CareQuality Commission

Requires improvement 🟠

West London Mental Health NHS Trust

Community-based mental health services for adults of working age

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)
RKL14	Lakeside mental health unit and Hounslow community services	Hounslow Recovery Team East	TW3 1SE
RKL14	Lakeside mental health unit and Hounslow community services	Hounslow Recovery Team West	TW13 5AL
RKL14	Lakeside mental health unit and Hounslow community services	Hounslow Assessment Team	TW7 6AF
RKL14	Lakeside mental health unit and Hounslow community services	Hounslow Early Intervention Service	TW7 6AF
RKL53	St Bernard's and Ealing community services	Ealing Assessment Team	W7 3HL
RKL53	St Bernard's and Ealing community services	Ealing Recovery Team East	W3 8NJ

Summary of findings

RKL79	Hammersmith and Fulham mental health unit and community services	Hammersmith and Fulham Early Intervention Service	W6 8NF
RKL53	St Bernard's and Ealing community services	Ealing Recovery Team West	UB2 4AU
RKL53	St Bernard's and Ealing community services	Ealing Early Intervention Service	UB2 4AU
RKL79	Hammersmith and Fulham mental health unit and community services	Hammersmith and Fulham Recovery Team (2 sites)	W6 8LN W3 7RQ
RKL79	Hammersmith and Fulham mental health unit and community services	Hammersmith and Fulham Assessment Team	W6 8LN

This report describes our judgement of the quality of care provided within this core service by West London Mental Health NHS 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 West London Mental Health NHS Trust and these are brought together to inform our overall judgement of West London Mental Health NHS Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the community based mental health services for adults of working age as **requires improvement** because:

- Community recovery team had large numbers of patients being supported by duty workers and the caseloads of junior doctors were very high. There were not enough staff deployed in in the teams to safely meet the needs of all the patients on their caseloads.
- The premises in which some of the teams were based could present a risk to staff due to the alarm systems or the layout of the premises.
- Patient crisis plans were not always kept up to date. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis.
- Records of patient care and treatment were not always accurate or up to date.

- Records of patient care were not always easy for staff to find.
- Staff in the recovery teams were supporting people over the age of 65 but needed training to meet their specific needs

However, patients we spoke to, and comments cards we inspected, were mostly very positive about the service they received. Staff had a good understanding of safeguarding adults and children policies and the procedures to keep people safe from abuse. Local leaders were visible and accessible to staff and despite high caseloads, most patients told us they could get appointments when they most needed them. Patients told us that they could easily contact their care co-ordinators when they needed to speak with them. The service worked well with other teams and agencies to enable patients to move between services as their needs changed.

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:

- Community recovery team had large numbers of patients being supported by duty workers and the caseloads of junior doctors were very high. There were not enough staff deployed in the teams to safely meet the needs of all the patients on their caseloads.
- The premises in which some of the teams were based could present a risk to staff due to the alarm systems or the layout of the premises.
- Patient crisis plans were not always kept up to date. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis.

However, staff had a good understanding of safeguarding adults and children policies and the procedures to keep people safe from abuse. Premises used by patients were generally clean, comfortable and clutter free. Staff knew how to report incidents and most felt able to do so without fear of recrimination. Medication was stored safely and staff had a good understanding of infection control measures. Risks to patients were monitored in the daily "zoning meetings" and patients requiring extra support were effectively identified.

Requires improvement ●

Are services effective?

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

- Records of patient care and treatment were not always accurate or up to date.
- Records of patient care were not always easy for staff to find.
- Staff were supporting patients over the age of 65 but had not received training to meet their specific needs.

However, patients were assessed and treatment plans or referrals to other teams and agencies were made. Patients' physical health was considered and staff supported patients to address their physical health care needs if they were willing. Risk assessments for patients were routinely carried out and most were up to date. Patient information was stored securely. Training was available to enable staff to further develop their skills and there was good multi-disciplinary working within the teams. Staff had a good understanding of the Mental Health Act and the Mental Capacity Act. Patients were supported to develop their skills and move forward with their treatment.

Requires improvement ●

Summary of findings

Are services caring?	**Good** 🟢

We rated caring as **good** because:

- Patients and their carers or relatives told us that staff treated them with dignity, kindness and respect. We saw and heard very positive interactions between staff and patients. We saw many positive comment cards about how well supported patients felt.
- Care plans generally showed that patients, and their families where appropriate, had been involved in developing the care plan.
- Carers needs were routinely considered and they were supported in their role.
- Patients were supported and encouraged to move forward when they felt well enough and could be helped to find jobs and training opportunities.
- There were independent advocacy services available to support patients and carers if they needed it and these were well advertised throughout the service.
- Patients being given thorough explanations of their condition and their treatment plans and their questions or concerns were addressed.
- Patients were encouraged to provide feedback about the service via electronic machines in reception areas or via questionnaires. The service displayed patient feedback and showed how they had responded.

Are services responsive to people's needs?	**Good** 🟢

We rated responsive as **good** because:

- Patients were prioritised based upon their need and risk. Urgent referrals were seen promptly.
- Patients were able to move through the services as their needs changed, although there was a long waiting list in most areas for patients to see a psychologist.
- Staff were flexible wherever possible and appointments could be made to suit the patient.
- Staff actively monitored and supported patients who did not attend for their appointments.

However result of very high caseloads, doctors were not able to offer routine follow up appointments as quickly as they would have wished to. There were long waiting lists for some psychological therapies.

