Good

Sussex Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX2E7	Department of Psychiatry	CRHT & Liaison	BN21 2UD
RX2E7	Department of Psychiatry	Health-based place of safety	BN21 2UD
RX2P0	Langley Green Hospital	Crisis Home Treatment Team	RH11 7EJ
RX2P0	Langley Green Hospital	Health-based place of safety	RH11 7EJ
RX277	Meadowfield Hospital	Crisis Home Treatment Team	BN13 3EF
RX277	Meadowfield Hospital	Sussex Mental Health Line	BN13 3EF
RX277	Meadowfield Hospital	Health-based place of safety	BN13 3EF

Summary of findings

RX213	Millview Hospital	CRHT	BN3 7HZ
RX213	Millview Hospital	Health-based place of safety	BN3 7HZ
RX213	Millview Hospital	AMHPs	BN3 7HZ
RX2L6	Woodlands	CRHT	TN37 7PT
RX2L6	Woodlands	Health-based place of safety	TN37 7PT

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
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

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Overall summary

We rated Sussex Partnership NHS Foundation Trust mental health crisis services and health-based places of safety as good because:

- People had access to safe and clean environments that were accessible by wheelchair users. Teams were well-staffed and had access to appropriate alarms systems that ensured people using the service and themselves were kept safe.
- Psychiatrists were available to all teams across the service. They had the flexibility to carry out medical reviews in people's homes. The service had systems in place to allow staff to medically support people in the absence of a doctor. Staff had access to equipment that allowed them to monitor people's physical health.
- Crisis teams had systems in place to safely manage people's risk. They were able to assess people quickly and followed clear procedures that ensured other work did not get overlooked.
- Crisis teams worked with people and their carers to collaboratively produce care plans that were meaningful and specific to their individual needs. Care plans were holistic and addressed people's physical, psychological and social needs. Carers were well supported by the service and staff routinely offered carers assessments.
- Teams used lessons learnt from incidents to improve practice and inform meaningful audits. Staff embraced duty of candour and were open and honest with people following incidents. Staff were supported by senior managers to ensure everyone involved was included in the outcome of incidents.
- Teams had effective handovers to allow them to efficiently manage their caseloads. They also had regular meetings where clinical and business issues could be discussed. Teams had effective links with services they worked closely with and this improved the experience of people using the services.
- People who used the service were treated with compassion, respect and dignity. People in HBPoS were offered refreshments and toiletries to keep them comfortable. Staff promoted people's independence whenever possible. People were involved in their care and kept informed of any delays and appointment changes. People were able to give feedback and teams used this information to improve their practice.
- The Sussex mental healthline was accessible 24 hours a day, seven days a week, to support people with mental health issues. People presenting at accident and emergency with mental health issues in East Sussex had access to the urgent care lounge, which offered a calm place to wait for assessment. Positive feedback had led to the trust securing funds to replicate this facility across the other four sites.
- Street triage, an initiative whereby mental health professionals work alongside police officers, had been responsible for significantly reducing the amount of people, with mental health issues, being taken into police custody. They had also reduced overall use of HBPoS by providing people with less restrictive ongoing care plans.
- Teams had sufficient administration support and made use of hot desk facilities in other trust locations to cut down on travelling time. This gave them more time to deliver direct care to people. Teams had systems in place to ensure staff could easily identify when important direct care interventions, such as supporting carers and monitoring physical health, had been completed.
- Staff embraced the trust's vision and values. They enjoyed their work and had no concerns with bullying or harassment. They felt supported, and listened to, by managers who were visible and fully involved in the day to day delivery of clinical care.

However:

- Staff were not consistently up to date with mandatory training requirements due to some courses having reduced availability.
- Crisis teams did not always offer people individual crisis plans or relapse prevention plans. The crisis information that was available was generic and consisted of useful contact numbers; however, some information was conflicting across teams. In addition, at night people only had access to the Sussex mental healthline. People requiring urgent support would need to make their own arrangements to get to accident and emergency.
- Crisis teams across the trust did not effectively share their practice. This led to teams approaching

Summary of findings

established crisis team roles, such as supporting people who were not engaging, and assessing whether people were appropriate for early discharge from hospital, with different levels of efficiency.

- People detained in health-based places of safety (HBPoS) occasionally had to wait more than three hours before being assessed due to delays in availability of approved mental health professionals and Section 12 doctors. This timescale exceed recommendations by The Mental Heal Act Code of Practice.
- People occasionally remained in HBPoS for extended periods due to lack of bed availability.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Staff were not always up to date with mandatory training requirements. They told us that certain courses, such as prevention and management of violence and aggression, were difficult to access.
- People were not always provided with individualised crisis plans or relapse prevention plans. This meant they were not appropriately prepared to support themselves outside normal working hours or after discharge from services.
- Teams did not have arrangements in place to calibrate physical health care equipment, such as alcometers and blood pressure machines. This meant that readings could become inaccurate over time.

However:

- People had access to interview rooms and health-based places of safety that were safe and clean. Staff used appropriate alarms systems that ensured help could be summoned in emergencies.
- All teams were well-staffed. Team leaders were able to use extra staff that were familiar with the service to meet the needs of people who used the service.
- Psychiatrists were available to all teams across the service. They worked with flexibility to ensure people received medical support appropriate to their needs. Staff had access to equipment that allowed them to monitor people's physical health.
- Staff had a good approach to recording and managing people's risk issues. They used a robust rating scale to ensure people were offered appropriate levels of support.
- All teams had a good approach to incident reporting. They were proactive in discussing incidents and used lessons learnt to improve practice. Staff were open and honest with people following incidents and shared information with them.

Requires improvement 

Are services effective?

We rated effective as good because:

Good 

Summary of findings

- Crisis teams were able to assess new referrals promptly. They had effective systems in place that allowed them to prioritise work dependent on risk. Shift co-ordinators were able to remain at the team base so they could maintain oversight on the workload.
- Crisis teams worked with people collaboratively to produce care plans that were meaningful and specific to their individual needs.
- Crisis teams and street triage made use of Patient Group Directives. These allowed them to administer medication in an emergency without having to wait for a doctor.
- People who used crisis service were offered psychological interventions. These varied from structured care plans based on cognitive behavioural therapy techniques, to group sessions that taught coping skills.
- All crisis teams assessed and monitored people's physical health. They were well supported by consultants and doctors who had the flexibility to provide medical reviews to people in their own homes,
- All teams carried out meaningful audits to enable them to monitor their performance. Teams discussed the outcome of audits and changed their practice in response to them.
- Teams had effective handovers to allow them to effectively manage their caseloads. They also had regular meetings where clinical and business issues could be discussed. Teams reflected on their practice and had a culture of learning from incidents. All teams across the trust contributed to a daily bed management meeting to ensure they had an oversight on bed availability.
- Teams had effective links with other services in their locality. They attended joint meetings and developed joint initiatives based on providing a seamless experience for people being transferred between services.

However:

- All crisis teams responded differently to supporting early discharges from the wards. There were no standard trust wide criteria that were available to all teams. This meant that decisions could be made due to bed pressures or, alternatively, teams could miss opportunities to support people at home, rather than them remaining in hospital.
- Crisis teams initially gave people a 72 hour care plan. This contained generic information on how they could access support if needed. However, we found some information was conflicting across teams, such as times that the mental healthline was accessible.

Summary of findings

- Staff were not consistently receiving regular supervision across all teams.
- Staff did not always accurately document the time of arrival of professionals who were assessing people in health-based places of safety.

Are services caring?

Good

We rated caring as good because:

- Staff from across the service treated people with compassion, respect and dignity. They discussed people's individual issues in a sensitive way and offered interventions that were flexible and creative.
- Carers were well supported by the service and staff routinely offered carers assessments. Carers we spoke with spoke highly of the service and told us that staff were open, honest and approachable. They received regular updates and felt staff listened to their views.
- Crisis teams allowed people to maintain their independence whenever possible. People were encouraged, and educated, to take responsibility for their medicine unless risks were identified.
- People had the opportunity to give feedback and this information was used by teams to improve people's experience.
- People using HBPoS were kept up to date with any delays in their assessments. They were given food and toiletries and the offer of music to maintain their comfort. Staff supported people to contact family, solicitors and advocates when required.

Are services responsive to people's needs?

Good

- Crisis teams were able to assess new referrals promptly. They had effective systems in place that allowed them to prioritise work dependent on risk. Shift co-ordinators were able to remain at the team base so they could maintain oversight on the workload.
- Crisis teams used hot desk facilities in other trust locations to cut down on travelling time. This gave staff more time for direct client care. Teams responded to feedback and used this flexibility to reduce the amount of different staff people would be seen by.
- The Sussex mental healthline was accessible 24 hours a day, seven days a week. Staff were knowledgeable and appropriately trained to offer general support or signpost effectively if risk was identified.

