Good

Greater Manchester West Mental Health NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Greater Manchester West Mental Health NHS
Foundation Trust
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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)
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Home based treatment team - Bolton	BL4 0JR
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Home based treatment team - Trafford	M33 7EG

Summary of findings

RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Single point of access team - Bolton	BL4 0JR
RXV17	Meadowbrook	Health based place of safety - Salford	M6 8HD
RXV60	Rivington	Health based place of safety - Bolton	BL4 0JR
RXV80	Moorside unit	Health based place of safety - Trafford	M41 5SL
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Mental health liaison team - Salford	M6 8HD
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Rapid assessment, interface and discharge (RAID) team -Trafford	M41 5SL
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Rapid assessment, interface and discharge (RAID) team - Bolton	BL4 0JR
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Salford police liaison service (pilot) working within Pendleton police station	M6 5RN

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

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

Where applicable, we have reported on each core service provided by Greater Manchester West Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Greater Manchester West Mental Health NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

- Staffing levels within the crisis teams helped ensure people in crisis received safe, appropriate and timely care. Teams had safe working practices and staff held manageable caseloads. Patients' individual risks were assessed and reviewed. Staff acted on adult and children's safeguarding matters. The three health based places of safety provided safe environments to assess patients. Staff learnt lessons following incidents to try and prevent further incidents happening.
- There was very effective multidisciplinary working in the crisis teams and good interagency working with acute hospital staff and the police. There were very good systems in place for ensuring the hospitals' duties under section 136 were met and very good clinical leadership into the health based place of safety. There was an alcohol worker working at the Trafford RAID service to support intoxicated patients. Nurses worked in police stations to provide professional and intensive support people who regularly presented to the police.
- Patients were treated with dignity and respect. Patients were involved in identifying their crisis support needs and in developing the assessment and intervention tools used in the home based treatment teams.
- Patients were usually seen quickly. Patients' individual needs were considered and met. There were good complaints processes.
- There were effective local, inter agency and crisis concordat meetings to improve services and patients' crisis experience. Staff were committed to providing high quality care and treatment and teams were managed by experienced and competent clinical leaders. There was a commitment to quality improvement such as improved health based places of safety environments, and improved staffing levels in crisis services.

However

- The rationale for changes in levels of support relating to patients under the Bolton home based treatment teams were not always explicitly recorded.
- It was not always clearly recorded that patients were informed of their rights verbally and in writing whilst in the health based place of safety and patients did not have access to a printed copy of the MHA Code of Practice.
- There were problems across the trust with getting ambulances to take patients to the health based place of safety and there were delays in assessing patients when subject to section 136 including the response of approved mental health professionals at night but where these occurred, delays were beyond the full control of the trust.
- In the home treatment teams, it was not always clearly recorded whether patients were given copies of their crisis care plans.
- There were differing crisis care pathways in each locality and information about each service did not fully inform patients and carers on the services available to them.
- Information on CQC's role in complaints literature was not up-to-date.

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:

- The three main health based places of safety provided safe environments to assess patients.
- Patients' individual risks were assessed and managed with summary and comprehensive plans recorded within electronic records.
- Staff ensured they considered and acted on adult and children's safeguarding.
- Staffing levels within the crisis teams helped ensure people in crisis received safe, appropriate and timely care.
- Staff learnt lessons following incidents to try and prevent further incidents happening through team discussions, support from senior managers and good systems.

However

- The rationale for changes in levels of support relating to patients of the home based treatment were not always explicitly stated in relation to patient presentation and risk.

Are services effective?

Good

We rated effective as good because:

- Care and crisis intervention plans were of a good standard.
- There was very good multidisciplinary working in the crisis teams and good interagency working with acute hospital staff.
- Mental health nurses provided telephone guidance and support to the police to improve police response to people in the community with actual or suspected mental health needs.
- There was a pilot service with mental health nurses working in police stations in two localities to support the police to better signpost and manage people who regularly contacted the police.
- There were very good systems in place for ensuring the hospitals' duties under section 136 were met and very good clinical leadership into the health based place of safety.
- There was a simple method for ensuring that the various professionals recorded their section 136 duties using a multicoloured form.
- Staff understood the when and how to assess patients' mental capacity and seek consent.

However

Summary of findings

- It was not always clearly recorded that patients were informed of their rights whilst in the health based place of safety and they did not have access to a printed copy of the MHA Code of Practice to refer to.
- There were problems with getting ambulances to take patients to the health based place of safety and delays in assessing patients particularly at night due to the response of AMHPs.
- The transport issues and delays were beyond the full control of the trust.

Are services caring?

Good

We rated caring as good because:

- There were positive comments from patients we spoke with about their experience of receiving care from crisis teams, especially the Trafford home treatment team.
- Staff provided very professional and respectful care in all the interactions we saw.
- Care interventions were holistic and used recovery principles and tools to help alleviate crisis.
- Patients were involved in identifying their crisis support needs.
- Patients were involved in developing the assessment and intervention tools used in the home treatment teams.

However

- Feedback from people who had been assessed in the health based places of safety was not routinely requested.
- In some teams it was not always clearly recorded that patients were given copies of their crisis care plans.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff within the crisis teams gatekept patients to prevent inappropriate admission to inpatient beds.
- Crisis staff ensured patients did not stay in hospital longer than necessary and promoted early discharge.
- Teams operated on a 24 hour 7 day a week basis.
- People were usually seen within four hours for a face to face assessment when referred into the crisis service and very quickly in the RAID teams.
- There was an alcohol worker working at the Trafford RAID service to support intoxicated patients.
- All the teams provided inclusive services and worked with everyone over the age of 16.

Summary of findings

- People within the health based places of safety were usually assessed quickly. Liaison teams had consultants who were approved to examine patients for detention which aided speedier MHA assessments. When there were delays they usually related to the availability of approved mental health professionals at night.
- Patients were made aware of the complaints policy. When complaints were raised these were responded to appropriately.

However

- There were differing crisis care pathways in each locality and information about each service did not fully inform patients and carers on the services available to them.
- Information on CQC's role in complaints literature was not up-to-date.

Are services well-led?

Good

We rated well led as good because:

- Staff were committed to providing high quality care and treatment in line with the trust's stated values.
- Staff morale was good.
- Teams were managed by experienced and competent clinical leaders. Staff were complimentary about the support and involvement of their line manager and more senior managers.
- Managers had effective local, inter agency and crisis concordat meetings to improve services and patients' crisis experience.
- Major redesign of the acute care pathway was well managed.
- Services were audited to ensure good quality services.
- We only found minor issues and where we found them we found managers and staff were usually aware of these and working to address these.
- There was a commitment to quality improvement. Developments included improved health based places of safety environments, improved staffing levels in crisis services, developing police triage services and integrated liaison services into the acute hospital. The liaison service in Salford was going through the peer accreditation process - Psychiatric Liaison Accreditation Network (PLAN).

Summary of findings

Information about the service

Greater Manchester West NHS Foundation Trust (GMW) provides crisis services and health based places of safety to people living in Bolton, Salford and Trafford.

The trust has three teams for adults of working age in mental health crisis.

- Home based treatment team - Bolton
- Home based treatment team - Trafford
- Home based treatment team - Salford

Home based treatment teams provided short term work to help support patients at home when in mental health crisis and support with earlier discharge from hospital. The teams aim to facilitate the early discharge of patients from hospital or prevent patients been admitted to hospital by providing support and treatment at home. In Salford and Trafford the home treatment teams carried out initial assessments of people who were not known to the service who were in mental health crisis; in Bolton this role was carried out by the single point of access team.

Across Bolton, Salford and Trafford there are three health based places of safety (HBPoS). Health based places of safety are used by the police to bring people under section 136 of the Mental Health Act (MHA). Section 136 of the MHA sets out the rules for the police to arrest a person in a public place where they appear to be suffering from mental disorder and are in immediate need of care or control in the interests of that person or to protect other people. The arrest enables the police to remove the person to a place of safety to receive an assessment by mental health professionals. This would usually be the HBPoS unless there are clear risks, for example, risks of violence which would require the person being taken to a police cell instead.