Are services well-led?	**Good** 🟢

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

Summary of findings

- Staff were aware of the trust's vision and values.
- Local leaders were visible and accessible to staff.
- Lessons learned from incidents were widely shared throughout the teams.
- Audits were being used to monitor and improve the services.
- Morale was generally good within the teams, despite high caseloads and organisational change.

However ongoing staff engagement is needed as senior managers were trying to encourage more staff feedback by introducing initiatives for staff to speak out without fear.

Summary of findings

Information about the service

West London Mental Health Trust provides a range of community-based mental health services for people of working age and older people with mental health problems.

Assessment teams provide an initial specialist mental health assessment of people referred to community mental health services. Following assessment, they refer patients to the most appropriate service to meet their needs.

Early intervention services (EIS) work with younger people who are experiencing a first episode of psychosis. They provide specific support and treatment over a three year period.

Community recovery teams support patients who have complex mental health and social care needs. They provide patients with longer term support. The recovery teams are "ageless" services which means they are not restricted to supporting patients of working age. However, the trust has separate cognitive impairment teams within the community who support and treat older adults with dementia and associated cognitive conditions.

We inspected the following services:

Hounslow assessment team;

Hounslow recovery team West:

Hounslow recovery team East;

Hounslow early intervention service;

Ealing assessment team;

Ealing recovery team West;

Ealing recovery team East;

Ealing early intervention service;

Hammersmith and Fulham assessment team;

Hammersmith and Fulham recovery team;

Hammersmith and Fulham early intervention service.

Hounslow community-based services were last inspected in June 2013. The other services have not been inspected before. There were no outstanding areas of non-compliance.

Our inspection team

The team was comprised of: a CQC inspection manager; two inspectors; a social worker; two senior nurses; a clinical psychologist; a consultant psychiatrist; and an expert by experience (a person with experience of using services).

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

- 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 at nine focus groups.

During the inspection visit, the inspection team:

- Visited twelve community services for adults of working age including: assessment teams; recovery teams; and early intervention services;
- Spoke with 54 patients who were using the services, either face to face or on the telephone;
- Spoke with ten carers or relatives of patients;
- Collected feedback from 153 patients and carers using CQC comment cards;
- Looked at 14 trust comment cards;
- Attended a carers forum;
- Attended a service user drop-in group provided by a voluntary sector organisation and spoke with a group of 8 patients;

- Spoke with the managers or interim managers of the teams;
- Spoke with 67 other staff members including: doctors; consultant psychiatrists; nurses; psychologists; occupational therapists; social workers; carer support staff; peer support workers; vocational workers; and administrative support staff
- Interviewed the clinical lead with responsibility for these services;
- Attended and observed eight home visits of patients who use services;
- Attended and observed 20 meetings including: meetings between patients and staff; referrals, allocation, business, reflective and multi-disciplinary meetings; and a discussion of high risk patients;
- Looked at 73 care and treatment records of patients; and
- 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

We spoke with patients and their relatives both in person and over the telephone. We received feedback from people from 153 comment cards which we collected from comment boxes that we had placed in community team offices before the inspection. We were also shown 14 comment cards from the trust comment box at Ealing assessment team. We attended a drop-in session at a local voluntary sector organisation for people who use mental health services and a carers forum in Ealing where we received feedback from patients and carers. Before the inspection visit, we met nine service user and carer groups. We also received information about community services from local organisations and individuals.

Most patients were very positive about the care and treatment they received. Patients described community staff as friendly, kind, helpful, respectful and polite. Most patients and carers felt listened to and included in their care. They felt they were offered choices in relation to their care and treatment. Some patients had copies of their care plans but others said they had not seen a care plan for a long time.

Patients liked the information leaflets staff gave them and remembered receiving information on local support groups and activities. Most patients said that, if they wanted them to be, their relatives were involved in their care. Some carers said communication with the community team could be better but also described being very happy with the support provided to them. Staff were responsive to patients' needs. Patients said that staff were aware of their cultural needs and took these into account. For example, patients who were fasting for Ramadan had been able to discuss and prepare for this with their care co-ordinator. Patients who were pregnant were able to discuss their treatment plans and were reassured by staff when they had questions concerning the effect of treatment on their pregnancy. Doctors and care co-ordinators addressed patients' physical healthcare needs as well as their mental health and offered patients support to access services such as smoking cessation.

One patient said that activity groups run by the early intervention service could be better. They did not always go ahead because of staff shortages. The patient really

Summary of findings

valued the group but had not felt involved in choosing the activities. Most patients using Hounslow early intervention service said they had a crisis plan in place. They knew who to contact if they were in crisis.

Before the inspection, people attending a local service user forum told us that appointments with the Hounslow recovery team East were sometimes cancelled and patients were not informed until they arrived. Some patients said they were "told off" if they were late and felt there was a pressure on staff to discharge them from the service.

The majority of patients we spoke with were unaware of the complaints process. However, most patients thought they would be able to find out how to complain if they needed to. Most patients told us that they had not had any cause to complain but felt confident that they would be listened to if they did complain. A number of patients told us that they were encouraged to provide feedback about the service and told us that they completed feedback forms. A few patients raised concerns about seeing different staff at every appointment and said there had been a lot of staff changes recently. They felt this affected the continuity of their care.