Summary of findings

- People in East Sussex were able to wait for assessment in the urgent care lounge located at the Department of Psychiatry. This offered a calm environment away from the accident and emergency department which was regularly overcrowded and noisy. The trust had recently secured funding to replicate this service across the other four sites.
- Consultants and doctors across all crisis teams had the flexibility to see people in their own homes to carry out medical reviews.
- All sites were accessible for people with mobility issues. Staff had access to clean and comfortable rooms that were soundproofed to assess people at team bases.
- Street triage had been operating for three years across the trust. They had been responsible for significantly reducing the amount of people, with mental health issues, being taken into police custody. They had also reduced overall use of HBPoS, across the trust, by making plans for people to be supported by less restrictive means. Street triage teams operated different working hours which were based on the need of the local demographic.

However:

- Crisis teams did not operate 24 hours a day due to current commissioning arrangements. The Mental Health Crisis Care Concordat states “People in crisis should expect local mental health services to meet their needs appropriately at all times”. After 9.30pm teams relied on senior nurse practitioners to answer the crisis team phone, or Sussex mental healthline, if people made contact. The senior nurse practitioners had other responsibilities, such as carrying out assessments, which impacted their availability.
- Crisis teams across the trust had different approaches to engaging people who were not attending appointments. The trust had no clear criteria that guided teams in the measures they should take to ensure these people were safe before discharging them.
- People detained in health-based places of safety (HBPoS) occasionally had to wait more than three hours before being assessed due to delays in availability of approved mental health professionals and Section 12 doctors. This exceeds timescales recommended by The Mental Health Act Code of Practice.
- People who had been admitted to HBPoS occasionally had long delays in being assessed and waiting for bed availability.

Summary of findings

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the trust's vision and values. They felt supported by their immediate colleagues and managers and enjoyed their roles. They had no concerns with bullying or harassment and, if they had concerns, felt they would be listened to.
- Senior managers and team leaders had full oversight of their team's daily operation. They attended meetings and shared relevant information with their staff.
- Teams had sufficient administration support to allow them to focus on direct care. They had systems in place to ensure staff could easily identify whether key interventions, such as supporting carers and monitoring physical health, had been completed.
- All crisis teams had completed the University College London's fidelity review that rated key components of crisis care. Teams had acted on findings and improved their performance at one year follow up.

However:

- Staff and senior managers felt they worked very much in isolation to other teams in the trust providing similar services. Opportunities to share lessons learnt from incidents or share good practice and innovation with other teams was limited.
- Staff were unable to complete some mandatory training courses due to low availability throughout the trust.

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Information about the service

The trust provides crisis or home treatment teams based at five sites; the Department of Psychiatry, which covered the Eastbourne area; Langley Green Hospital, which covered the Crawley area; Meadowfield Hospital, which covered the Worthing area; Mill View Hospital, which covered the Brighton and Hove area; and Woodlands, which covered the Hastings area. Between them they served the population of Sussex.

The teams consisted of mental health professionals who provided short-term support to people experiencing a mental health crisis. They aimed to prevent admission to a psychiatric hospital by providing treatment in the community, usually in people's own homes. The service was supported by the Sussex mental healthline and senior nurse practitioners to allow access 24 hours a day, seven days a week.

The trust also had a health-based place of safety at each of the five sites. These were used for people detained under section 136 of the Mental Health Act. A section 136 is an emergency power given to the police. It allows a person to be removed from a public place to a place of safety for assessment, if it appears to the police officer that the person is suffering from a mental disorder. The health-based place of safety was also used when police have executed a warrant under section 135(1) of the Mental Health Act and is a safe place to carry out an assessment when required. A section 135(1) warrant is issued to police officers by the courts. It allows them to enter private premises to remove a person to a place of safety if there are concerns for their own, or others safety resulting from their mental state. An assessment under the Mental Health Act can then be arranged to assess whether they should be in hospital or be better supported at home.

The trust also provided a street triage service. This allowed police and mental health services to work together to ensure people received appropriate care when police were called to a person in distress.

This core service was inspected by the Care Quality Commission in January 2015 as part of our comprehensive mental health inspection programme. We rated it as good in all five domains; safe, effective, caring, responsive and well-led. There were no actions required for the provider to undertake.

Our inspection team

The team was led by:

Chair: James Warner, Consultant Psychiatrist and National Professional Advisor for Old Age Psychiatry.

Head of Inspection: Natasha Sloman, Care Quality Commission.

Team Leader: Louise Phillips, Inspection Manager, Care Quality Commission.

The team that inspected this core service comprised one CQC inspector, a CQC inspection manager, one consultant psychiatrist, one nurse, one clinical psychologist and a Mental Health Act reviewer.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all five health-based places of safety; five crisis response/home treatment teams; the trust's 24 hour mental health line and two acute day service teams across five sites. We looked at the quality of the environments and observed how staff were caring for people who use services;
- spoke with 15 people who were using the service and two carers of people using services;
- spoke with the managers or acting managers for each of the teams;
- spoke with 48 other staff members; including doctors, nurses, support workers, occupational therapists, psychologists, pharmacists and administration staff;
- spoke with three acute service managers with responsibility for these services;
- attended and observed four hand-over meetings and three multi-disciplinary meetings;
- attended and observed one home visit and two therapeutic groups;
- listened to two calls received by the Sussex mental healthline;
- looked at 66 treatment records of people who used the services;
- carried out a specific check of the medication management across all teams;
- 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

People who used the service told us that staff treated them with dignity and respect. They felt involved in their care, listened to and that the support they were given had a positive impact on their mental health. People told us that staff were patient and compassionate and that they felt comfortable discussing sensitive issues. They also appreciated the support they were given in regards to social issues; one person told us that staff had been instrumental in helping him secure more appropriate accommodation.

Carers of people who used the service told us that staff included them in their relatives care when appropriate. They were also given individual support to discuss any stress they may be experiencing.

Good practice

The Sussex mental healthline received 31,266 calls between 1 August 2015 and 1 August 2016. The majority of calls were from the Worthing area with 7,454 calls into the helpline. Of these 22 had resulted in the caller being referred into the accident and emergency department for more support and 40 resulted in an ambulance being required for the caller. Less than 2% of all the calls received by the helpline across the county resulted in an escalation to accident and emergency, an ambulance being called or a referral to the senior nurse practitioner.

The Department of Psychiatry provided an urgent care lounge. This gave people, presenting to accident and

Summary of findings

emergency departments with mental health issues in East Sussex, a calm area to wait for assessments. It had been well received and the trust had secured £630,000 to provide similar facilities in the other four hospital sites.

Street triage was in operation in four areas of Sussex. It had started as a pilot scheme in October 2013 in Eastbourne and had gradually been commissioned throughout the county. Street triage consisted of mental health professionals working alongside police officers.

They provided on the spot advice to police officers who were dealing with people with possible mental health issues. Street triage had significantly reduced the occurrences of people with mental health issues being taken into police custody. It had also reduced overall use of people needing to be taken to a health-based place of safety as skilled staff were able to assess risks and offer less restrictive options.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that mandatory training is sufficiently available to meet staff demand.

Action the provider SHOULD take to improve

- The trust should ensure that crisis teams support people to produce individualised plans that they can refer to when in crisis or relapsing.
- The trust should ensure that physical health monitoring equipment is regularly calibrated.
- The trust should ensure that crisis teams approach early discharge with consistency across the service.
- The trust should ensure that generic information provided to people is consistent across the trust.
- The trust should ensure that all clinical staff are receiving regular supervision.
- The trust should ensure that people in health-based places of safety do not experience delays that exceed timescales recommended in The Mental Health Act Code of Practice.
- The trust should ensure that Mental Health Act documentation is completed fully and accurately.
- The trust should consider how they could provide a more accessible service to people experiencing mental health crisis outside normal working hours.
- The trust should ensure that crisis teams have a uniform approach to supporting people who are not engaging with the service.
- The trust should ensure that important information, such as outcomes of audits and innovative practice, is shared across all teams offering the same service within the trust.

Sussex Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CRHT & Liaison	Department of Psychiatry
Health-based place of safety	Department of Psychiatry
Crisis Home Treatment Team	Langley Green Hospital
Health-based place of safety	Langley Green Hospital
Crisis Home Treatment Team	Meadowfield Hospital
Sussex Mental Health Line	Meadowfield Hospital
Health-based place of safety	Meadowfield Hospital
CRHT	Mill View Hospital
Health-based place of safety	Mill View Hospital
AMHPs	Mill View Hospital
CRHT	Woodlands
Health-based place of safety	Woodlands

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 we spoke with had good knowledge of the Mental Health Act, especially the areas that were relevant to their practice. Training was mandatory and completion rates varied across the five sites from 76% to 48%. Crisis teams had a protocol in place to support people on Section 17 leave. Staff were experienced and knew the circumstances whereby a person may benefit from a Mental Health Act assessment. Staff knew the role provided by approved mental health professionals and knew how to contact them to initiate the assessment process.