There was a telephone triage service established into the existing teams that the police could use prior to bringing someone in on a section 136. There were also pilot projects in a small number of police stations across the trust's geographical area with nurses working from the police stations to support the police to better manage people in the community.

Section 136 allows people to be detained for a period of up to 72 hours so they could be examined by doctors and assessed by an approved mental health practitioner (AMHP) to consider whether compulsory admission to hospital was necessary. National best practice guidance from the Royal College of Psychiatrists states that the assessment should occur quickly and within three hours and ideally with two hours. The three HBPoS were available 24 hours a day, seven days a week and 365 days per year.

The trust's three HBPoS are:

- Health based place of safety - Salford
- Health based place of safety - Bolton
- Health based place of safety - Trafford

The trust also worked within the neighbouring acute hospitals to provide professional mental health treatment, support and input. These teams also provided an element of crisis service input as part of the crisis care pathways, for example at night. The teams were:

- Mental health liaison team - Salford
- Rapid assessment, interface and discharge (RAID) team - Trafford
- Rapid assessment, interface and discharge (RAID) team - Bolton

The RAID team at Trafford provided liaison services to both the urgent care centre at Trafford General Hospital and to Trafford residents who presented in the emergency department at Wythenshawe Hospital.

The health based places of safety were staffed and managed by the liaison services at Salford and Trafford and by the single point of access team at Bolton. The environment of the health based place of safety were owned by the trust with the exception of the HBPoS at Trafford which was owned by the local acute trust but staffed by mental health professionals employed by the trust.

Summary of findings

Our inspection team

The team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Nicholas Smith, Head of Inspection, Care Quality Commission

Team Leaders: Sarah Dunnett, Inspection Manager, Care Quality Commission

The team that inspected the mental health crisis services and health-based places of safety included a CQC inspector, a CQC Mental Health Act reviewer and two specialist advisors - a nurse and a social worker.

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 the trust's mental health crisis services and health based places of safety, asked a range of other organisations for information and sought feedback from patients at focus groups.

We carried out announced visits between 9 and 11 February 2016 visiting:

- Two out of three of the trust's home based treatment teams:

  - home based treatment team - Bolton

  - home based treatment team - Trafford.

- The single point of access team in Bolton.
- All three hospital liaison services to look at the elements of the crisis care pathway that they oversaw. These were :

  - rapid assessment, interface and discharge (RAID) team -Trafford

  - rapid assessment, interface and discharge (RAID) team - Bolton

  - mental health liaison team – Salford.

- All three health based place of safety used across the trust:

  - health based place of safety - Salford

  - health based place of safety - Bolton

  - health based place of safety - Trafford.

- The Salford police liaison service (pilot) working within Pendleton police station.

During the inspection visit, the inspection team:

- looked at the environments of the three health based places of safety overseen by the trust
- looked at the environments and equipment where the home treatment teams were based
- looked at the arrangements for the management of medicines
- spoke with seven patients who used the service during the inspection
- spoke with 25 members of staff from a range of disciplines and roles, including consultant psychiatrists, operational or clinical managers, nurses, support time recovery workers, occupational therapists and social workers

Summary of findings

- spoke with a police representative about patients who were detained using section 136 of the Mental Health Act (MHA)
- met with a group of approved mental health professionals who were involved in carrying out MHA assessments, including assessments within the health based place of safety
- attended five multidisciplinary team meetings
- accompanied staff on three home visits observing how they provided care and treatment to patients
- looked at 43 care records relating to patients under the home treatment teams or recent episodes of admissions to the health based place of safety under section 136 of the MHA
- looked at recent audits of section 136 MHA activity across the trust
- looked at the minutes, declaration and action plan of the local multi-agency crisis concordat meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Prior to the inspection we spoke to several groups of patients who were largely complimentary about the services they had received. Patients especially commented on the Trafford home treatment team giving professional and timely input. We also received a small number of less positive comments about Bolton services via the local Healthwatch. These largely related to the difficulty in navigating the crisis services for people new to services.

Due to the nature of the service and people being in crisis, we were only able to speak to seven patients on the inspection. Patients gave largely positive comments stating that staff were very caring, offered them appointments at times that suited them and really helped them through their mental health crisis.

There was no-one being cared for in the health based places of safety (HBPoS) on the days we inspected them. We were therefore unable to speak to anyone who had direct experience of using the HBPoS.

People had an opportunity to comment on the services they received on comment cards prior to the inspection. We received one comment card from a patient receiving support from within crisis services. The cards commented favourably on Trafford home treatment team stating it was good.

Good practice

There was very good clinical leadership into the health based places of safety with team manager, senior manager and consultant psychiatrist oversight. This was especially the case at the services at Salford.

There was an alcohol worker integrated into the Trafford rapid assessment, interface and discharge service to support intoxicated patients.

There was a pilot service with mental health nurses working in police stations at some localities to support the police to better signpost and manage people who regularly contacted the police.

The multi-agency form for recording section 136 episodes was colour coded which provided a simple but effective way of ensuring that different professionals completed the sections of the forms relevant to them which helped to enable them to discharge fully their responsibilities when placing or assessing someone on section 136.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff record information given to patients about their rights when subject to section 136 whilst in the health based places of safety (HBPoS), ensure that patients in each HBPoS have access to a hard copy of the Mental Health Act (MHA) Code of Practice to refer to and ensure that patients are given correct contact address details for raising complaints about MHA powers to the CQC.
- The trust should ensure that crisis staff record the rationale for changes to levels of support more explicitly in relation to patient presentation and risk and record whether patients have received a copy of their care plan.
- The trust should continue to raise interagency issues with the relevant parties, including improving rates of the police informing trust staff prior to bringing someone to the health based place of safety, problems in the local ambulance response to convey patients to the HBPoS and the response of the approved mental health professionals to assess patients especially at night via the emergency duty social work team.
- The trust should improve the information available to the public to enable patients and relatives to navigate its' crisis care pathways.

Greater Manchester West Mental Health 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
Home based treatment team - Bolton - Bolton	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Home based treatment team - Trafford	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Single point of access team - Bolton	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Health based place of safety - Salford	Meadowbrook
Health based place of safety - Bolton	Rivington
Health based place of safety - Trafford	Moorside unit
Mental health liaison team - Salford	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Rapid assessment, interface and discharge (RAID) team - Trafford	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Rapid assessment, interface and discharge (RAID) team Bolton	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Salford police liaison service (pilot) working within Pendleton police station	Greater Manchester West Mental Health NHS Foundation Trust - HQ

Detailed findings

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.

- Staff had a good understanding of the duties placed on them when patients were under a community treatment order (CTO) under the crisis teams or when they were brought in on a section 136.
- There was no one on the home treatment team caseload that was subject to a CTO when we inspected. Staff were aware of their role in recalling patients on a CTO where this may be necessary.
- Mental Health Act assessment for people brought into the health based places of safety could usually be arranged within reasonable timescales. At night the approved mental health professional role was provided by the emergency duty social work team based in the local authority. This sometimes led to delays in assessments at night due to other priorities coming into the emergency duty teams but this was beyond the full control of the trust.
- The multi-agency form used to record section 136 episodes were well completed in the majority of cases with key information recorded.

