trust, local commissioners, police forces and ambulance service. The duties of all agencies were identified and set out to ensure that patients received timely and effective assessment. Staff we spoke with were aware of the trust's vision and values and they understood the joint agency protocol.

Good governance

Audits were not carried out on the use of section 136 and the use of health based places of safety but the monthly monitoring meetings reviewed performance indicators, such as three-hour wait times, the number of times section 136 was used and outcomes following admission. The group discussed section 136 MHA records, which included quantitative data on the use of section 136 such as how long patients remained in the suite. However, although the information recorded helped audit the use of section 136 and the health-based places of safety, it was not complete. For example, although breaches such as delay in assessments were recorded, the reason for delay was not recorded consistently. The meeting minutes we reviewed recorded breaches in 10 out of 86 admissions. For five of these, the reason for the delay was not clear.

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Where there were problems, these were discussed and resolved at the monthly monitoring meeting. The environments of the health-based places of safety afforded dignified care.

Leadership, morale and staff engagement

The health-based places of safety did not have regular staff based there. The units were managed by the ward managers of the adjacent acute admissions wards or psychiatric intensive care units. Staff told us that they felt well supported by their managers and peers. Staff understood their responsibilities in relation to the duty of candour and their role in the process for any future incidents where patients experienced harm.

Commitment to quality improvement and innovation

There were systems to monitor the service in order to improve performance. We saw evidence that the locality multi-agency groups reviewed performance indicators, such as three-hour wait times, the number of times section 136 was used and outcomes following admission.

At Rotherham and Doncaster, the street triage team had reduced detentions under section 136 Mental Health Act 1983 (MHA) by 32% in Rotherham and by 23% in Doncaster. Additionally, fewer patients were admitted through street triage interventions than were admitted informally and under the MHA through section 136 detentions. In Rotherham, 30% fewer patients were admitted following a street triage intervention and 17% fewer in Doncaster.