Good practice

- The trust provided a "primary care plus" service which was based at GP practices. The primary care plus team worked with GPs to provide care and treatment for patients' mental and physical health needs in one place. The service helped support patients who were being discharged from secondary care mental health services, such as the recovery teams and helped prevent the need for referral to secondary care. The service was set up in September 2013 and, having successfully established itself, was in the process of recruiting additional nurses with funding from the local clinical commissioning groups.

- Recovery teams had dedicated carer support workers who carried out assessments for carers of patients using the service and provided emotional support.

- Vocational workers and peer support workers were established in the service to provide patients with support to achieve their goals.

- Ealing recovery team West provided regular mindfulness groups for staff to help support them.

- A manager in one of the early intervention services had developed a series of workshops on spirituality, religion and culture called 'informing our mental health interventions' along with a cultural competency tool to help staff deliver interventions to diverse groups of patients and their families.

- The trust was developing a personality disorder pathway service which was based within the Hammersmith and Fulham recovery team but operated throughout the trust. The service had a "virtual team", providing consultations for staff to enable them to provide effective interventions for patients who had complex personality issues. The virtual team included a psychiatrist, an art therapist, a senior nurse and a psychologist. For patients who were ready to engage in more in depth psychological interventions, the service also provided direct therapy sessions.

- Ealing recovery team East provided clinic type sessions to support patients to manage their housing and welfare benefit related issues

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure there are sufficient suitably qualified staff so that patients have a care co-ordinator rather than being held by duty staff and junior doctors

are not holding large caseloads of patients, which creates a risk to the safety and welfare of patients. Recovery team patients must have a named clinician responsible for their care and treatment.

Summary of findings

- The trust must ensure that patients have personalised crisis plans that reflect their individual circumstances and must ensure these are up to date. These must be stored in patient records where they can be found quickly by all staff.

- The trust must ensure that the premises used by staff and patients are safe. The provider must ensure that staff safety alarms work and can be heard in an emergency

- The trust must ensure that accurate and complete patient care records are maintained.

- The trust must ensure that staff are trained to meet the specific needs of older patients.

Action the provider SHOULD take to improve

- The trust should ensure that the majority of staff working in the Ealing early intervention service are permanent employees in order to provide a more consistent staff team and consistent support to patients.

- The trust should ensure that all staff carrying out trust business follow the trust's lone working policy.

- The trust should take steps to inform all patients about how they can make a formal complaint about the service.

- The trust should ensure the premises used by the Ealing early intervention service is a comfortable temperature for staff and patients using them.

The trust should continue with its work to promote staff engagement so that staff feel able to raise issues or concerns without fear of reprisals.

Care Quality Commission

West London Mental Health NHS Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hounslow recovery team east	Lakeside mental health unit and Hounslow community services
Hounslow recovery team west	Lakeside mental health unit and Hounslow community services
Hounslow assessment team	Lakeside mental health unit and Hounslow community services
Hounslow early intervention service	Lakeside mental health unit and Hounslow community services
Ealing recovery team west	St Bernards and Ealing community services
Ealing recovery team east	St Bernards and Ealing community services
Ealing early intervention service	St Bernards and Ealing community services
Ealing assessment team	St Bernards and Ealing community services
Hammersmith and Fulham recovery team	Hammersmith and Fulham mental health unit and community services
Hammersmith and Fulham assessment team	Hammersmith and Fulham mental health unit and community services
Hammersmith and Fulham early intervention service	Hammersmith and Fulham mental health unit and community services

Detailed findings

Mental Health Act responsibilities

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

- We reviewed eight community treatment orders in different teams and found that staff had completed them appropriately. They were in date and had effective rationales.

- Staff said they had access to and received very good support from the MHA administrator.

- However, there were wireless connectivity problems at the Claybrook Centre and Old Oak Road where the Hammersmith and Fulham recovery team was based, which meant that it was difficult for staff employed by the local authority to check CTO information on the patient record database. This could cause delays for staff who needed to check CTOs.

- There were also inconsistencies in the "uploading" of approved mental health professional reports to the electronic patient record system which meant that not all CTO information could be accurately confirmed in a timely manner. We saw that managers had been informed of the connectivity problems in 2014 but the problems were still evident when we carried out the inspection.

- Staff had to complete MHA first tier tribunal reports for patients which impacted upon their workloads.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act.

- The majority of staff were aware of the process for assessing patients' capacity to consent.

- It was doctors who mainly carried out mental capacity assessments when other professionals would have been expected to have a greater role.

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

Summary of findings

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

- Community recovery team had large numbers of patients being supported by duty workers and the caseloads of junior doctors were very high. There were not enough staff deployed in the teams to safely meet the needs of all the patients on their caseloads.
- The premises in which some of the teams were based could present a risk to staff due to the alarm systems or the layout of the premises.
- Patient crisis plans were not always kept up to date. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis.

However, staff had a good understanding of safeguarding adults and children policies and the procedures to keep people safe from abuse. Premises used by patients were generally clean, comfortable and clutter free. Staff knew how to report incidents and most felt able to do so without fear of recrimination. Medication was stored safely and staff had a good understanding of infection control measures. Risks to patients were monitored in the daily "zoning meetings" and patients requiring extra support were effectively identified.