However:

- Whilst records showed that people had their rights under the MHA explained to them on admission to the heath based place of safety, it wasn't always clearly recorded that patients understood their rights and staff were not asked to record if patients had been given their rights orally and in writing.
- Some of the HBPoSs did not have a current copy of the MHA Code of Practice available to staff working within them, assessing professionals and for patients to refer to.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients using the home treatment teams lived in the community and therefore had a high degree of autonomy and independence to determine aspects of their daily lives.
- Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible.
- Patients were given information packs about the home treatment services and other available services; in addition the trust website had good quality information on mental health medication and treatments. This helped to ensure that patients were supported to make informed choices over their care and treatment.
- Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA ensuring patients best interests.
- Staff within the hospital liaison services had advised and supported staff in the emergency departments and wards in the acute hospitals to support assessments of patients' capacity. This occurred when more complex decisions were being considered and on implementing Deprivation of Liberty Safeguards where patients on the acute wards were subject to significant restrictions which may amount to a deprivation of liberty.

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

Home based treatment team - Bolton

Home based treatment team - Trafford

Mental health liaison team - Salford

Rapid assessment, interface and discharge (RAID) team - Trafford

Rapid assessment, interface and discharge (RAID) team - Bolton

Single point of access team - Bolton

Salford police liaison service (pilot) working within Pendleton police station

Safe and clean environment

The home treatment teams' work was mainly done through visiting patients in their own homes to provide an assessment and ongoing care and treatment to support people in mental health crisis. Where there were concerns about staff safety, staff visited in pairs or arranged to see patients in safer alternative venues. In these cases, patients were offered interview rooms within the trust's hospitals (as most teams were located in offices next to in-patient wards) and at other venues such as GP practices.

The liaison teams saw patients in the emergency department of the local general hospital at Bolton and Salford and at the urgent care centre at Trafford. Interview rooms available for use by the teams were clean, well maintained and safe environments. The assessment room used by liaison staff at Salford offered privacy but was more limited in space. Staff were able to raise an alarm if they felt unsafe in interview rooms through an in-built alarm system.

Safe staffing

Teams were mainly staffed by band 6 nurses. There were two whole time equivalent nursing vacancies in each of the Bolton and Trafford home treatment teams but there were plans in place to recruit to these teams. The home treatment teams had their substantive levels increased as part of the acute care pathway review, prior to a slight reduction in hospital beds. There were team managers in place; the manager at Bolton home treatment team was moving to another job but a new manager had been recruited to replace them. The out of hours crisis function was managed through a duty system which was co-ordinated between the home treatment teams.

Staff we spoke with told us there were sufficient numbers of staff to manage the demand for home treatment and liaison services to deliver the care and support which patients needed. Staff reported manageable caseloads which helped keep patients safe. Staff were able to work within targets such as ensuring patients were seen or offered an assessment within four hours of the referral being made.

There was limited use of agency staff within the teams due to the specialist nature of the role. Sickness was reported as low within the home treatment teams. Where sickness and short term absences needed to be covered, staff were available to provide overtime using a bank system.

There was a dedicated consultant psychiatrist who was based within the teams which meant that patients had rapid access to a psychiatrist when required. There was adequate medical cover during the day and night. A doctor could attend in an emergency and was available on call on the hospital site out of hours.

Out of hours crisis care was provided by nursing staff from the home treatment teams working out of hours and liaison staff in the acute hospitals if people required a face to face assessment. This meant patients had access to specialist medical and nursing input providing a 24 hour a day, seven day a week service.

Staff had completed relevant training to carry out their role. Staff received mandatory training and extra role specific training as required. Mandatory training included basic life support, equality and diversity, fire safety awareness, health and safety, infection control, information governance and safeguarding. All teams maintained appropriate training compliance rates of above 75% in most areas of mandatory training. The main exception to this which was indicated prior to the inspection was the Trafford home treatment teams take up of basic life support which was showing as 19% which was low. When we looked into this we found that staff in the team had

Good

Are services safe?

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

completed higher level intermediate life support training as they were staff who also worked on the acute mental health wards either on a rotational or bank staff basis so they did not require basic life support training.

Assessing and managing risk to patients and staff

Staff undertook risk assessments of patients at the initial assessment and updated these regularly; risks were managed on an ongoing basis. Risk assessments were comprehensive and recorded within electronic records so could be accessed across the trust. There was a summary risk assessment on each file which was used for an overview which could be referred to more quickly. Staff explored the risk of suicidal ideation and ensured that patients were kept safe through increasing contact or arranging admission to hospital where necessary.

In a small number of files, there was no explicit written rationale as to why particular levels of support were given to each patient at any given time; however this was often inferred though the daily clinical notes and frequency of visits after reading written records rather than through a clearly determined escalation or reduction in risks. In one record in the Bolton home treatment team, one patient with particular identified risks cancelled multiple appointments and records did not fully record the team's attempts to proactively meet with this patient. We discussed this with the team manager who assured us this patient was due to be seen that day.

Most home treatment teams had an approved mental health professional (AMHP) within the team which helped ensure timely Mental Health Act assessments occurred either directly or through the duty system. AMHPs within the teams helped staff understand how staff could manage significant risks and bring people into hospital compulsorily if needed.

People referred into the teams were usually seen quickly and well within four hours of the initial referral. When taking a referral into the service, for example from a GP, staff checked whether people needed to be seen immediately. None of the teams had a waiting list for services. Home treatment staff worked closely with patients on the adult acute wards to provide intensive home treatment and early discharge.

There were effective safeguarding arrangements in place with proper consideration of adult and children's safeguarding. Staff were trained in safeguarding with very good uptake of mandatory training; some teams had 100% attendance at safeguarding training. Staff knew how to make a safeguarding alert when appropriate. At multidisciplinary meetings, there were appropriate safeguarding discussions where patients were vulnerable themselves or posed a potential risk to another vulnerable adult or child. Any active safeguarding issues were flagged in patients' electronic notes and on the whiteboards in team offices so staff were aware of these. Clear information about reporting safeguarding issues was displayed in office areas where staff were based. Safeguarding procedures were available on the trust intranet. The safeguarding leads for the trust had visited some teams to raise the profile of safeguarding issues and discussed strategies for managing more difficult safeguarding cases

Staff recorded their whereabouts on the team noticeboard including their expected time of return. Teams had a code word so that staff could alert and receive assistance in urgent situations. Each team had arrangements in place to ensure staff were safe including visiting patient homes in pairs, ensuring staff returned to the office or rang in following a home visit. Staff meeting minutes recorded discussions around specific patients who posed risks to staff so that staff were aware of measures in place on how these patients could continue to receive treatment without putting staff at risk. This meant that there were good personal safety protocols in place including lone working practices.

Staff supported patients with ensuring they took their prescribed medication. Staff liaised with the consultant psychiatrist who advised patients' GPs of any suggested changes in medication. The patient's GP would then prescribe the medication. A specialist team within the trust worked with patients when medication was being titrated to ensure patients received appropriate treatment that optimised patients recovery, balanced with managing recognised side effects.

Track record on safety

There were 287 incidents reported between 1 January 2015 to 3 December 2015 within crisis services across all reportable incident categories. The trust was generally a high reporter of incidents which helps promote a safety culture. There were 13 incidents categorised as severe that involved the death of patients receiving services of the community crisis teams from the 12 month period before the inspection. This included unexpected deaths or the

suspected suicides of patients open to or recently accessing all the home treatment, single point of access, rapid assessment, interface and discharge (RAID) or liaison teams.

One recent coroner's ruling related to the liaison service at Wythenshawe Hospital which were jointly provided by the Trafford RAID team and another trust. We saw that improved joint working practices had been introduced to address the matters raised by the coroner.

Staff had a general awareness of the duty of candour requirements. These regulations ensured staff were open and transparent and explain to patients and their relatives if and when something goes wrong. The manager of one service explained following a recent incident which involved the death of someone who had recently been seen by the liaison service, managers gave an apology and an explanation to a relative.

Reporting incidents and learning from when things go wrong

Staff were aware of how to complete an incident form and their responsibilities in relation to reporting incidents. Incidents were analysed by the service manager to identify any trends and appropriate action was taken in response to these.