Mental Health Act documentation of people who had been bought into health-based places of safety (HBPoS) was generally completed accurately. There were minor issues around recording the time that Section 12 doctors and approved mental health professionals had been contacted or arrived; and recording that the person had their rights explained to them. On occasions Mental Health Act assessments did not commence within three hours of the person arriving at a health-based place of safety. This exceeded recommendations in the Mental Health Act Code of Practice (paragraph 16.47). We were told that this target was not always met due to availability of approved mental health professionals and section 12 doctors.

On occasions people remained in a HBPoS for extended periods. We were told that on all occasions assessments had been completed and people were waiting for beds to become available.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were aware of the Mental Capacity Act and its guiding principles. Most staff had a good understanding of when people may be lacking capacity and how this could be tested. They told us that if they had any concerns they would refer them to the team consultant. Training was mandatory and completion rates varied across the five sites from 70% to 58%. People detained in a health-based place of safety were asked about their consent before medicine or physical observations were given and this was recorded on CareNotes. Staff were aware that treatment could be given if it was felt that this was in the person's best interests. Staff knew that a consultant had to be involved in prescribing any medicines.

Requires improvement

Are services safe?

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

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

Our findings

Mental health crisis services

Safe and clean environment

- Crisis teams and health-based places of safety were located on five different sites. The 2016 patient-led assessments of the care environment (PLACE) score for cleanliness across four of the sites were; Department of Psychiatry 100%; Woodlands 100%; Meadowfield Hospital 96%; and Langley Green Hospital 96%. The trust did not provide a score for Mill View Hospital. The trust's average score was 97%, with the national average score being 98%.
- Staff across all crisis teams had access to interview rooms to see people who used services. Staff used appropriate personal alarm systems when assessing people and all rooms had glass panels or spy holes so any potential risk issues could be further monitored by colleagues.
- All crisis teams we visited had equipment to monitor people's vital physical signs, such as blood pressure and temperature, and to take blood samples. Staff generally carried out these activities at people's homes and had access to transportable sharps bins so used needles could be disposed of safely. Staff undertook these activities in the interview rooms if people were seen at the team base.
- We found all physical health equipment to be well-maintained and stored safely. However, we found no evidence that equipment was regularly calibrated. This meant that readings could become inaccurate over time.
- We looked at all areas that people who used the services had access to and found them to be visibly clean with well-maintained furniture. The Department of Psychiatry site included an urgent care lounge that provided a waiting area specifically for people who had presented at accident and emergency with mental health issues. This area included a computer and phone with lots of cables. We asked staff how this potential risk was managed and were assured that people awaiting assessment were not left unattended. A support worker had been specifically employed to support people using the urgent care lounge.

Safe staffing

- All crisis teams we visited were either fully staffed or had minimal vacancies. All vacancies had been recruited into or were being advertised. We were told that the trust had a policy of not backfilling posts for maternity leave. This could lead to an extra reliance on bank staff, or leave certain disciplines, such as occupational therapy or psychology, short-staffed during this period.
- Between 1 April 2015 and 31 March 2016, the average staff turnover, across the five teams, was 13% with the highest being 23% at Woodlands. Average staff sickness was 5% with the highest being 9% at Woodlands.
- Team managers told us that they did not use agency workers. Permanent staff, doing extra shifts, and regular bank staff covered short term absences, such as sickness or annual leave, and helped to manage demand on caseloads. The team manager at Meadowfield Hospital ensured that staff took annual leave regularly during the year to avoid an influx of requests at the end of the financial year.
- Team managers were able to adjust staffing levels according to their caseload numbers and perceived workload. For example, the service manager at Langley Green Hospital told us that an extra member of staff would be added if the caseload exceeded 22. Teams relied on their knowledge of the caseload, when adjusting staffing levels, and did not have a system in place that calculated staff requirements based on the caseload. For example, people rated red requiring more staff resource than people rated green.
- During our inspection, crisis team caseloads ranged between 11 at Meadowfield Hospital and 31 at the Department of Psychiatry. All teams were managing their caseloads safely and we found no situations where urgent assessments or arranged contacts had to be cancelled. The service manager for the Langley Green Hospital team told us that, earlier in the year, the team's caseload increased to 37. This increased staff stress levels and tasks such as supervision were being overlooked in order to manage the caseload. The team

Requires improvement

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held a meeting to discuss how this could be avoided in the future. They introduced a longer handover on a Monday with the aim being able to identify potential discharges and communicate these better to community teams. They also had a longer handover on Friday to review this work.

- Staff, who were responsible for coordinating shifts, showed good understanding on how to safely manage the caseload during busy periods. They told us that people presenting with lower risk would be contacted to rearrange alternative contact. Shift coordinators across all teams were protected from leaving the office so they could respond to incoming work.
- All teams included a consultant psychiatrist and staff grade doctors. Teams had access to on call doctors out of hours, who were located within the sites.
- Staff were expected to complete mandatory training. Overall completion rates across the service were 76% for August 2016 which showed an 8% increase from June 2016. We received training data from the service and completion rates not exceeding 75% in key course were;
- medicines management for nurses; Meadowfield Hospital 50% and Langley Green Hospital 66%;
- Mental Health Act; Meadowfield Hospital 55%, Mill View Hospital 65%, Langley Green Hospital 48% and Department of Psychiatry 68%. The trust had a current target of 65% for this training;
- Mental Capacity Act and Deprivation of Liberty Safeguards; Meadowfield Hospital 67%, Mill View Hospital 70%, Langley Green Hospital 66%, Department of Psychiatry 58% and Woodlands 67%. The trust had a current target of 65% for this training;
- prevention and management of violence and aggression; Meadowfield Hospital 25%, Langley Green Hospital 33% and Department of Psychiatry 66%;
- resuscitation and basic life support; Meadowfield Hospital 66%, Langley Green Hospital 60%, Department of Psychiatry 66% and Woodlands 66%;
- safeguarding children, Woodlands 67%.
- Staff did not always have appropriate levels in mandatory training that would have given them essential skills for working within crisis services, such as medicines management for nurses; and prevention and management of violence and aggression. We were told that prevention and management of violence and aggression had been difficult to access due to limited availability.

Assessing and managing risk to patients and staff

- We observed a sample of care records across the teams and found people's risk assessments were present and up to date. The one exception was the crisis team at the Department of Psychiatry where two out of eight care records did not have an updated risk assessment. We observed this team's daily handover and heard staff discuss risk issues in detail and record it on their caseload board. This meant that risk was managed well whilst the person was under the team.
- All crisis teams used a 'RAG' (Red, Amber, and Green) rating system to identify levels of risk for people using the service. Current RAG ratings were clearly displayed on teams' caseload boards and interaction with the person was based on assessed risk factors. All patients assessed as red had a minimum of one daily visit within the first 72 hours of admission to the team. We observed the morning handover at the Woodlands team and saw staff using this system to good effect. Staff demonstrated a good knowledge of the patients, their needs, any presenting risks, either to themselves or others, and updated their RAG rating accordingly.
- People's care records at Langley Green Hospital contained individualised crisis plans that detailed what the person, their carer or the team should do in the case of an escalation of risk or deterioration in mental health. We saw little evidence of individualised crisis planning in the other teams, although the Meadowfield Hospital team supported people to make relapse prevention plans. When people using the service were admitted to the caseload, they were informed how to contact the service or the 24 hour mental healthline, if they required immediate support. Care plans only identified the support needs for people in terms of their recovery. Individualised crisis plans and relapse prevention plans can allow people to take ownership of their mental health issues and lead to reduced reliance on services
- Team handovers were detailed and staff demonstrated flexibility to respond to people's needs and risks. Contact with people was then based on these factors. Teams were seen to increase contact where necessary and we saw that two people were receiving three visits daily. This meant that teams had the capacity to manage high risk people in the community as a realistic alternative to inpatient care.
- Teams had a shift co-ordinator who was office based who would oversee the team's activity for the day. The

Requires improvement

Are services safe?

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daily plan for team activity was written on a white board and the shift co-ordinator ensured that tasks were completed and the board updated throughout the day. We found that all teams had different systems for recording information on caseload boards and daily planning boards. Although staff understood the content on the boards, in some teams, they did contain a lot of important information with little evidence that the information was recorded elsewhere. This meant there was an over reliance on the whiteboard.