Our findings

Safe and clean environment

- Staff in some offices were issued with panic alarm fobs so that they could summon assistance in an emergency. This provided a safety measure for staff to see patients in an interview room on their own. Other offices had panic alarms fitted in the rooms where patients were seen. The alarm system at Hammersmith and Fulham assessment team had both a nurse call and a panic alarm. However, staff said the nurse call system could not be heard and they were trying to get this replaced with just one effective system. Some rooms where

patients were seen at Ealing recovery team east did not have panic alarms fitted and the manager said there were no plans to remedy this. Following the inspection, the trust told us that patients were risk assessed before being seen in the area. They also said they had added panic alarms to the list of renovation works and in the interim had reminded staff to use their lone worker devices when seeing patients alone in unalarmed offices.

- The teams had access to a clinic room on each site providing the equipment that staff needed to give patients effective treatment. Clinic rooms contained suitable equipment for patients to have a physical examination or to have a depot medication if required. Staff said the assessment teams rarely used their clinic rooms.

- Clinic rooms contained audit checklist logs for cleaning, temperature (room and fridge where applicable), infection control and equipment maintenance. Most audit check lists were completed routinely and effectively. Ealing assessment team at Cherrington House did not perform regular audits of checklist logs because they rarely used the clinic. We inspected the clinic room at Cherrington House and found the temperatures were correct, the clinic was clean and well organised and the medication kept there was in date and effectively stored.

- Most premises were clean and well-ordered in patient areas. A patient toilet at Ealing recovery team east had torn flooring and smelled strongly of urine and another had a bin which was over flowing, with the contents spilled onto the floor. The manager told us that funding for renovation works had been agreed and would be taking place in the near future which would address the toilets. Following the inspection, the trust told us that an additional bin had been provided in the toilet and the cleaner would empty the bins more frequently.

- All teams, except the Ealing early intervention service had easy access to emergency equipment. This was checked regularly to ensure it was fit for purpose. The Ealing early intervention service had access to emergency equipment kept by another team adjacent

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to the service. The Ealing early intervention service did not have a first aid box nor any trained first aiders in the unit; they relied upon the adjacent service to provide this.

- All sites, except the Ealing early intervention service, had automated external defibrillators available. The Hammersmith and Fulham recovery team had two, one in reception and one in the clinic room but the latter was not in use. A replacement had been ordered but had not arrived.

- Most services had closed circuit television cameras in operation which covered entrances and waiting areas. This provided an element of security for staff, patients and visitors to the premises.

- Service managers had carried out quarterly workplace assessments. These included assessments of the physical environment.

- Staff at the Ealing early intervention service were concerned about the security of the premises in which they worked and concerned about the safety of staff. The trust provided us with two identical copies of a workplace assessment conducted at the Ealing early intervention service premises. The two documents were dated 20 March 2015 and 16 June 2015. The reports identified that there were significant risks associated with the premises. These included blind spots where someone could easily hide near the entrance to the service. The service was located in an isolated part of the hospital site. Further risks were identified in the interview rooms. Patients and visitors could only be partially restricted from entering areas occupied by staff and no measures had been taken to secure the office area. The waiting room was small and the reception area offered no protection to the receptionist from anyone entering the building and did not prevent access to the office areas. The service manager told us that when the receptionist was on their own in the premises the door was kept locked as a precaution. He described a serious incident that had occurred in 2013 when a staff member had been attacked in the office and was unable to get away. Staff told us that known high risk patients were not seen in the office because of the risks involved. There was no local risk register in place and no indication that the risks were being regularly reviewed.

Staff and patients could be put at risk by the lack of security measures. Staff were not aware of any plans to improve security or to address any of the identified risks at the premises.

Safe staffing

- The trust provided us with information on the caseloads of all recovery team staff. This showed that the maximum caseload for a community psychiatric nurse in Hounslow recovery team east was 33, with 27 patients on care programme approach (CPA) which meant they were likely to have more complex needs and 6 receiving standard care. Two nurses had over 30 patients on their caseloads and two had caseloads of 25 – 29. Social worker caseloads were generally lower in order to take account of their particular work responsibilities, such as AMHP rota duties. The maximum caseload for a social worker in the team was 22. However, the team had 209 patients who had not been allocated to a named clinician. The trust told us most of these patients would be seeing a doctor rather than a nurse or social worker. Hounslow recovery team east staff told us that at least 60 patients were being supported by duty staff. Some teams had the same regular duty staff, which meant that patients who supported solely by the duty workers would be more likely to have contact with the same member of staff than if staff took turns in covering the duty role.

- There was a similar situation in Hounslow recovery team west. The maximum recorded caseload for a community nurse was 26, with five nurses holding over 20 patients. The maximum caseload for a social worker was 23 with most social workers having caseloads of fewer than 17 patients. One doctor was allocated 166 patients, with nine on CPA and 157 receiving standard care. In addition, 264 patients were not allocated to a named clinician.

- In the Ealing recovery team west two doctors had caseloads of over 175 patients. Most of these patients received standard care. Six community nurses were holding caseloads of 30 patients or more. The majority of their patients were on CPA. One social worker had a caseload of 29 and two had caseloads of 25-28. Thirty four patients were not allocated to a named clinician and 17 were allocated to the former team manager, who was no longer working at the service. The interim

Are services safe?

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manager of the team told us there were 10 patients awaiting allocation to a care co-ordinator and 12 more that would need to be reallocated as a staff member was leaving.

- In the Ealing recovery team east one doctor had a case load of 289, 283 of whom received standard care. Other doctors in the team had caseloads ranging from 1-250. One nurse had 31 patients, all of whom were on CPA. Eight nurses had caseloads of between 22-29 patients. Social worker caseloads generally ranged from 15-22. There were 2096 cases held in the team and ten cases not allocated to a team member.