The manager within one RAID liaison team talked about an apparent suicide incident which occurred with one patient having been seen by liaison workers shortly before the incident. The risk assessments identified there had been discussions on suicidal ideation and staff had recorded

their rationale for their assessments. Staff were receiving support to attend the inquest in this case. Staff were debriefed and supported after serious incidents. Actions from incidents and patient alerts were regularly discussed in team meetings and at individual supervision to ensure lessons were learnt.

Health based place of safety - Salford

Health based place of safety - Bolton

Health based place of safety - Trafford

Safe and clean environment

The three health based places of safety (HBPoS) used across the trust provided a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983. The HBPoS in Bolton and Salford were in trust premises. The HBPoS at Trafford was staffed by the trust but the environment was within the urgent care centre of the local acute trust. The physical space of all three of the HBPoS provided good environments to assess people with enough space to accommodate the range of professionals who may be involved in the assessment. There was full consideration of ligature risks with further improvements planned to reduce the potential for ligaturing.

All three units consisted of an assessment room with appropriate furniture and a separate toilet. Furniture was appropriately weighted to prevent these being thrown. Windows were mesh designed to enable fresh air but to prevent people escaping from the HBPoS area.

There were observation windows into the assessment room with a layout which enabled staff to observe all areas at all times. There were no blind spots except in the toilets at Bolton and Trafford where patients would be risk assessed prior to permitting entry. The toilets at Salford allowed discrete observations. The units were well maintained with all of the furniture in good condition.

Emergency equipment, including automated external defibrillators and oxygen, was in place and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked regularly. Most staff had undertaken training in life support techniques.

There were alarms available in the units to summon additional staff if required from adjacent wards and clinical areas. Staff said that on the rare occasions that the alarm was used staff had responded very quickly.

The rooms were very clean and were on the daily schedule of cleaning.

Safe staffing

The HBPoS were staffed by the RAID team in Trafford, the liaison team at Salford and the single point of access team at Bolton as and when people were brought to the unit. At night the home treatment teams at Bolton and Trafford provided the staff to the HBPoS; with the liaison team in Salford continuously providing the service into the HBPoS there. The team managers ensured that appropriate staff were allocated to facilitate the assessments.

The police would stay in attendance during the assessment where the person presented with significant risks. Where

Good

Are services safe?

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

there were two trust staff in attendance and there were no significant risks indicated, then police were able to leave people within the health based place of safety for the assessment. On occasions, the police had left people in the HBPoS and not stayed where the threshold for the police staying was met. This occurred most frequently in Salford. These incidents had been flagged up and were subject to joint reviews.

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

The arrangements for staffing the HBPoSs generally worked well with no incidents of closure of the HBPoS due to staffing difficulties. AMHPS and representatives from the police corroborated that the arrangements worked well. Appropriate medical cover was available from the trust to ensure that a timely response was available to people requiring assessment within the HBPoS.

Assessing and managing risk to patients and staff

The designated nurse would receive the person who was subject to the section 136 and a process was in place for an approved mental health professional (AMHP) to be contacted regarding co-ordinating a MHA assessment. At the health based place of safety, a joint risk assessment by staff in the HBPoS and the police was completed for all people admitted. Throughout the detention period effective systems were in place to assess and monitor risks to individual patients to determine whether the police officer would be required to remain at the place of safety to provide support.

We saw completed mental and physical health assessments in all of the records that we reviewed. When risk assessments had been conducted for patients and the risks were assessed as too high the police would either stay or the individual would be transferred to the police custody suite.

As part of the locally agreed protocol, police undertook a body search on all people before their arrival at the HBPoS. Following an incident of a patient not being searched by the police, causing a subsequent fire, trust staff had been reminded to insist on a search by the police. Staff we spoke with across the trust had good awareness of this incident and their role in preventing a reoccurrence.

Staff were trained in prevention and management of violence and aggression which meant that they were trained to restrain people using approved and appropriately safe techniques. Staff from nearby units were also on hand to respond to incidents in the HBPoS.

On occasions, people may be prescribed medicines to help with extreme episodes of agitation, anxiety and sometimes violence. This is known as rapid tranquillisation. Following rapid tranquilisation, nursing staff were required to record regular observations such as patient's blood pressure, temperature, oxygen saturation and respiratory rate. We saw one episode of rapid tranquilisation used on a person within the health based place of safety out of necessity. The care records for this patient showed that the patient had been properly cared for after being given rapid tranquilisation. Staff were not aware that there was a trust wide form in place to formally record observations separately.

Track record on safety

There were eight episodes of restraint in the six months between 1 July 2015 and 31 December 2015 involving staff within teams that oversaw the health based places of safety. Two of these involved elements of prone restraint.

There was one serious incident in the 12 months prior to the inspection within the health based place of safety. A person who was not searched properly by the police was brought into the health based places of safety (HBPoS). The patient started a fire causing damage to one of the HBPoS which led to it being out of action for a number of weeks.

Reporting incidents and learning from when things go wrong

Regular multi-agency meetings were well established to oversee the operation of section 136 and the use of the health based places of safety. The analysis of incident data and areas for improvement were routinely discussed in these monitoring meetings. The themes from these meetings included incidents about people not being conveyed to the HBPoS in an ambulance which was the preferred method of transport, the police not ringing ahead or seeking advice from the telephone triage service and the availability of AMHPS especially out of hours. All of these were beyond the full control of the trust but managers in the trust raised these with the other agencies to seek improvements in each of the identified areas.

Good

Are services safe?

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

Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. Following an incident of a patient not being searched causing a subsequent fire, trust staff had been reminded to insist on a search by the police. Staff we spoke with across the trust had good awareness of this incident and their role in preventing a reoccurrence.

There was a recent incident where someone was taken to the HBPoS and the police did not stay and left without the agreement of the liaison team. This was despite the person being extremely aggressive and having to be managed by several police officers and placed in leg restraints and handcuffs. Several calls to the police resulted in the police returning to the HBPoS. There was an initial 72 hour review into this incident held jointly between the trust and the local police force with each organisation carrying out their own fuller review to ensure all lessons learnt were identified and shared. The managers in the relevant HBPoS felt that this incident had been escalated appropriately within each organisation so that senior managers could discuss safer practices going forward.

All incidents were reviewed by team managers and forwarded to the clinical governance team for the trust 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.

Staff were provided with support and time to talk about the impact of serious incidents.

Are services effective?

Good

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

Our findings

Home based treatment team - Bolton

Home based treatment team - Trafford

Mental health liaison team - Salford

Rapid assessment, interface and discharge (RAID) team - Trafford

Rapid assessment, interface and discharge (RAID) team - Bolton

Single point of access team - Bolton

Salford police liaison service (pilot) working within Pendleton police station

Assessment of needs and planning of care

We looked at care records of patients receiving crisis services; records were stored electronically. Patients had an appropriate crisis assessment which included a risk assessment and an assessment of patients' crisis, and their wider circumstances including their family, employment and financial circumstances. The assessment included discussions about patient's physical and psychological needs and preferences. A home treatment intervention care plan was then developed with the person to meet their identified needs. The intervention plans we looked at were regularly reviewed, centred on the needs of the individual person and demonstrated knowledge of current, evidence-based practice. Care and intervention plans recorded were of a good standard overall.

Home treatment intervention plans were solution focused. There was clear evidence of a plan of care delivered in patients' homes to prevent hospital admissions, appropriate referral to other services such as other community teams, inpatient admission or discharge to primary care based on patient needs. Assessments of patients focused on patient's strengths, self- awareness, and support systems in line with recovery approaches.

Best practice in treatment and care

We found evidence which demonstrated the teams had implemented best practice guidance within their clinical practice. For example staff were following guidance on suicide prevention and integrated best practice into their risk assessments.