- Staff we spoke with across all teams were knowledgeable about safeguarding issues concerning both adults and children. Training rates across the service were, safeguarding adults 95% and safeguarding children 91%. We observed staff make calls to the children safeguarding team to update them, following visits to people who used services. Care records we reviewed showed regular liaison with children safeguarding teams. We saw one example where a children safeguarding referral had been made for the sibling of a patient, as there were concerns that, when unwell, the patient may cause harm to their sibling, either directly or indirectly. All teams caseload boards flagged whether people had children in the household on admission to the team.
- All teams followed lone-working protocols and staff spoke of the importance of this. The majority of home visits carried out by teams were conducted by two staff as this had been identified in order to manage risks in the community environment. Staff would only do lone visits if the environment had been risk assessed as safe.
- All staff we spoke with knew what to say on the phone to alert their colleagues that they were in danger. The Langley Green team had a robust policy displayed in their office which allowed colleagues to assess the level of danger by asking questions that could be answered yes or no. Staff on lone visits were responsible for phoning the office if they were running late. Teams across the service did not use a uniform method to highlight staff that were lone working. The shift co-ordinator was responsible for monitoring that staff returned safely from visits and raising concerns if required.
- We found that staff completed medicine charts correctly and used the appropriate symbols to indicate that the person was self-medicating. We reviewed 23 medicine charts across the Langley Green Hospital and Department of Psychiatry teams and found two did not have people's known allergies recorded.
- We found medicine reconciliation was routinely done by all teams as part of the admission process. The task was completed by administration staff and was included in the admission checklist. All teams had administration staff located in the team office so they were embedded in the team.
- All teams had locked medicine cupboards where they kept a stock of frequently used medicines. Other medicines were dispensed to people via FP10, which allowed people to collect medicine from a pharmacy. The team would then advise the person's GP to continue prescribing. We saw clear criteria at the Department of Psychiatry team which outlined when stock medicine should be used. It considered risks such as overdose, poor compliance and ability to pay prescription charges. All teams had a system to store people's own medicine if there was a risk of overdose or poor compliance. We saw all stored medicines included a form with the person's given consent and a running stock check of medicine quantity. The team at Meadowfield Hospital only stored people's medicines and did not hold stock. All teams had appropriate systems to dispense and transport medicine. Staff told us they were able to access refrigerated medicine bags from the adjoining wards if required.
- The team at Mill View Hospital had a medicine fridge that was not monitored. We were told it was not used by the team but when opened it contained one vitamin B injection. We were assured that the injection would be disposed of.

Track record on safety

- Between 1 June 2015 and 31 May 2016 there were 30 incidents across the five teams that were reported to Strategic Executive Information System. The majority, 28, were incidents of self-harm, with one medicine incident and one unauthorised absence. The team at Langley Green Hospital, where the medicine incident had occurred, had the learning from this incident clearly displayed in their office and had altered practice to reduce recurrence.

Requires improvement

Are services safe?

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

- Between the same period 27 incidents required investigation. Again the majority, 25, concerned unexpected or avoidable death or severe harm, with the other two relating to a loss of confidence in the service, adverse media coverage or public concern.
- One of the five prevention of future death reports in the 12 month period up to 30 April 2016 related to this core service. As a result the service was carrying out more robust assessments when deciding if a person was ready for early discharge from inpatient care to crisis team support. This included having designated workers to carry out these assessments.

Reporting incidents and learning from when things go wrong

- Staff in all teams had a good approach to reporting incidents and were competent in using the trust's electronic incident reporting tool, Ulysses. Team managers insisted that all incidents of self-harm or minor overdose were reportable. We reviewed the incident reporting at the Langley Green Hospital team and saw that 60 incidents had been reported since the start of the year. All had been reviewed by the service manager and closed or escalated appropriately.
- All teams had embraced duty of candour and we saw that this was discussed in team meetings. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. For example, the team at the Department of Psychiatry had developed a protocol to contact people within 10 days of an incident. Staff were instructed to compassionately explore what could have been done differently, as well as offering an apology. The team manager made themselves available to support staff if required.
- Staff had regular forums to receive feedback from incidents and discuss learning. These included team meetings, handovers and supervision. We reviewed three sets of team meeting minutes from the Mill View Hospital team, for the period May to June 2016, these demonstrated that incidents were discussed and time was set aside for incident de-briefs to take place for staff.
- The teams utilised two trust wide clinical psychologists to deliver protected time to reflect on incidents. We observed a weekly 'learning from incidents' meeting at the Department of Psychiatry that was well attended by staff and managers. Staff discussed a recent issue concerning a person who felt they had received poor communication. The discussion was open and honest and staff valued others opinions. They also discussed practical issues, such as how technology could have been better used to share information.
- We found all teams responded positively to feedback. We saw minutes of a meeting where an issue regarding someone not being allowed their preferred location for a Mental Health Act assessment had been discussed in detail. Staff acknowledged how things could have been done differently. We saw clear evidence of feedback being given to staff following a root cause analysis into a person's death. Following this investigation changes were made to the 72 hour care plan to prompt staff to consider specific risks.
- All staff we spoke with who had been involved in incidents, felt supported by their colleagues, managers and the trust.
- We found that services in East Sussex and West Sussex had regular meetings where incidents and learning could be discussed. However, we found that opportunities for all five teams to share learning were limited. Managers confirmed that incidents and learning in their individual teams was not routinely shared across all teams. The trust distributed a newsletter called 'report and learn' that summarised learning from incidents across the trust, however, this did not give staff sufficient opportunity to contribute their views. We were told that the acute community service managers had recently met to discuss issues across the service; however this was not a regular meeting space.

Health-based places of safety

Safe and clean environment

- The layout of the health-based place of safety (HBPoS) at the Department of Psychiatry, Mill View Hospital and Woodlands allowed staff to observe people in all areas of the facility. The facilities at Meadowfield Hospital and Langley Green Hospital each had a blind spot in one corner. Staff in these facilities were aware of this and would position themselves according to where the person was to maintain eye contact. We were shown refurbishment plans for the facility at Meadowfield Hospital that would eliminate the blind spot. This work was due to go ahead when an appropriate contingency

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plan for covering the facility, whilst it was out of action, was agreed. A senior manager at Langley Green Hospital responded to our feedback by ordering a curved mirror to manage the blind spot in the interim period.

- Staff attending to the HBPoS had access to emergency medical equipment located in the nearest adjoining inpatient ward. This meant they were able to respond to any physical health emergencies. However, staff had not carried out checks to ensure equipment could be bought to the facilities within three minutes of an emergency situation occurring. This is the quality standard to responding to a resuscitation as recommended by the national resuscitation council, and is also contained within the trust's own rapid tranquilisation policy.
- Staff attending to the HBPoS had appropriate personal call alarms which allowed them to summon support if necessary.
- We found all sites had access to an alcometer. Staff used these to ensure people's alcohol levels were appropriately low to allow a proper assessment to take place. Currently the service had no arrangements in place to calibrate the alcometers. This meant that the readings could become inaccurate over time.
- All HBPoS were visibly clean. During our inspection, domestic staff deep cleaned the facility at the Department of Psychiatry following an incident with bodily fluids. We saw that equipment and methods used complied with Control of Substances Hazardous to Health regulations. The facility at Langley Green Hospital clearly displayed its cleaning rota and it was up to date.
- All HBPoS were well lit and had beds to allow people to lie down comfortably. The facility at Meadowfield Hospital had some lightweight furniture that people could throw and cause to potential harm to themselves or others. It also was quite a small space which could make have an impact on people being safely restrained. We were told both these issues would be addressed in the pending refurbishment.

Safe staffing

- Health-based places of safety (HBPoS) had different staffing arrangements. Langley Green Hospital had four qualified staff and Meadowfield Hospital had one qualified staff dedicated to hosting the HBPoS. Meadowfield Hospital had advertised seven times for staff with no success. Other staffing requirements were absorbed by appropriately trained staff from the inpatient wards and crisis teams. All facilities were next to inpatient wards so extra staff could be deployed quickly if necessary. We were told that the Woodlands HBPoS occasionally was unable to acccept people due to a lack of available staff. The street triage service in East Sussex was able to accept people into HBPoS to ensure that staffing issues did not impact them using available facilities.
- We were told the street triage services across the trust did not have any vacancies.
- Consultant psychiatrists were available to support people using all HBPoS.
- We were unable to obtain exact mandatory training data for staff that co-ordinated HBPoS as the majority of staff were provided by inpatient wards and crisis teams. However, staff we spoke with told us they had completed mandatory training.