- In the Hammersmith and Fulham recovery team one doctor had 103 cases, 101 of which received standard care and another held 82 cases, all but one of which were receiving standard care. While some doctors held one or two cases, most held between 40-60. One nurse had 30 cases, 28 of which were on CPA. Most nurses held case loads of between 17-29 with the majority of their cases being on CPA. 11 Social workers in the team held case loads of between 20 and 29. There were 2273 cases held in the team and 226 cases were not allocated to a member of the team.

- The high number of unallocated patients meant that caseloads for some doctors in particular were likely to be much higher than those recorded.

- As well as carrying out clinic consultations for patients; recording patient notes; providing consultation to other staff; performing duty rota responsibilities and "on call" rota cover; doctors had to check and confirm medication charts for community patients receiving depot injections. We checked the trust medicines policy reviewed in April 2015 and it confirmed that it is imperative that information was transcribed accurately to prevent errors and loss of information. With caseloads so high, there was a risk that junior doctors were not able to ensure that all patients received safe and high quality care and treatment.

- The inability of recovery teams across all boroughs to allocate care coordinators in a timely manner was recorded as 'red' or high risk on the trust risk register dated June 2015. The trust acknowledged there was a risk of delays to patient care and treatment. The risk register dated June 2015 also noted an 'amber' risk in relation to the failure of Hounslow recovery team west

to reduce caseloads resulting in deterioration in service quality and increased levels of risk. The Hammersmith and Fulham early intervention service had 14 cases waiting to be allocated to the recovery team, one of which had been waiting since October 2014. The inability of the recovery team to effectively allocate the patients who needed a care co-ordinator was having a negative impact upon the work load and efficiency of other teams as well as causing a delay for patients.

- The average caseload for staff in the Hounslow and Ealing early intervention service was between 11 and 22 patients. The proposed caseload size for the service had been 17 to 19 patients. The model of care included more face to face contact with patients in their first year within the service. This was gradually reduced over the three years the patient spent with the service. The model of care was evidence based but the high caseloads made it difficult for the early intervention services to achieve their goals. Staff told us the service had become more about risk management rather than being able to focus on the recovery needs of patients experiencing their first episode of psychosis. The service lead was disappointed that high caseloads seriously impacted the delivery of family interventions which they were not able to provide. The Hammersmith and Fulham early intervention service told us that a full time worker in the team should have 15 patients but they actually had 18 patients on their caseloads. However, they were able to provide family interventions for those patients assessed as requiring them.

- Trust staff vacancy figures showed that Ealing recovery team west had a vacancy rate of 10%. However, the trust staff vacancy information did not highlight that there were no permanent care co-ordinators working in the Ealing early intervention service. There were seven staff working in the service who were all locum staff. Four of the locums had been in the team for six months or less, one had been in post between six and 12 months and two had been in post for 18 months. The trust had agreed to increase the staff complement by two further posts. Two more locum staff were being recruited to fill those posts. The team had struggled to recruit and retain permanent staff. There was a risk to the consistency and continuity of care and treatment provided to patients by the failure to recruit permanent staff. Staff were concerned about locums who were new in post taking high risk patients. Staff told us that there

Are services safe?

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had been a recruitment "freeze" but they had been able to fill most vacancies with locum staff. Five out of thirteen nurse posts at Ealing recovery team east were vacant but all were covered by locum. Two of the locums had been in post for around two years and three for less than a year. There was one health care assistant vacancy which had been covered by a bank member of staff for over a year. Of the seven social worker posts in the team, there were three vacancies, two of which were covered by locums. Staff told us that three key members of the Hammersmith and Fulham assessment team were about to leave the team. The Hounslow assessment team had two vacancies for social workers. The team manager had tried on three occasions to recruit to the posts but had been unsuccessful in recruiting either permanent or locum staff.

- The clinical director for primary and planned care told us that vacancy rates in both the Ealing and Hammersmith & Fulham community teams were 25% and the vacancy rate in Hounslow community teams was slightly higher at 29%.

- The majority of adult community team staff had completed trust mandatory training. More than 75% had completed mandatory training in all areas except breakaway training (73%) and information governance (70%). Locum staff also completed trust training. Safeguarding training was provided by the local authority and staff who were required to, were trained to enquiry level (previously known as investigation level). The Hammersmith and Fulham early intervention service were 100% compliant with their mandatory training. Some locum workers told us that they had excellent access to training in the teams.

Assessing and managing risk to patients and staff

- We observed very good assessment and management of risk in most of the teams we visited. There was a robust risk management system in place that used a traffic light system of red, amber and greed to categorise risk. Teams held daily 'zoning' meetings where the multi-disciplinary teams discussed high risk patients that were being supported by the team. The zoning meetings also considered patients on the waiting list who were waiting to be allocated a care co-ordinator.

We saw that patients were allocated based upon their risk and need, not just based upon length of time they had been on the waiting list. This meant that those patients most in need were seen more quickly.