Staff provided interventions to assist patients to manage their crises and distress such as anxiety management, psychological interventions, medication awareness and relapse prevention work. The teams also provided a range of activities and therapeutic interventions to patients to support their recovery including through support time recovery workers who assisted patients with practical issues, such as attending the job centre, benefits office or citizens advice bureau and helped them engage in the community. Crisis teams offered a range of short term interventions including solution focused therapy and cognitive behavioural therapy as well as formal initial psychology input through psychologists based in the teams. Patients also had reviews of medication to optimise their medical treatment and help patients recover from their mental distress.

Once a patient had been accepted into the services, patients received home visits from a core key worker team so that they were seen regularly by the same team members rather than any available staff. Patients commented favourably in the continuity of care they received.

Patient's physical health needs were considered alongside their mental health needs. This included monitoring symptoms, alerting the general practitioner or encouraging or making referrals to the appropriate health care professionals. Patients received proactive physical health checks for example the Trafford home treatment team ran physical health clinics run by the home treatment teams in local health centres.

Some teams had informally benchmarked themselves against the accreditation standards of their service through the Royal College of Psychiatrists' (RCP) home treatment accreditation scheme which aimed to work with teams to assure and improve the quality of crisis resolution and home treatment services. The Salford liaison service was going through accreditation as part of the RCP's psychiatric liaison accreditation network assessment with the other services planning to learn from this process and apply for accreditation themselves.

Skilled staff to deliver care

A full range of mental health disciplines provided input to the teams. There was evidence of effective multidisciplinary team working within the service. The home treatment teams generally included community mental health nurses at band 6, support time recovery

Are services effective?

Good

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

workers, social workers, approved mental health professionals (AMHPs), occupational therapists, psychologists, administrative support, consultant psychiatrists and more junior doctors including speciality doctors and higher trainees.

Staff had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. Staff told us that their manager supported them to access specific training to meet the needs of patients who used the service. Team meetings often had an educational element. However from the data that we were provided with at trust level about training uptake there were a small number of gaps in uptake of some mandatory training falling slightly below the expected 80% target. Despite these gaps, we did not identify any concerns about staff knowledge from speaking to staff and patients or through looking at records.

Figures showed that 86% of staff within crisis services and the HBPoS had an annual appraisal in the last year. Staff confirmed that they had received an appraisal, felt supported and were aware of their own personal development goals. Staff received regular clinical and managerial supervision with 70% having had clinical supervision at least six times a year. Staff were committed to providing high quality and responsive crisis care which met patients' needs.

Multi-disciplinary and inter-agency team work

There was good multidisciplinary team (MDT) working with visible and active consultant psychiatrist input within the teams. Teams worked using an integrated health and social care model. The teams had daily MDT meetings to review patients. We sat in on MDT reviews and there was a comprehensive discussion about all the patients on caseload with all available staff in attendance. The MDT at Bolton was less effective because the time was not protected so not all staff were available and during the MDT some staff left to attend home visits. However notes were made of the MDT and in individual patient records. Medical staff were responsive, going out on request to undertake joint assessments when concerns had been raised.

The teams had established positive working relationships with a range of other services internally including community mental health teams, the mental health inpatient wards, and other services across the trust. There were also very strong inter agency arrangements with good contact with general practitioners, the local authority, the emergency department and wards of the neighbouring acute hospitals and local services.

The Bolton home treatment team worked with and alongside the single point of access team who received initial referrals and provided initial assessments to then signpost patients to the most appropriate service. The Trafford home treatment team worked with a local mental health charity who were commissioned to provide one crisis bed placement which the home treatment team could access. This was reported as working well and provided a useful alternative to admission to hospital and helped provide respite for patients in crisis and their carers. The home treatment teams had effective working arrangements with the acute wards to holistically plan patient's transition between services.

Teams had a shared understanding of each other roles and were committed to working together to ensure patients' needs were met. This helped to ensure patients were moved through the health system and received care from the most appropriate team at any given time in their recovery including when they were in mental health crisis.

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

Staff were aware of the statutory requirements of the Mental Health Act. Staff showed good understanding despite MHA training not being a required mandatory training with only 26% of staff attending formal MHA training in the last year. Staff told us about how they could request an assessment under the MHA for people requiring inpatient care and this would generally be co-ordinated quickly by an approved mental health professional.

Home treatment teams had approved mental health professionals (AMHPs) integrated within the teams as well as the localities having AMHP hubs. This meant that when a person required a Mental Health Act assessment, it could usually be arranged within reasonable timescales. At night the AMHP was provided by the emergency duty social work team based in the local authority. This sometimes led to delays in assessments at night due to other priorities coming into the emergency duty teams. The assessment process under the MHA was also facilitated due to medical staff being based in the home treatment and hospital liaison services so the medical staff could provide one of the medical recommendations required under the MHA.

Are services effective?

Good

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

There was no one on the home treatment team caseload who was subject to a community treatment order (CTO) when we inspected them. A CTO is an order used when patients are discharged from hospital to enable them to be recalled to hospital if they become unwell and also places conditions on patients whilst they are living in the community. Staff were aware of their role in contributing to discussion about placing patients on a CTO when they were being considered for discharge from detention in hospital and when recalling patients on a CTO where this may be necessary.

Staff within the hospital liaison services had advised and supported staff within the emergency departments and wards within the acute hospitals to consider whether patients in their care required assessment under the MHA.

Good practice in applying the Mental Capacity Act

Overall we found that services were compliant with the requirements of the Mental Capacity Act (MCA) 2005.

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Patients were given information packs about the home treatment services and other available services; in addition the trust website had good quality information on mental health medication and treatments. This helped to ensure that patients were supported to make informed choices over their care and treatment. Patients using the home treatment teams lived in the community and therefore had a high degree of autonomy and independence to determine aspects of their daily lives.

Staff routinely checked if patients' consent to the assessment and treatment when receiving care from the home treatment teams, including whether there were any doubts about patients' capacity to consent. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA ensuring patients best interests. Formal training rates were low with only 28% of staff attending formal MCA training in the last year.

Staff within the hospital liaison services had advised and supported staff within the emergency departments and wards within the acute hospitals to support assessments of patients' capacity when more complex decisions were being considered. Acute hospital staff had also used liaison staff for advice on implementing Deprivation of Liberty Safeguards where patients on the acute wards were subject to significant restrictions which may amount to a deprivation of liberty.

Health based place of safety - Salford

Health based place of safety - Bolton

Health based place of safety - Trafford

Assessment of needs and planning of care

Physical health checks were undertaken when people were brought in to the health based places of safety (HBPoS) on a section 136. These were usually undertaken through arrangements between the trust and the ambulance service. In most cases, it was carried out by a paramedic who conveyed the person to the HBPoS or if an ambulance did not convey, by receiving trust staff. This meant that people had baseline physical assessments before being admitted to the HBPoS, helped to ensure people did not have any significant health problems and any ongoing physical health problems were followed up appropriately.

Records relating to section 136 episodes were stored securely and available to staff when they needed to. Care records included an overview report produced in paper format which were stored securely in team offices. More comprehensive daily record details were kept in the electronic records of care received in the HBPoS and any decision to admit people to hospital or for further follow up. Information was readily available so staff could check patient details and section 136 decisions and also helped audit the use of section 136 and the use of the HBPoS.

Best practice in treatment and care

People assessed in the health based place of safety were given an information leaflet explaining the powers and responsibilities under section 136. This ensured that people understood where they were, what the assessment process was and an explanation of their rights.

The trust had telephone police triage teams in all three localities. This meant that police has access to professional advice prior to bringing people into the HBPoS in line with guidance within the crisis concordat. The aim of this service was to ensure people got the medical attention or professional input they need quickly whilst also diverting people from inappropriate police custody or section 136 assessments.

Are services effective?

Good

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

The trust benchmarked itself against the Royal College of Psychiatrists' (RCP) guidance on section 136, for example the time spent in the HBPoS was audited against the RCP ideal time frame of two hours.