Assessing and managing risk to patients and staff

- We found all HBPoS had robust arrangements with police regarding assessing risk. Staff would identify potential risk when police made a phone referral. Staff would undertake a risk assessment on arrival whilst the police were still present. Police were asked to remain longer than the standard thirty minutes handover period if risk was high.
- Street triage teams worked with the police across the trust. These teams consisted of mental health professionals who provided on the spot advice to police officers who were dealing with people with possible mental health issues. They assessed risk and whether less restrictive options were appropriate.
- Health-based places of safety and medical staff had access to equipment from the adjoining inpatient wards to monitor people's physical health.
- Staff were aware of procedures to be followed in the event of people requiring rapid tranquilisation. We viewed two care records which showed regular physical health monitoring following rapid tranquilisation.

Track record on safety

- Between 1 June 2015 and 31 May 2016 there were six incidents across the five HBPoS that were reported to Strategic Executive Information System. Two were

Requires improvement

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incidents of self-harm, one medicine incident, one unauthorised absence, one violent behaviour and one delay in treatment. All six incidents required investigation.

Reporting incidents and learning from when things go wrong

- Staff told us that self-harm, use of rapid tranquilisation, safeguarding issues, restraint and any injuries, such as falls whilst people were intoxicated, would all be recorded as incidents. They had access to, and were competent in using the trust's electronic incident reporting tool, Ulysses.
- We saw an example of duty of candour being exercised by staff at the Meadowfield HBPoS. They had written an apology to a person who had used the facility after there had been a significant delay in them being assessed.
- Senior managers and senior nurse practitioners, in the different areas, attended monthly meeting where all incidents were discussed. Staff told us that they got feedback on these discussions and were able to contribute their views. Staff who worked for street triage were able to feed into, and get feedback from, a quarterly meeting where incidents were an agenda item.
- Staff told us they were supported and able to de-brief after 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

Mental health crisis services

Assessment of needs and planning of care

- All teams we visited had a target to assess people within 24 hours of referral. We were told that this target was always met and people were generally assessed much quicker. During our inspection all referrals were discussed at handovers and allocated an assessment within that shift. We were told that all referrals were triaged with regard to risk or whether any interim support, such as family members, was in place. Shift co-ordinators were able to respond to urgent referrals by reallocating less urgent work.
- All teams provided a service to discharge people early from inpatient care. We found the Mill View Hospital team to be very proactive in this area. Their caseload of 26 included nine people who had been discharged from the ward. The team at Meadowfield Hospital had only facilitated 16 early discharges between 1 May 2016 and 31 August 2016. The team at Langley Green Hospital had a caseload of 16 including two people who had been discharged from the ward. Their service manager told us the allocated early discharge worker had recently left, with a new worker starting in three weeks time. We viewed emails between the previous worker and ward staff, which showed collaborative discussions to address potential barriers to discharge to the crisis team.
- All teams had appropriate assessment tools that allowed staff to identify people suitable for early discharge. However, we found no set criteria was used trust wide. We were aware that a recent unexpected death had occurred following a person being discharged to a crisis team. Clear criteria for all teams would reduce the likelihood of further incidents.
- We looked at care plans from 30 care records of people who used the service across the five teams. We found all care plans viewed at the Langley Green Hospital, Woodlands and Mill View Hospital teams to be up to date, recovery focussed and covered a full range of issues. This was also the case at the other two sites; however, we found only three out of six care plans, for people under the Department of Psychiatry, were present. The Meadowfield Hospital team had all care plans completed but two out of five had not been uploaded to the electronic care records, CareNotes. We discussed this with staff and were told that they were waiting for people to sign them before uploading them. One of these people had been with the service eight days but had not been easy to engage. We saw that other teams would upload care plans immediately, as CareNotes contained a function whereby staff could record that the person had signed at a later date. Care plans were routinely signed by the person or there was evidence to show that they had been offered or given a copy of their care plan.
- All teams provided people with a generic care plan for the first 72 hours. Team managers told us that these allowed staff time to engage with people and form individualised care plans. It contained information about how the service would support them and gave useful crisis contact numbers. Although all teams used similar information, we found some were conflicting. For example, the Meadowfield Hospital team stated that the Sussex mental healthline was 24 hours a day, whilst the Langley Green Hospital team stated this service provided support only up until 9pm.
- All 30 care records we viewed contained meaningful progress notes which allowed staff, who were making subsequent contacts, to be aware of the current plan. They were clear and up to date with evidence that risk was updated as new information became available or situations changed.
- People who used services across all teams had a folder containing hard copies of information such as care plans, treatment charts, consent forms and so on. These were used to relay information and gain signatures during home visits. These folders were securely stored at team bases. These documents were also uploaded onto CareNotes and other information relating to people's care was only accessible to staff via individual password.
- Staff told us that they were gaining confidence in using CareNotes. The system was installed in February 2016 and we found that some of its functions were not being used across all teams.

Best practice in treatment and care

- Teams used Patient Group Directives to allow identified staff to prescribe and administer medicines in an emergency without having to wait for a doctor.
- Teams approach to providing psychological interventions varied across the service. The team at Meadowfield Hospital worked with a clear emphasis on

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psychology. Staff were trained in delivering behavioural activation and graded exposure. Behavioural activation is an evidence based treatment for depression that supports people to plan their daily structure around achieving collaboratively agreed tasks. Graded exposure is an evidence based treatment for anxiety that supports people to face their fears in a controlled way. The team also offered a weekly coping skills group. This delivered four topics, managing stress and tension; interpersonal skills; tolerating distress and self-compassion, over a four week cycle. It was an open group which meant people on the caseload could attend when they wanted.

- People on the caseloads of the Langley Green Hospital team and caseloads of teams in East Sussex (Department of Psychiatry and Woodlands) were able to access acute day services in their respective area. These offered group sessions such as, mindfulness, relaxation, managing low mood and creative arts. We observed a group at Langley Green Hospital facilitated by an occupational therapist. The facilitator managed the group well and gave delivered appropriate content and hand-outs.
- We were told that the Mill View Hospital team were keen to move from a medical model to a more psychosocial based approach. Funding was being sought to develop the Open Dialogue model, which facilitates people's support network to openly discuss mental health issues. The consultant from the Department of Psychiatry team was also keen for their team to offer more psychosocial interventions. The service had recently employed a clinical psychologist and it was hoped their role would include training staff to provide psychosocial interventions. We found that the average length of stay with the Meadowfield Hospital team was approximately five weeks, whilst it was approximately three weeks in the other four teams. We were unable to collect any data to evidence the ongoing benefits of each team's support in relation to requiring further services in the future.
- All teams employed social workers and offered support for people experiencing a social crisis. One person told us they had received invaluable support from the Department of Psychiatry team in resolving housing issues that had affected their mental health.
- Staff assessed people's physical health needs on admission and offered support if issues were identified. Physical health appointments were recorded on the white board and staff ensured that attendance at physical health appointments was supported by the team as required. The team at Langley Green Hospital had recently started recording people's vital signs and physical health description during the initial home visit. Support workers were being trained in how to use equipment that monitored people's physical health. They also carried information on normal physical health ranges. If people's physical health was outside normal range they would contact the team for advice from qualified staff.
- People did not receive medical reviews routinely. Consultants would use information from previous medical reviews if they had been carried out recently. In the care records we reviewed, we saw that medical reviews took place when required, for example to initiate medicine, monitor medicine or to conduct a comprehensive mental state examination. Consultants and doctors had sufficient capacity to carry out medical reviews in people's homes.
- All teams used the Health of the Nation Outcome Scales, which measures the health and social functioning of people with mental illness. The Meadowfield Hospital team used outcome scales that monitored people's depression and anxiety. They also monitored how people were benefitting from the weekly coping skills group by asking them to complete the group session rating scale. This allowed people to comment on the group, the facilitator and the topic.
- We found all teams carried out regular clinical audits based around people's care whilst under the team. We saw that the service manager at Langley Green Hospital team audited 10 care records per month. Work that was below standard was identified with an action plan, such as to be discussed within supervision. The consultant at the Department of Psychiatry team had recently audited the amount of different staff people saw during a crisis episode. This had been based on feedback that people felt they saw too many different staff. This audit had led to the team being more mindful about the geographic area they covered and making better use of hot desk facilities.

Skilled staff to deliver care

- The teams were multi-disciplinary to meet the needs of patients, and included social workers, occupational therapists, psychiatrists, psychologists, community psychiatric nurses and support workers. All teams had administrative support to enable the team to focus on

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clinical work rather than administrative tasks. Pharmacist support was available to all teams. We spoke with the pharmacist, who covered the Department of Psychiatry and Woodlands, and they told us they facilitated a medicine group which provided people with education around effective medicine management.