- There was inconsistent use of crisis plans across the teams. Most patients using Hounslow early intervention service said they had a crisis plan in place and they knew who to contact if they were in crisis. However, when we reviewed five patient care records in Hounslow recovery team east we found that although all five patients had crisis plans in place these had not been updated for four patients in more than 16 months. One patient's crisis plan had not been reviewed since 2010 and was clearly out of date. Two other patients' crisis plans had not been reviewed since 2012 and 2014 respectively. There was a potential risk to the safety of patients because crisis plans were not up to date. Out of date crisis plans were unlikely to be helpful to the patient in a crisis and may have caused delays in obtaining appropriate help. In the Ealing early intervention service we reviewed five patient care records and none of them had crisis plans in place. There was evidence of discussion of crisis plans with patients recorded in the progress notes but the crisis plans were not in a place where they could easily be found in the event of a crisis. In the Hounslow recovery team west we reviewed the records of two patients we had visited at home with their care co-ordinator. One patient had a crisis plan in place. The second patient had a crisis plan but this was dated 2010 and did not reflect the patient's current situation. The National Audit of Schizophrenia recorded that at 56%, the trust had a lower than average proportion of patients who reported knowing how to get help in a crisis. The average trust score for England was 74%.

- Staff were trained in safeguarding and knew how to make an alert. Almost all clinical staff and 87% of non-clinical staff had completed safeguarding children level 1 training and 92% of staff had completed safeguarding children level 2 training. 84% of staff had completed safeguarding adults training. There was a safeguarding lead in each team who could provide advice and staff knew who this was. The contact details for the child and adult safeguarding leads were on display in the service reception areas. The trust had a dedicated director of safeguarding supported by a safeguarding team. They had attended the Hounslow assessment team to talk

Are services safe?

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

through the new safeguarding policy and procedure with staff. Open safeguarding cases were discussed at multi-disciplinary meetings to ensure staff were aware of them. Progress with safeguarding enquiries was monitored and the patients had safeguarding protection plans in place. We observed staff raise a safeguarding concern during a multi-disciplinary meeting and we observed staff effectively dealing with safeguarding issues. Records showed that safeguarding concerns were regularly made and staff we spoke to showed confidence in the processes and procedures. Staff told us that they had excellent relationships with local police safeguarding teams.

- Patients taking certain medicines had their blood checked regularly to ensure they maintained therapeutic levels of the medicine and to detect any signs of serious side-effects. Medicines were stored securely and managed safely.

- The trust had a lone working policy in place to support staff working alone in the community and to promote their safety. However, staff and managers told us that some staff did not have a lone worker safety device issued to them for use on community visits. For example, locum staff in the Hounslow assessment team did not have a device and there were no plans to obtain more. Some staff who were based in the teams but employed by other organisations such as the local authority did not have a safety device and were told that this was due to funding issues. Many staff told us that lone working arrangements were sometimes not followed by team members. A number of staff told us that they had been issued with the safety devices but chose not to use them because they did not believe they would be effective in keeping them safe. The workplace inspection report for Hounslow recovery team west stated that not all staff had been issued with lone working devices and new devices were expected in July 2015. The team manager had also identified the need for staff to have training in the lone working policy. The trust acknowledged that if staff were not using safety devices or not following the lone working policy there was a risk of harm to staff. This was included on the trust risk register as a 'red' or high risk dated June 2015. Improvements in lone working practice were high on the

trust agenda and were discussed in team meetings. However, most teams were making effective use of staff "movement boards" and had systems in place to check if staff were not back when they had planned to be.

Track record on safety

- There were 29 serious incidents recorded in the last 12 months in the recovery, assessment and early intervention teams across all three boroughs. There were 11 suspected suicides between April 2014 and March 2015. Five of these deaths were of patients using the assessment team or recovery team west in Ealing.

- The Hounslow assessment team manager told us there had been 25 incident reports in the last year. These mostly related to verbal aggression, threats of violence and intoxicated people demanding to be seen.

Reporting incidents and learning from when things go wrong

- Staff knew what type of incidents they should report and how to report them. Staff had been given training and a briefing to enable them to report incidents appropriately. The clinical director of primary and planned care reviewed and graded all 72 hour incident reports and had good oversight of the incidents that occurred. Some staff said that the incident reporting system was complex but others said it was straight forward. Staff had been recently encouraged by their managers to complete incident recording and this was now reflected with standing agenda items in team meeting minutes.

- Staff told us they reported all incidents that happened. However, a few staff said they were reluctant to complete incident forms because they feared they would be blamed for what had happened.

- Staff had learnt lessons from when things had gone wrong. Incidents were discussed at clinical improvement group meeting and team meetings so the learning could be shared. This included learning from incidents that had occurred in other teams and services in the trust. Staff gave us examples of incidents that had occurred and the subsequent improvements that had been made as a result, to try and prevent the same incident from happening again.

Are services safe?

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- Information about learning from incidents across the trust was displayed on the front page of the trust intranet.

Are services effective?

Requires improvement ●

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

Summary of findings

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

- Records of patient care and treatment were not always accurate or up to date.
- Records of patient care were not always easy for staff to find.
- Staff were supporting patients over the age of 65 but had not received training to meet their specific needs.

However, patients were assessed and treatment plans or referrals to other teams and agencies were made. Patients' physical health was considered and staff supported patients to address their physical health care needs if they were willing. Risk assessments for patients were routinely carried out and most were up to date. Patient information was stored securely. Training was available to enable staff to further develop their skills and there was good multi-disciplinary working within the teams. Staff had a good understanding of the Mental Health Act and the Mental Capacity Act. Patients were supported to develop their skills and move forward with their treatment.

Our findings

Assessment of needs and planning of care

- Comprehensive assessments of patients' needs were carried out. Although, in one assessment we observed, the doctor made a very superficial assessment of the patient's needs. The Ealing assessment team used the electronic patient record 'progress notes' section to record assessment information which meant that as more entries were made, the information became harder for staff to find. This led to the risk of information not being easily available when staff needed it.