Skilled staff to deliver care

Qualified staff from the rapid assessment, interface and discharge liaison teams usually undertook the co-ordination of admissions to the health based place of safety suites, operating as the section 136 coordinator. The exception was in Bolton where this role was carried out by staff within the single point of access team. The coordinating staff were band 6 nurses who had good knowledge of the requirements when people were brought in under section 136.

The health based places of safety were near to the acute wards or the psychiatric intensive care units; so staff from these units could be called to assist where necessary.

There was guidance available to staff that included a checklist of action to be completed.

Multidisciplinary and inter-agency team work

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure had been jointly agreed by the trust, relevant local authorities, the local police force and ambulance service which worked across the trust's geographical footprint. There was a commitment to multi-agency working to improve the arrangements for conveyance and assessment when people were brought in under section 136. The trust had worked with these agencies to try and address common issues, for example to try and improve the rates of the police ringing through prior to bringing someone to the HBPoS.

Links with the police in the operation of section 136 was good. For example, in Bolton there was a police officer who worked at Royal Bolton hospital and liaised between the police and the health services including the trust. Good joint working relationships were in place at both a strategic and operational level and attendance at the quarterly monitoring meetings was good with representatives from a variety of agencies present.

There were local arrangements in place to ensure proper risk assessment before decisions were jointly made about the police officers leaving people and therefore passing responsibility for ensuring the assessment was completed wholly to trust staff. On the rare occasions when people needed to be transferred between health based places of safety, the rationale was recorded and checks made to ensure the 72 hour limit was not breached.

Adherence to the MHA and the MHA Code of Practice

Staff had a good understanding of the duties placed on them when people were brought in on a section 136 to ensure they worked within the Mental Health Act (MHA), the Code of Practice and the guiding principles.

The multi-agency form used to record section 136 episodes recorded key information required by the MHA Code of Practice. For example, if there had been a transfer of patients to a different place of safety and the time spent in the HBPoS to ensure patients weren't cared for longer than necessary. The forms were well completed in the majority of cases with key information recorded. The form was colour coded which provided a simple but effective way of ensuring that different professionals completed the sections of the forms relevant to them to enable them to discharge fully their responsibilities when placing someone on a section 136.

Whilst patients on a section 136 cannot appeal against their detention and do not have an automatic right to independent advocacy input; they do have the right to refuse treatment, the right to seek legal advice and the right of complaint. Records showed that most people had their rights under the MHA explained to them on admission to the heath based place of safety. It wasn't always clearly recorded that patients understood their rights and staff were not asked to record if patients had been given their rights orally and in writing. The last annual audit of section 136 stated that only 81% of people brought in on a section 136 had their rights read or rights leaflet given to them. Some of the HBPoS did not have a current MHA Code of Practice available to staff, assessing professionals and for patients to refer to.

Information on Advocacy and Independent Mental Health Advocacy Services (IMHA) services were available to people. People were not routinely being provided with information on their right to legal support whilst under police powers in the health based places of safety.

Are services effective?

Good

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

Good practice in applying the Mental Capacity Act (MCA)

Staff were aware of the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice.

There was evidence in records that mental capacity issues relating to the assessment process and any decisions following the assessment were being reviewed. These assessments routinely took place by the AMHP to decide if the patient had capacity to consent to admission to hospital informally or whether powers under the Mental Health Act needed to be used. The electronic records kept by the trust included details of any advance statement made by patients. We saw an example where the home treatment staff followed an advance statement where a patient had determined their own preferred crisis response.

Good

Are services caring?

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

Our findings

Home based treatment team - Bolton

Home based treatment team - Trafford

Mental health liaison team - Salford

Rapid assessment, interface and discharge (RAID) team - Trafford

Rapid assessment, interface and discharge (RAID) team - Bolton

Single point of access team - Bolton

Salford police liaison service (pilot) working within Pendleton police station

Kindness, dignity, respect and support

We observed positive interactions between staff and patients during home visits with people giving complimentary statements about the care they received. Prior to the inspection we spoke to several groups of patients who were largely complimentary about the services they had received. Patients especially commented on the Trafford home treatment team giving professional and timely input. We also received a small number of less positive comments about Bolton services via the local Healthwatch. These largely related to the difficulty in navigating the crisis services for people new to services.

Due to the nature of the service and people being in crisis, we were only able to speak to seven patients during our inspection. People gave largely positive comments.

People had an opportunity to comment on the services they received on comment cards prior to the inspection. We received one comment card from a person receiving support from within crisis services. The cards commented favourably on Trafford home treatment team stating it was good.

We saw in some teams a number of compliments made by patients into the standard of care people received.

We carry out an annual survey of community mental health patients by sending a questionnaire to patients receiving community mental health services in the trust. There were no significant issues of concern from the last survey in 2015 in relation to patients' experiences of crisis care. The trust was performing about the same in areas of questioning which related to crisis care. The survey confirmed that most people surveyed knew who to contact in a crisis out of hours. Results of the survey also confirmed that those who had contacted crisis services, the majority of people received the help they needed.

The involvement of people in the care that they receive

The tools used by staff to explore patients' crises had been developed with patients' contributions and were recovery focused. These included a simple map of care which provided a visual care plan, an activity diary and a mental health thermometer for patients to record their mental health using easily understandable tools. Crisis care plans were written and reviewed, where possible, with the involvement of patients. Patients had opportunities to discuss their current crisis, their health, beliefs, concerns and preferences to inform their individualised treatment. Patients were involved in identifying their own crisis support needs as well as identifying their own strengths. Records showed that patients had received ongoing review of their crisis interventions. In some teams it was not always clearly recorded whether patients were fully involved or given copies of their crisis intervention plans.

Patients were able to decide who to involve in their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

We observed a small number of clinical meetings between staff and people using the services of the home treatment teams. Consultations were carried out in a participative manner with home treatment staff supporting patients to reflect on their needs, crisis, progress and recovery.

Patients were asked to complete a short questionnaire when they were discharged from the home treatment teams and following contact with the liaison teams. The small number of returns identified patients having positive experiences of their contact with the crisis services. Patients were involved in interviewing staff. There was evidence of patient involvement when the urgent care services were reorganised at a strategic level.

Health based place of safety - Salford

Health based place of safety - Bolton

Health based place of safety - Trafford

Good

Are services caring?

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

Kindness, dignity, respect and support

There was no-one being cared for in the health based places of safety (HBPoS) on the days we inspected them. We were therefore unable to speak to anyone who had direct experience of using the health based place of safety.

Staff working in the HBPoS explained how they managed and supported people within the HBPoS in what were often confusing and distressing circumstances. Staff ensured that people's needs were met and helped to facilitate assessment of people subject to section 136. Staff clearly understood the underpinning principles of providing dignified, respectful and compassionate care.

Staff explained how they attempted to calm people and begin to build a therapeutic relationship with people to fully support them and help facilitate a comprehensive assessment of people.

The involvement of people in the care they receive

Patients' rights whilst detained were routinely explained to them. However it was not always clear if patients were informed of their rights both verbally and in writing. In addition, the patients understanding of their rights were not routinely recorded so it was not always clear from the records if patients understood their rights. There was access to information in different accessible formats. Interpreting and advocacy services were also available if necessary.

Feedback from patients who had experienced the health based place of safety was not routinely requested. Whilst there was no system to collect feedback, managers across the locality were getting together to discuss common themes from the trust's health based places of safety and had identified the need to meaningfully capture feedback from patients that go through the HBPoS as part of this.

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

Home based treatment team - Bolton

Home based treatment team - Trafford

Mental health liaison team - Salford

Rapid assessment, interface and discharge (RAID) team - Trafford

Rapid assessment, interface and discharge (RAID) team - Bolton

Single point of access team - Bolton

Salford police liaison service (pilot) working within Pendleton police station

Access and discharge

All new referrals were made through the home treatment teams at Trafford and through the single point of access team at Bolton. These teams reviewed each new referral based upon the information they received and assessed the information and decided what action to take. All new referrals were usually contacted within four hours. People were contacted by telephone on the day of referral and then an appointment was offered as soon as possible. There were team managers and clinical leads at each team who could ensure that people phoning into the crisis service could speak with a member of the team promptly and would co-ordinate a visit or assessment quickly if a person needed this. Calls were answered promptly during our visit. This meant that the home treatment teams were able to respond promptly to people in mental health crisis and ensure people received support when their mental health was deteriorating. People were seen very quickly in the liaison services.