- All staff received a comprehensive induction when joining the trust. We saw the local induction pack for the Department of Psychiatry. It fully explained staff roles and expectations as well as covering site orientation, lone-working, care record security, wellbeing, health and safety and training information.
- We reviewed four supervision records at the Mill View Hospital team. Peer support was taking place monthly for all staff. However, line management supervision was less frequent, with one member of staff having had two supervision sessions in 2016 at the time of our inspection. Supervision notes demonstrated a discussion of team issues and dynamics but only one file showed any discussion of patient needs and discussion. There was limited evidence of staff training and development needs being discussed.
- Supervision across the other four teams was happening more frequently, although we noticed a significant improvement in the last two months across the service. We reviewed three supervision records at Langley Green Hospital and found them to be very thorough, with caseload and training needs discussed at length. Staff were also given the option to discuss their work life balance, and we saw how staff were given flexible shifts to manage things like their partner's pregnancy.
- We reviewed staff appraisal data for the Meadowfield Hospital and Langley Green Hospital teams and saw that all staff had received an appraisal within the last year.
- Staff across all teams were able to access additional training to enhance their roles. Training on offer included; working with self-neglect, complex personality disorders and motivational interviewing. Uptake on these additional training was varied and we were told that releasing staff for bespoke training was a challenge. We found that all teams had staff trained in mentoring students and being able to take blood samples.
- Team managers had good systems to be able to manage poor staff performance. We saw an example of this being used to good effect within the Langley Green Hospital Team. We also saw, within this team, an example of a staff member on long term sickness being well supported.

Multi-disciplinary and inter-agency team work

- All teams had regular team meeting where clinical and business issues could be discussed. We reviewed minutes from meetings across all teams and found many examples of staff discussing clinical issues and being updated on what was happening within the service.
- The crisis service attended a daily trust wide bed management meeting. This was attended by senior members of the management team in addition to team managers from crisis teams and community adult mental health teams. The meeting reviewed bed availability across the trust as well as the reasons for inpatient admissions in the last 24 hours. The meeting we observed included discussion of what additional action, if any, could have been taken to avoid these admissions. An agreement was made to schedule a review of one admission to see if there were any lessons that could be applied to reduce the likelihood of re-admission for the same patient, and other patients, in the future.
- We observed four handovers across the service. All staff attended, including medical and administrative staff, and contributed to holistic discussion around people's needs and progress. Work for the shift was clearly allocated by the shift co-ordinator.
- We found that all teams had good systems in place to share information with other services, in particular the inpatient wards and community adult mental health teams. Staff would attend team meetings of these services regularly. The Department of Psychiatry team and their local adult community team had developed robust care plans to support people presenting with complex personality disorders. It enabled both teams to give brief intensive support to these people whilst aiming to avoid a full crisis team admission. The Langley Green Hospital Team had recently introduced a more comprehensive handover every Monday. Following this, weekly summaries were recorded on CareNotes that allowed community care co-ordinators to keep track of progress without having to trawl through progress notes. The team also identified people approaching discharge so community teams could prioritise them for

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care co-ordinator allocation, if applicable. They responded to the fact that the community team had a waiting list for allocation by identifying a transitional worker. This worker visited people one day a week to allow them to be discharged from the crisis team whilst they were waiting care co-ordinator allocation.

- All teams had arrangements with their respective community adult mental health teams to joint assess referrals from primary care services if it was felt they might require crisis team support. This meant that people would not need to be assessed twice and reduced unnecessary stress.
- We viewed minutes from a multi-agency professionals meeting which discussed plans for a person who was regularly presenting to crisis services at Meadowfield Hospital. The outcome allowed all agencies involved to work consistently. We saw that presentations to crisis services reduced significantly following this meeting.
- All teams had good links with relevant agencies external to the trust. We saw contact details for safeguarding and housing services, displayed in all team bases.
- The service manager at the Department of Psychiatry had delivered training to the local GP surgeries aimed at reducing the amount of inappropriate referrals into secondary mental health services. We were also informed that secondary services in the Crawley area (Langley Green Hospital) offered a GP consultation line from 8.30am – 6.30pm which allowed GPs to discuss potential referrals with mental health workers.

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

- We found staff had good knowledge of the Mental Health Act which was mandatory training. We found that 68%, 76%, 48%, 65% and 55% of staff had completed it at the Department of Psychiatry, Woodlands, Langley Green Hospital, Mill View Hospital and Meadowfields Hospital teams respectively.
- Staff told us that they would support people in the community whilst on extended Section 17 leave from the ward. These arrangements were rare and would be reviewed weekly. The team ensured they had copies of relevant Mental Health Act documentation. We were told that this arrangement would be short term and, if it was extended, they would expect the person's section to be rescinded.
- We were told that if staff felt a person required assessment under the Mental Health Act, they would be referred to the approved mental health professionals who would take a lead on arranging this. The teams would put management plans in place to manage risk until the assessment took place.

Good practice in applying the Mental Capacity Act.

- Staff were required to complete training in the Mental Capacity Act. We found that 58%, 67%, 66%, 70% and 67% had completed training at the Department of Psychiatry, Woodlands, Langley Green Hospital, Mill View Hospital and Meadowfields Hospital teams respectively
- Staff we spoke with had some understanding of the Mental Capacity Act and its guiding principles. They told us that, although issues around people lacking capacity were rare, if they did have any concerns they would make the person an appointment with the team consultant.
- We found that teams did not routinely discuss advance decisions with people using the service and their carers. These allow people to make advance plans around issues such as treatment they would prefer and people they would like involved, if their mental state deteriorated to a point where they were unable to make informed decisions.

Health-based places of safety

Assessment of needs and planning of care

- We received data from the Department of Psychiatry, Langley Green Hospital and Woodland of health-based places of safety (HBPoS) use between 1 June 2016 and 31 August 2016. These facilities had been used 124 times, with three occasions, all at Langley Green Hospital, where people had remained for extended periods due to no bed availability. We also saw that a person under 18 was kept at the HBPoS at Meadowfield Hospital for over five days. We reviewed their care records and find that a clinical decision had been made to keep the young person there rather than admit to an adult ward. We saw that a specialist child and adolescent nurse from the community monitored them regularly.
- We reviewed care records and Mental Health Act documentation of 36 people who had been bought into HBPoS within the three months prior to our inspection. We found staff documentation at Meadowfield Hospital, Mill View Hospital and Woodlands to be of a high

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standard. We found some minor issues with documentation at the Department of Psychiatry and Langley Green Hospital. These concerned recording the time that Section 12 doctors and approved mental health professionals had been contacted or arrived; and recording that the person had their rights explained to them.

- We were told at all sites that availability of approved mental health professionals was an ongoing issue, particularly after 4pm and at weekends. This meant that people were not always assessed within three hours of arriving at the HBPoS, This practice did not comply with the Mental Health Act Code of Practice or the trust's own policy.
- Street triage teams assessed people in their vehicle or at a police station in order to produce a brief statement of risk and ongoing plan.

Best practice in treatment and care

- Street triage used appropriate Patient Group Directives (PGD) that allowed them to prescribe and administer certain sedating medications in emergency. Teams had locked medicine cupboards in police stations. The PGD had been in operation for nine months, prior to our inspection. We were told that the Hastings team had not needed to use it yet; however, they had the use of a locked box within the boot of their vehicle for this purpose. Pharmacists had inputted into decisions around medicine storage systems for street triage and further staff training was planned.
- Street triage vehicles carried defibrillators and we were told that this had recently been used to save someone life.
- All care records we viewed, and five people we spoke with, confirmed that a physical health check had been carried out on arrival at HBPoS.
- We saw that audits were in place to monitor use of all HBPoS. This included length of waiting time for assessment, length of stay, outcomes following assessment and data around gender, ethnicity and age. The service manager at Langley Green Hospital told us they had used this data to secure funding for a crisis lounge. This would free up HBPoS and inpatient beds by providing an area where people could wait for Section 136 aftercare and medicines for discharge.

Skilled staff to deliver care

- Staff were suitably qualified and received training specific to the role. All staff were confident in communicating with people in distress. We were told that restraint was rarely used and the majority was just supporting people by hand. HBPoS received 1003 presentations in the last year which is an average of 19 a week.
- Staff for HBPoS and street triage received supervision through their core teams that supported their specific roles. Street triage gave staff from across the acute care pathway the opportunity to shadow them as part of their continuing professional development.

Multi-disciplinary and inter-agency team work

- We saw minutes from a monthly meeting for HBPoS issues and quarterly meetings for street triage. They were attended by relevant stakeholders and reviewed practice and discussed incidents.
- The service manager at Langley Green Hospital told us they carried out a pilot in January 2016 that involved mental health workers accompanying the local ambulance service (SECAmb) on 999 calls concerning mental health. The pilot ran for 4 weeks on Friday – Sunday evening and staff responded to 28 calls. Of these only four needed to be taken to accident and emergency. A six month extended pilot was due to start in November 2016.