- Where needs had been identified there were usually care plans in place to address these. Patients' physical as well as mental health needs were addressed. Patients' physical health needs were also discussed in multi-disciplinary team meetings we observed.

- We reviewed 10 patient records in the Hounslow assessment team. All patients had a care plan in place.

The care plan formed part of the letter sent to patients' GPs. However, at the Hounslow recovery team west we reviewed the care records of two patients we had visited when accompanying a care co-ordinator. We noted that the care plans for both patients had not been reviewed for more than six months and did not reflect the patients' current needs.

- Information about patients was stored securely on the patients electronic records system. However, this was not always kept up to date and was sometimes inaccurate. For example, at Ealing recovery team west we accompanied a staff member on a home visit to a patient. The patient had been discharged from hospital two weeks earlier but their care record indicated they were still in hospital and their care plans had not been updated to reflect their return home. For another patient their medicine administration record indicated they were on a community treatment order. When we checked the patient's care record it was clear this had been rescinded some weeks before. Therefore, the record was not accurate and was confusing for staff. We reviewed four further patient care records at Ealing recovery west team and found recording was inconsistent and lacked important details. Three made no reference to patients' physical health needs. One patient's crisis plan identified relapse indicators but did not detail what should be done in those circumstances. For two patients, important information about them was only recorded in progress notes, including care plans and risk assessments. This made it difficult for anyone other than the care co-ordinator to find them. There was a risk that inappropriate care would be provided because care records were not always accurate or complete.

- Team managers told us that they reviewed case records during individual supervision with staff but there had been no formal auditing of patient care records to determine the accuracy and quality of recording.

- Managers in the Hammersmith and Fulham assessment team carried out weekly audits of assessments and AMHP assessment paperwork. Where information was missing they recorded this, advised the worker and also advised the worker's supervisor. The issues were then discussed in supervision. Managers were able to show us that this information was effectively utilised in order to support staff to improve their performance.

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Best practice in treatment and care

- We saw evidence that staff considered national institute for health and care excellence (NICE) guidelines when making treatment decisions. Staff were able to access NICE prescribing guidelines on the trust website. Doctors prescribed medicines in line with the guidelines. Staff in the early intervention service were aware of guidelines aimed at improving the physical health care of patients. Staff ensured that patients had regular physical health checks and an annual assessment.

- Psychological therapies offered were in accordance with those recommended by NICE. These included family interventions, cognitive behavioural therapy, acceptance and commitment therapy and dialectical behavioural therapy. Psychologists offered advice to other disciplines.

- Staff used health of the nation outcome scales to measure outcomes for patients. Psychologists measured outcomes for patients attending therapeutic groups before, during and after a course of treatment in order to assess their progress and the effectiveness of the therapy. Patient progress towards reaching their recovery goals was reviewed periodically. However, the early intervention service did not use any outcome measures or rating scales. They were working in partnership with a London university to develop appropriate outcome measures.

- Clinical staff participated in clinical audits.

- Staff considered the physical health needs of patients. These were discussed in staff meetings and referrals meetings. When the Hounslow assessment team received a non-GP referral they contacted the patient's GP to request a copy of their encounter record. This was to make sure they understood the physical as well as mental health needs of the patient. Patients in the recovery teams and early intervention service had an annual health check. Patients were supported to address physical health care issues such as smoking cessation if they wanted to. The National Audit of Schizophrenia recorded that the trust scored higher than the England average for monitoring patients' smoking, alcohol consumption and substance misuse.

Skilled staff to deliver care

- All new staff underwent an induction before they took up their full responsibilities. Locum staff were provided with a detailed induction to make sure they understood trust policies and procedures and the ethos of the service.

- Staff were able to undertake further training to equip them in their role. For example, some staff were studying for a master's degree, completing training in dual diagnosis and undertaking psychotherapy training. Three staff in the Hounslow early intervention service were undertaking a course in family interventions, which would enable them to deliver effective evidence-based interventions with patients and their families. However, psychologists told us opportunities for professional development were poor and they received little support from the trust. They had no protected time for research and some said they felt professionally isolated from their peers within the trust.

- The Early intervention service ran development workshops for staff. These covered topics such as relapse minimisation, compassionate focussed therapy and attention deficit hyperactivity disorder presentations within early intervention services. This helped staff develop their skills and knowledge. The Hammersmith and Fulham assessment team had a social worker with specialist knowledge of the Mental Capacity Act who delivered a training programme.

- The Hounslow assessment team staff attended a trust dual diagnosis forum every six weeks in order to improve the teams understanding of dual diagnosis issues. A consultant from the substance misuse service was due to meet the team to discuss any concerns they had and provide shadowing opportunities for staff. The Hammersmith and Fulham assessment team had a support worker who worked specifically with patients who had drug and alcohol issues.

- The recovery teams had become "ageless" services two years before and had started providing care and treatment to older patients with mental health problems. Staff told us that at the time of the change in age range they had been told they would receive additional training to ensure they were able to meet the needs of older patients effectively. However, this training had never been provided. This meant there was a risk

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that staff were not effective in meeting the needs of older patients because they were potentially unaware of some of the complexities and differences in needs compared with younger adults.

- A specialist old age psychiatrist provided one clinic per fortnight in support of the recovery teams. However, staff considered there was a shortfall in terms of old age psychiatric expertise in the teams. A consultant specialised in old age psychiatry attended the Ealing assessment team and provided home visits for patients when this was needed.