The service was operated by staff on a locality basis at night with each team having a home treatment nurse and workers in the RAID or hospital liaison team to support people in crisis at night.

If people were in crisis, they were triaged to see whether they required a Mental Health Act assessment.

The teams accepted referrals from a range of sources including self-referrals from patients or their carers, GPs, the inpatient wards and from the community mental health team (CMHTs). CMHTs managed the majority of crises of patients on the CMHTs and because CMHTs worked into the evenings and at weekends, this helped to alleviate some of the usual pressures on home treatment teams.

The teams visited people in their own home or at offices near to the home treatment teams dependent upon their needs and level of risk. People were also supported by regular telephone calls or an agreed level of contact.

The crisis teams were the gatekeepers for inpatient beds. The percentage of patients' admissions which were gate-kept by the home treatment teams across the trust was consistently higher than the national average. This included at Bolton where the home treatment team received information from the single point of access team prior to assessing and gatekeeping people into inpatient beds. This meant that patient admissions were assessed to ensure that only those patients that require an inpatient bed are admitted to hospital. Patients in crisis were usually able to access a bed within their own locality when an inpatient admission was needed. On occasions, patients were admitted and treated in a different part of the trust.

Home treatment teams worked upon the principles of the recovery model. This meant that the teams focused on assisting patients to remain within the community and avoid admission to hospital where possible. The home treatment teams facilitated the early discharge of some patients from hospital by offering them intensive support during the transition from hospital to the community to reduce the risk of them relapsing whilst promoting their recovery. This meant that crisis staff ensured patients did not stay in hospital longer than necessary. The home treatment teams 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 leave periods from the ward.

Relations between staff within the home treatment teams and staff within community teams was good across the trust. Patients were transferred onto or back to the CMHTS when patients no longer required intensive home treatment.

The facilities promote recovery, comfort, dignity and confidentiality

Home treatment teams provided support to patients who were experiencing an acute crisis and deterioration in their

Are services responsive to people's needs?

Good

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

mental health and to prevent the need for the person to be admitted into hospital. Staff provided a range of flexible support to patients dependent on their needs. This included telephone contact and face to face visits with people in their own homes or at other venues as appropriate. At night, patients were offered telephone support and the option of attending their local liaison service to receive an assessment and support.

Staff were committed to providing care to patients which promoted people's privacy and dignity.

Care focused on patient's holistic needs and not just on treating their mental distress or illness. For example care plans showed staff supporting patients with major changes and life events, money and benefits issues, family issues, work, volunteering and educational opportunities.

We observed staff assessing and providing crisis care to patients and saw people were treated with dignity and respect on all the interactions. Patients commented that staff were very flexible and arranged appointment at times that suited them.

There were good systems in place to request patient's consent to pass information on to relatives so that patient's permission was properly obtained before key details or updates were passed to relatives.

Meeting the needs of all people who use the service

Staff had a good understanding of the needs of their local communities, for example Trafford had a large African Caribbean population in one ward, a large South Asian population in central Bolton and a large Jewish community in Salford. Staff could access interpreting services which provided face to face and telephone interpreting services. We were given examples by staff where interpreters had been accessed to support patients whose first language was not English to attend assessments. Patient's individual, cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at meetings.

Listening to and learning from concerns and complaints

Teams were proactive in their approach to gaining feedback from people who used the service. Patients were given a questionnaire at the end of their treatment with the home treatment teams to complete to comment on their experiences.

Patients knew how to raise concerns and were given written information about making complaints as part of an information pack.

The teams had received eight compliments which had been recorded formally at trust headquarters. The teams did not receive many complaints from patients – with 24 complaints in the last 12 months; three of which were upheld and seven were partially upheld. The team with the most complaints were the single point of access team in Bolton with seven complaints. Where complaints had been raised, we saw that the trust had worked to resolve these complaints.

Complaints and concerns which people had raised were discussed at the service meetings. We found evidence to show that managers had taken timely action in response to complaints which they had received. For example, during one team meeting the team manager reminded staff to record the involvement of family members following a complaint. Complaints were therefore well managed.

Health based place of safety - Salford

Health based place of safety - Bolton

Health based place of safety - Trafford

Access and discharge

The trust had telephone police triage services so police could receive professional mental health advice prior to conveying people to the health based places of safety. This was a relatively new initiative and staff reported that regularly police were reporting to the health based places of safety (HBPoS) without telephoning first. These were raised at locality interagency meetings.

The development of the new HBPoS and joint working arrangements with the police forces reduced the numbers of people being assessed in police cells. Arrangements meant there was seldom a delay in ensuring that people were assessed in a timely manner under section 136. The timely availability of staff also meant that the police were able to hand over individuals to health staff within an appropriate timescale both during the day and at night.

People within the HBPoS were seen quickly and where there were delays they usually related to the availability of assessing doctors (section 12 doctors) external to the trust or approved mental health professionals (AMHP). The main delay was due to the availability of the AMHP at night. The AMHP service at night was provided by the local authority

Are services responsive to people's needs?

Good

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

emergency duty teams (EDT) so there were sometimes delays in AMHPs attending depending on other presenting cases to the EDT. This was beyond the full control of the trust.

The facilities promote recovery, dignity and confidentiality

Assessment we saw had been completed in a timely manner and well within the 72 hours required by the MHA and code of practice. We did not identify any additional or arbitrary restrictions when people were placed in the HBPoS.

Patients had access to drinks and meals could be provided throughout the time patients were cared for in the HBPoS.

The environments of all the HBPoS provided a dignified environment for the assessment of people. There was a separate entrance for parking immediately outside for police to bring people directly into the units which helped maintain the safe and dignified conveyance of patients. There were separate staff areas for staff to meet and discuss the assessment and maintain confidentiality.

The HBPoSs provided clean and comfortable areas to carry out assessments including separate toilet areas, appropriate and comfortable furniture so where there were delays in assessments patients could make themselves comfortable. All of the HBPoS environments did appear clinical in appearance with bare walls and no wall art giving a spartan appearance.

If patients required physical health treatment, they would be taken to a designated room within the emergency department of the local acute hospital. The designated room at Bolton was being upgraded to provide an environment more fit for purpose.

On occasion, more than one person required the HBPoS at each locality at any given time. However this occurred on an infrequent basis. We were told that a second section 136 detainee would be conveyed to another suite within the trust. On very rare occasions, patients may be conveyed to designated rooms within neighbouring hospitals.

Where people were not admitted following initial assessment, staff confirmed that the trust would pay for a taxi to return the person home if no suitable alternative transport was available.

Meeting the needs of all people who use the service

The joint agency policy explained how the needs of people detained on section 136 would be managed and the appropriateness of the relevant places of safety. This included circumstances when the police custody suites were more appropriate than the HBPoS within the trust. This was usually if patients were presenting with extreme violence and aggression that could only be managed in a police cell.

The HBPoSs were available for all patients over the age of 16. People under 16 were taken to a more suitable facility in a neighbouring trust. The exclusion criteria included people who had acute medical needs where such patients were generally taken to the emergency department or where people were suspected of committed a criminal offence, people who were intoxicated and those who pose a significant risk of violence and aggression where these people would be taken into police custody for assessment. It was rare for people with learning disabilities to be brought in for section 136 assessments and where this occurred specialist consultant psychiatrists were called to help assess them.

The trust routinely collected data from all HBPoS to monitor the service. This included information about age, gender, ethnicity and disability and other protected characteristics including marital status and religion.