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

- We reviewed care records and Mental Health Act documentation of 36 people who had been bought into HBPoS within the three months prior to our inspection. We found staff documentation at Meadowfield Hospital, Mill View Hospital and Woodlands to be of a high standard. We found some gaps in documentation at the Department of Psychiatry and Langley Green Hospital. These concerned recording the time that Section 12 doctors and approved mental health professionals had been contacted or arrived; and recording that the person had their rights explained to them.

Good practice in applying the Mental Capacity Act.

- Staff had a good understanding of when people may be lacking capacity and how this could be tested. People's consent was gained before medicine or physical

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observations were given and this was recorded on CareNotes. Three out of the five people we spoke with who had used HBPoS told us they had been able to refuse medicine with no concerns.

- Staff would contact a consultant if people did not give consent and it was felt that giving treatment was in the person's best interests.

Good

Are services caring?

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

Our findings

Mental health crisis services

Kindness, dignity, respect and support

- Across all teams we observed staff that were committed to providing a positive experience for people who used the service. We accompanied staff from the Meadowfield Hospital team on a home visit and found staff respectful, compassionate and approachable. They were able to discuss sensitive issues, such as suicidality, in a way that allowed the person to feel comfortable and listened to. They displayed flexibility about when and where contact could take place. We observed staff at Woodlands considering how a person's current lack of contact with their children was having a negative impact on their mental health. The team agreed to arrange a contact visit for the person with their children.
- The mental healthline staff were supportive and kind in their conversations with callers. They were able to signpost appropriately, but also provided support and a friendly interaction to people in the community.
- We spoke to seven people, and two carers of people who used the service. All spoke highly of staff in terms of their communication, knowledge and professionalism. We viewed 33 comments collected from people who had used the Department of Psychiatry team between 1 April 2016 and the time of our inspection. Only one comment was negative, with two being neutral in terms of people feeling they were discharged too quickly. Staff across all teams were proud of their good work and celebrated compliments at team meetings.
- All staff had an understanding of the importance of maintaining people's confidentiality. We saw minutes from a Department of Psychiatry team meeting where staff discussed how they could be more flexible when assessing people in their preferred location. Staff explored how this could be done without other people hearing confidential information.

The involvement of people in the care they receive

- All teams actively involved people in care planning. Staff initially used three consecutive daily visits to support people and gain an understanding of issues that needed to be addressed. We saw evidence of collaborative care planning between people using the service and staff, although this was not always recorded accurately on CareNotes. Teams had good systems in place to allow this work to be done in people's homes.
- All teams allowed people to take ownership of their medicine unless there were identified risk issues. Staff were able to provide people with NHS endorsed information on medicine and pharmacists were available to provide further medicine management advice if necessary.
- All teams identified carers on their caseload board and routinely offered carers assessments. If these were outstanding, it was flagged on the caseload board so staff could follow it up. We spoke with two carers and both confirmed they had received support including the offer of a carers' assessment.
- We saw minutes from the Meadowfield Hospital team meeting where staff were made aware of a new carers' group and encouraged to promote it.
- We received data from the Department of Psychiatry team which showed they were giving people the opportunity to feedback on the service. It also showed they had a significant increase in responses over the two months prior to our inspection. Data received showed one response during June 1016, with 13 during July 2016 and six during August 2016.

Health-based places of safety

Kindness, dignity, respect and support

- We observed staff interacting with people who were using health-based places of safety (HBPoS). They were interacting with people in a polite and respectful manner. They kept themselves available and were responsive to people's needs.
- All people we spoke with had been treated with kindness and dignity whilst in HBPoS. We heard that staff kept them updated on what was happening, were approachable and observed them respectfully.
- All HBPoS had private side entrances. This meant people did not enter through main entrances maintaining their confidentiality, privacy and dignity.
- People were offered refreshments and toiletries so they were able to take a shower. One person, who had used the Meadowfield Hospital facility, told us that staff had washed their clothes for them. The Langley Green Hospital facility would offer music to help people relax.

Good

Are services caring?

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

The involvement of people in the care they receive

- People told us they were fully involved in their care whilst in HBPoS. All professionals explained their role and why they were assessing them. People felt involved in decisions about their care and that they were made in line with their best interests.
- People we spoke with were offered advocacy and solicitors.
- We saw that family members were contacted, kept up to date and invited to visit if assessments were delayed.
- People using HBPoS were able to give feedback through the friends and family survey.

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

Mental health crisis services

Access and discharge

- All teams were able to respond to urgent referrals. Staff had good knowledge of current caseloads supported by robust zoning systems, which meant they were able to identify work that could be rescheduled. This freed up qualified staff to respond to urgent referrals.
- Teams worked across large geographical areas effectively and used hot desk facilities within community mental health teams. This allowed them to manage their workload more effectively. Staff who wrote progress notes away from the team base would contact the shift co-ordinator with updates if necessary.
- The service did not operate 24 hours a day seven days a week.Between 9.30pm and 7am people who used the service could access support via the trust wide mental healthline or by attending accident and emergency departments. The service was unable to accommodate assessments in people's homes outside normal working hours. The Crisis Care Concordat recommends that 'service users and GPs have access to a local 24-hour helpline staffed by mental health and social care professionals' and that 'people in crisis referred to mental health secondary care services are assessed face to face within 4 hours in a community location that best suits them.'
- The mental healthline was staffed by unqualified staff, who offered guidance and support to people with mental health support needs across Sussex. Staff had full access to CareNotes, so could access current care plans and risk assessments for callers already known to the trust. Staff updated progress notes to ensure continuity of approach for individuals. Any escalation of risk could be logged directly into CareNotes to inform community staff of current concerns. Staff could access the senior nurse practitioner for advice and guidance if the nature of the call caused concern.However, the senior nurse practitioner was not always available as they also covered mental health assessment needs in accident and emergency.
- We observed the mental healthline staff taking calls from the public. They were able to deal with a variety of concerns and could tailor their responses to meet the needs of the individual. This included a general well-being conversation to sign-posting to other agencies for support. Staff used a clear algorithm to support them to decide when and how to escalate a call, should the need arise. This included clear guidance on when to use emergency services to respond to a caller in distress.Between 7am and 1pm there was only one member of staff available to answer the phone. Staff acknowledged that if they had to instigate an emergency 999 call to support the caller, this would require them to hang up the call on the helpline to phone the emergency services.This could potentially place callers at increased risk whilst the healthline staff spoke to the emergency services.
- The operational hours of the crisis teams meant that people who were having supervised sedative medicines, would have to take them relatively early. We were told that arrangements were made so that staff would do these tasks on their way home, however, this still meant the latest they could be given was around 9pm. The team at the Department of Psychiatry had one staff member working until midnight and were able to facilitate later visits. The trust did not have a policy to support people to travel to meet the senior nurse practitioner at the team base overnight, such as funds for taxis.
- We found all teams had clear criteria which did not exclude people. The Mill View Hospital team demonstrated a flexible approach to supporting a person who were at risk of malnutrition due to self-neglect. They devised a care plan which included monitoring of health and weight and the provision of meals. Initially meals were provided by the team, as part of the care plan, and developed to the person being supported to shop and cook for themselves as their health improved.
- A referral of a person known to the Woodlands team was re-activated without re-assessment as the patient had been assessed by psychiatric liaison in the accident and emergency department.The team had prior knowledge of the patient and recorded in the notes that the patient would be distressed by further re-assessment, it was therefore decided to re-allocate and support the person by using the existing assessment.

Are services responsive to people's needs?

Good

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

- People presenting to accident and emergency departments with mental health issues in East Sussex were transferred or directed to the urgent care lounge based at the Department of Psychiatry.This aimed to improve people's experience by providing a calm space whilst waiting for assessment. The service had been able to recruit a band five nurse and band two support worker to cover this facility 24 hours a day. The band five nurse worked until midnight; therefore, people could not be admitted after 11pm, although people already admitted would not be asked to leave. A sofa bed was available for people who stayed during the night.
- All teams offered people the option of starting clozapine whilst remaining in the community. Clozapine is an antipsychotic medicine which requires people's physical health to be strictly monitored in the first two weeks of use. All teams had clozapine care plans which ensured administration and monitoring guidance was followed. We were told that between February 2016 and August 2016 poor communication had led to people, starting clozapine, not being given the community option. This meant they were required to be admitted to hospital. We were told this had now been resolved and the team were again taking referrals for people being titrated on clozapine.
- All teams had different approaches to managing people who did not attend appointments. Teams would discuss these cases in handovers and act according to individual risks and past history. However, no team had clear criteria of steps that should be taken before it was deemed the person was safe to be discharged. The Langley Green Hospital team would often escalate people they were concerned about to Street Triage who could facilitate a visit with the police outside normal working hours.
- All teams offered flexibility with appointment times and location, including medical reviews, if appointments were rescheduled to respond to more urgent work, or staff were running late, people were informed as soon as possible.