A range of patient information was readily available for people placed in the HBPoS which included information on mental health conditions and treatments as well as local services which provide support. Staff confirmed that they had access to translation services and interpreters where required.

Listening to and learning from concerns and complaints

The teams received 24 complaints in the last 12 months; three of which were upheld and seven were partially upheld. Of these two complaints related to care specifically received in the HBPoS at Salford; one was partially upheld regarding the care received whilst in the HBPoS and one was not upheld.

Information about raising concerns and complaints was available to people who were assessed in the health based

Are services responsive to people's needs?

Good

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

place of safety units. Information in leaflets and in other literature contained out of date contact details for the CQC when informing patients of our role in looking into complaints about MHA powers.

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

Home based treatment team - Bolton

Home based treatment team - Trafford

Mental health liaison team - Salford

Rapid assessment, interface and discharge (RAID) team - Trafford

Rapid assessment, interface and discharge (RAID) team - Bolton

Single point of access team - Bolton

Salford police liaison service (pilot) working within Pendleton police station

Vision and values

The trust's vision was to achieve improved lives and optimistic futures for individuals affected by mental health and substance misuse problems. The values of the trust were as follows:

- We are caring and kind
- We go the extra mile
- We value and respect
- We are welcoming and friendly
- We work together

The vision and values of the trust were displayed in home treatment team offices.

Staff were aware of the trust's vision and values. Staff were motivated and dedicated to provide recovery focused, high quality care and treatment to patients in receipt of community mental health services. Staff worked together with the inpatient wards and community mental health teams in line with the trust's values.

The urgent care review process carried out by the trust across the three localities which led to reduced inpatient beds and improved community mental health services. This change process was well managed with increased staffing levels and greater capacity within home treatment teams being introduced prior to the reduction in inpatient beds.

Good governance

There was an effective governance framework in place to support the delivery of good quality crisis services. Teams had comprehensive team meetings to discuss performance, new initiatives and any areas of concern.

We found the services were well managed. Staff had clear roles and a management structure that was understood by all.

The trust had a good governance structure in place to oversee the running of the crisis teams.

Leadership, morale and staff engagement

Managers within the crisis services were committed to providing a good quality service and were effective leaders. Staff told us they felt valued and were supported by effective managers and their peers.

There were good processes to share information via team meetings and debriefings. There was good communication from the board to teams and upwards. Morale was good across the teams we visited. Managers had effective local, inter agency and crisis concordat meetings to improve services and patients' crisis experience.

Managers carried out local audits to improve performance, for example the Trafford home treatment team manager had carried out a care plan audit which identified the need for improved recording to show that patients were involved in their care plans.

Commitment to quality improvement and innovation

There was a commitment to quality improvement with improved staffing levels in crisis services as part of the urgent care review, telephone police triage services and innovative services working with regular presenters to the police, improved community mental health team input extending into the evenings and weekends and home treatment services and RAID liaison services being available 24 hours a day, 365 days a year to provide mental health assessment to individuals with urgent mental health needs. The Trafford RAID was available during the hours of operation of the local urgent care centre.

Staff in some home treatment teams were looking to Royal College of Psychiatry (RCP) peer review accreditation and

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the high police presenter project had been evaluated internally. The Salford liaison service was going through accreditation as part of the RCP's psychiatric liaison accreditation network assessment.

Health based place of safety - Salford

Health based place of safety - Bolton

Health based place of safety - Trafford

Vision and values

There was a commitment to working together with other agencies in line with the trust's values to ensure people brought into the health based places of safety (HBPoS) received co-ordinated assessment. There was an agreed joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by the trust, local police forces and relevant NHS ambulance service. The duties of all agencies were identified and set out to ensure that people received effective and timely assessment.

Staff were aware of the trust vision, values and the joint agency policy for the implementation of section 136.

Good governance

Managers audited the use of section 136 and the use of health based places of safety, producing quarterly reports which identified themes and shortfalls in adherence to the trust policy and to the MHA Code of Practice. The results of the audits were discussed at local interagency meetings which were held in the three main localities of Bolton, Salford and Trafford. The section 136 audit reports included quantitative data on the use of section 136 (for example, how long the police remain at the trusts' health based places of safety, and how long it takes for clinicians to attend and assess) and qualitative data such as the outcome of the assessment, reasons for delays in initiating a MHA assessment and any episodes of people turned away from the place of safety. Where problems arose these were discussed and resolved either in the meetings that occurred in each locality or in discussion between appropriate senior staff in relevant agencies. There was a police liaison officer who helped to address problems or facilitate discussion between the police and the staff of the trust.

Overall the audit demonstrated high levels of compliance with national standards for the safe treatment of people subject to section 136. This included 98% of people detained under section 136 were taken to an appropriate health based place of safety rather than a police station. The majority of people in the health based places of safety were seen within three hours from contact to assessment – the longest wait was eight hours. Where there was a delay, 38% required medical treatment and 25% were intoxicated.

However, the audit did identify areas of improvement. These included recording rights with 19% of records not showing whether people had their rights read or rights leaflet given to them whilst in the HBPoS. Of those taken to the HBPoS, only 18% of people were admitted informally and 5% were detained under the Mental Health Act which the audit considered a low conversion rate. Forty percent of people brought to the HBPoS by the police were discharged without any mental disorder. This showed that on occasions people were being inappropriately brought into the health based place of safety on a section 136. The trust staff were providing training to front line police officers to improve mental health awareness and the extent of police powers in relation to people with mental health needs.

Audit reports were shared with the police liaison group to improve practices within the police and there were other recommendations including encouraging to record the attendance of assessing section 12 doctors and AHMPs at assessment and to provide an explanation where a section 12 doctor had not attended. The improved promotion of the telephone triage line would, in time, help to improve the rates of inappropriate episodes of section 136.

In each locality, there had been investment in new health based places of safety to ensure that the environments provided dignified care to patients and ensure they were fit for purpose.

Leadership, morale and staff engagement

The health based places of safety did not have dedicated staff based there. The day to day staffing and management of the HBPoS were overseen by the RAID team at Trafford and the liaison service at Salford. At Bolton, the management and staffing were from the single point of access team during the day and the home treatment team at night. Staff within these teams told us that they felt well supported by their direct managers and peers. Staff also reported senior managers were accessible and approachable. Whilst all localities had very good and experienced leaders overseeing the HBPoS, the clinical

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leadership of the HBPoS at Salford was particularly impressive with the consultant psychiatrist and interim manager having very good oversight of the current issues and working arrangements.

Staff were broadly aware of new regulations regarding duty of candour and their role in the process for any future incidents where patients experienced harm.

Commitment to quality improvement and innovation

In each locality, there were good systems in place to monitor the service in order to improve the performance. The group regularly reviewed performance indicators, such as four-hour wait times, the number of times section 136 was used and delays in assessments. Staff liaised with the services involved in assessments and reviewed the effectiveness of the HBPoS.

The environments of the health based places of safety met or exceeded the Royal College of Psychiatrists' (RCP) guidance on the health based places of safety environment. The RCP guidance had been used to draw up the plans for the new HBPoS in each locality. Whilst there was no ongoing formal benchmarking to ensure that the environments continued to meet the guidance, where minor environmental problems had been identified, these were being addressed.

The trust was working with the local police to improve their response to people with mental health needs. This included staff working at a strategic level by providing appropriate training to front line police officers across Greater Manchester. Each locality had a telephone triage line available to the police, to receive general advice on managing people with suspected or actual mental health needs and to receive specific information on individual patients where there was a pressing need to share information. In Trafford, the trust had worked with the local police station and had identified people with mental health needs who were also high presenters to ensure these people received intensive and effective mental health support.

Staff in the acute hospitals reported a commitment to working collaboratively. Trust staff had contributed to discussions about improved assessment environments within the emergency department at Royal Bolton hospital.