The facilities promote recovery, comfort, dignity and confidentiality

- Teams had access to interview rooms to see people who preferred not to be seen at home. These were of appropriate size, soundproofed and had comfortable furniture.
- All sites we visited had waiting areas that contained information, such as local advocacy services and how to complain. The team at the Department of Psychiatry showed us a folder which contained up to date details of local agencies and groups that people could access for further support.

Meeting the needs of all people who use the service

- All sites we visited were accessible by wheelchair users, this extended to interview rooms within the sites.
- We saw minutes from a Meadowfield Hospital team meeting, where a tool was being made available for team managers to audit the team's interventions for people with autism. This meant they would automatically be flagged when on the caseload.
- Staff told us they were able to access information leaflets in other languages via the trust's intranet.
- Staff, including administrative staff, knew how to book interpreters. They also had access to interpreters via telephone.

Listening to and learning from concerns and complaints

- Between 1 June 2015 and 31 may 2016 the crisis teams received eight complaints. Three for the Langley Green Hospital team, two each for the Department of Psychiatry and Woodlands team, and one for the Mill View Hospital team. Two were fully upheld and two were partially upheld. All related to poor treatment or staff attitudes.
- All teams had information leaflets which contained information on how to complain and give feedback. Six out of seven people we spoke with told us they had been given information on how to complain, the other person was unsure.
- Staff knew how to handle complaints. We looked at minutes from team meetings across all teams and found that complaints were discussed, lessons were learnt and feedback was given.

Health-based places of safety

Are services responsive to people's needs?

Good

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

Access and discharge

- The Mental Health Act Code of Practice, paragraph 16.47, recommends that the assessment process will commence within 3 hours from the time of arrival at the health-based place of safety (HBPoS) where there are no clinical grounds to delay the assessment. We were told that this target was not always met due to availability of approved mental health professionals and section 12 doctors.
- We were aware that four people had remained in HBPoS for more than 72 hours at Meadowfield Hospital and Langley Green Hospital within the three months prior to our inspection. We were told that on all occasions that assessments had been completed and people were waiting for beds to become available. Langley Green Hospital was creating a crisis lounge to reduce these incidents.
- Street triage started in October 2013 as a pilot scheme and has since been commissioned across the trust. We received data that showed the service had contributed to a steady decrease in use of police custody as follows;
- 2011/2012 - 1036;
- 2012/2013 – 941;
- 2013/2014 – 794;
- 2014/2015 – 683;
- 2015/2016 – 119.
- We received data that showed that street triage had also contributed to an overall reduction in the use of HBPoS across the trust with 1003 people being detained in 2015/2016 compared to 1425 in 2014/2015. This also led to a reduction in transfers between police custody to HBPoS with 40 in 2015/2016 compared to 105 in 2014/2015. The Worthing street triage team (Meadowfield Hospital) responded to 20 call outs during July 2016. Of these, three were bought to HBPoS and 17 were either referred to the crisis team, psychiatric liaison at accident and emergency or discharged home with a request for assessment forwarded to their GP.
- Street triage teams had different commissioning arrangements and operated different hours. The Eastbourne team (Department of Psychiatry) worked 2pm to 10pm, 7days a week 2-10pm. The Hastings team (Woodlands) worked 9am to 9pm, Wednesday to Sunday. The Worthing team (Meadowfield Hospital) worked 3pm to 11pm, Monday to Friday and 7.30am to 11pm, at the weekend. We did not receive working times for the Crawley team (Langley Green Hospital).
- Across the trust there was no central system that allowed the police and street triage to easily find out which HBPoS were available. This meant people were often in police cars for extended periods whilst an available facility was found.

The facilities promote recovery, comfort, dignity and confidentiality

- People using HBPoS were provided with a safe where they could store their valuables. Systems were in place to ensure people's belongings were safeguarded.
- All HBPoS contained a bed or couch which allowed people to remain comfortable. We saw audits at Mill View Hospital which showed their mattress was cleaned regularly.
- Written information on people's rights was available, as well as information on advocacy and solicitors.

Meeting the needs of all people who use the service

- All HBPoS were accessible by wheelchairs.
- People had access to information to different languages.
- Staff were able to access interpreter. They could be booked for face to face contact or via telephone.
- One person, who used the Langley Green Hospital facility, was given information in their own language and privacy to pray.
- We were told that street triage teams working hours had been agreed based on need in their respective locations.

Listening to and learning from concerns and complaints

- Between 1 June 2015 and 31 may 2016 HBPoS had received one complaint. This related to poor treatment at the Langley Green Hospital facility.This completed was not upheld.
- Staff knew how to handle complaints. We looked at minutes from section 136 liaison meetings and found that complaints were discussed, lessons were learnt and feedback was given.

Are services well-led?

Good

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

Our findings

Mental health crisis services / Health-based places of safety.

Vision and values

- Most staff we spoke with understood and agreed with the trust's vision and values. Staff, who had recently completed the trust induction, told us that vision and values were discussed at length.
- All team leaders had a good oversight of issues relevant to their teams. Teams were integrated with consultants and administration staff working in the team office. This ensured that team objectives were discussed by everyone.
- Staff spoke highly of team leaders and senior managers and felt they were visible and approachable. We saw minutes of meeting across the teams which showed senior managers within the acute care pathway regularly attended.
- Some staff we spoke with did not know who the name of the chief executive. Staff told us they received information e-mails, from the chief executive, to inform them of developments in the trust, however, they could not remember the last time this had happened. We spoke with a trainee psychiatrist who told us the chief executive attended and contributed to a recent training event.

Good governance

- Crisis teams had good local governance systems in place to ensure effective and safe practice. However, all teams operated different service models in as a result of separate commissioning arrangements across the county.
- Lessons from incidents and best practice developments were not consistently shared across all locations within the trust, managers we spoke to acknowledged that they did not pro-actively engage as a group to ensure best practice was applied across all teams. This meant that resources could be wasted by teams duplicating development processes.
- Staff told us they prioritised direct care activities and this affected their focus on some issues such as supervision. We found that supervision rates had improved in all teams in the two months prior to our inspection.
- Staff we spoke with had a good understanding of safeguarding, Mental Health Act and Mental Capacity Act issues that were relevant to their caseload. However, staff were not always up to date in mandatory training in these areas.
- All teams had systems to flag adherence to key performance indicators on their caseload boards. These included, assessing physical health needs; offering carers assessments; and identifying children in the household.
- Team leaders told us that they had enough autonomy and resources, such as administrative support, to manage their teams. They also felt confident approaching senior managers for support.
- Staff were aware of the trust and local risk registers. They were able to submit items to this and local risk registers were agenda items in team meetings.

Leadership, morale and staff engagement

- Staff we spoke with enjoyed their roles. They felt support by colleagues and senior managers, who would assist with clinical issues, particularly when the service was busy. We saw how the Langley Green Hospital team had successfully adjusted their way of working in response to having a high caseload.
- According to data collected between 1 January 2016 and 31 March 2016, 38% of staff across the trust would recommend the trust as a place to work, whilst 35% would not recommend the trust as a place to work. This is below the national average of 62% and 19% respectively.
- Staff told us they received their work rota with sufficient time to be able to plan a healthy work life balance.
- Staff told us that they were not concerned by, or aware of, any recent incidents of bullying or harassment within their teams.
- Staff told us they knew how to whistleblow and would feel confident in doing so. Most said they would do this internally and were not aware they could raise concerns directly to the Care Quality Commission if they were concerned of repercussions.
- Staff felt able to input into service development. They told us that all decisions around service development are discussed at team meeting and they felt their opinions and feedback was taken into consideration.

Commitment to quality improvement and innovation

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.

- All five crisis teams had been part of a study conducted by University College London. The CORE crisis resolution team fidelity review rated 39 items that should be provided by crisis teams. Teams were reviewed and given a rating, then reviewed again one year later. The Woodland team started with an overall score of 131 out of 195, against an average of 120, and their score increased to 149 after a year. The team scored highly in accessibility to patients ; involvement with families and wider social networks; and visits are long enough to discuss patient and families' concerns. Areas identified for further improvement included the team helping to plan the patients' and service response to future crises, the provision of induction for new staff and ongoing training and supervision in core competencies.
- The Meadowfield Hospital team started with an overall score of 134 out of 195, against an average of 122, and their score increased to 153 after a year. The team scored highly in many areas, including providing clear information about treatment plans and visits; assessment of carers' needs; and provision of psychological intervention. Areas identified for further improvement included the team responding quickly to new referrals; and the team helping to plan the patients' and service response to future crises. We did not receive data, regarding the study, from the other teams.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Staffing Staff had not completed appropriate rates of mandatory training. The trust did not provided sufficient availability of face to face mandatory training. This was a breach of Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.