- Recovery team staff attended the complex care forum which took place monthly. The forum provided advice on the care and treatment of patients with personality disorders. The Hounslow recovery team east manager had invited an expert in personality disorders to provide three sessions to staff aimed at increasing their knowledge and skills in this area.

- Staff had received an annual performance appraisal in the last 12 months. Staff received regular individual supervision. Psychologists received supervision from a national leader in schema therapy. There were opportunities to attend reflective practice groups. Ealing recovery team west provided regular mindfulness groups for staff.

- Ealing recovery team east facilitated social workers to take temporary placements in their team in order to further develop their skills and experience.

Multi-disciplinary and inter-agency team work

- The community teams included nurses, social workers, psychologists, occupational therapists, carers support workers, peer support workers, vocational workers and medical staff. Hammersmith and Fulham assessment team also had a drug and alcohol advisor and a housing advisor in the team.

- Staff shared information and worked effectively. We attended a range of multi-disciplinary team meetings and saw how well the different disciplines worked together. We saw mutual professional respect within the teams.

- Hounslow assessment team staff wrote back to GPs with the outcome of any assessment including recommendations for further treatment and follow up. Letters following an urgent assessment were sent within

24 hours. For routine referrals the target was five days. The manager acknowledged that although most of the team were able to meet the target there was one clinician who was regularly late although this was being addressed. Other staff confirmed that some discharge letters had not been sent to GPs following assessments in 2014. Patients were given a copy of the letter.

- The Hounslow and the Ealing assessment teams met weekly with a link worker from the improving access to psychological therapies team to discuss referrals and outcomes. This helped facilitate safe and appropriate patient transfers. The Hounslow team also met with recovery team managers on a monthly basis in order to ensure that patients were safely transferred between the two teams. Managers acknowledged there were some difficulties transferring patients because of lack of capacity in the recovery teams.

- The recovery teams worked closely with the home treatment teams to prevent patients being admitted to hospital if they could be supported more intensively at home. It was recognised that there was a high demand for in-patient beds. Recovery team managers reported some communication difficulties with in-patient teams. Recovery teams sometimes received very little notice of CPA meetings which made it difficult for them to attend. This was a particular concern when a patient was nearing discharge from hospital. Managers attended the weekly bed management meetings to help identify patients who could be discharged back to the community.

- Most patients we asked were aware of the 24/7 service user telephone service which provided support, advice, information and sign posting

Adherence to the MHA and the MHA Code of Practice

- Eight community treatment orders (CTO) in different teams were reviewed and found staff had completed them appropriately. They were in date and had effective rationales.

- Staff had access to and received very good support from the MHA administrator.

- However, there were wireless connectivity problems at the Claybrook Centre and Old Oak Road where the Hammersmith and Fulham Recovery Team was based,

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which meant that it was difficult for staff employed by the local authority to check CTO information on the patient record database. This could cause delays for staff who needed to check CTOs.

- There were also inconsistencies in the "uploading" of approved mental health professional (AMHP) reports to the electronic patient record system which meant that not all CTO information could be accurately confirmed in a timely manner. Managers had been informed of the connectivity problems in 2014 but the problems were still evident when we carried out the inspection.

- Staff had to complete MHA first tier tribunal reports for patients which impacted upon their workloads.

Good practice in applying the MCA

- Staff had received training in the Mental Capacity Act.

- The majority of staff were aware of the process for assessing patients' capacity to consent.

- It was doctors who mainly carried out mental capacity assessments when other professionals would have been expected to have a greater role.

Are services caring?

Good 🟢

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

Summary of findings

We rated caring as **good** because:

- Patients and their carers or relatives told us that staff treated them with dignity, kindness and respect. We saw and heard very positive interactions between staff and patients. We saw many positive comment cards about how well supported patients felt.
- Care plans generally showed that patients, and their families where appropriate, had been involved in developing the care plan.
- Carers needs were routinely considered and they were supported in their role.
- Patients were supported and encouraged to move forward when they felt well enough and could be helped to find jobs and training opportunities.
- There were independent advocacy services available to support patients and carers if they needed it and these were well advertised throughout the service.
- Patients being given thorough explanations of their condition and their treatment plans and their questions or concerns were addressed.
- Patients were encouraged to provide feedback about the service via electronic machines in reception areas or via questionnaires. The service displayed patient feedback and showed how they had responded.

Our findings

Kindness, dignity, respect and support

- Staff spoke respectfully about their patients and showed concern for them during home visits and clinic appointments. Staff treated patients with kindness and respect. They actively listened to their opinions, questions and wishes. Staff used a person centred approach. Risk assessments and treatment options were discussed with patients.

- Most patients we spoke with, or received feedback from, were positive about the care and treatment they had received from the community mental health teams. Patients described community staff as friendly, kind, helpful, respectful and polite.

- Some patients said information about the service had been given to them whereas others had not. Patients liked the information leaflets staff gave them and remembered receiving information on local support groups and activities. Most patients said that their relatives were involved in their care if they wished them to be. Some carers said communication with the community team could be better but also described being very happy with the support provided to them.

- Staff showed a good understanding of the needs of individual patients. Staff were committed to patient care and care was patient centred.

- Staff were responsive to patients' needs. Reception staff were particularly responsive to patients' needs and most were well known to patients. We observed very kind interactions between reception staff and patients. We saw that telephones were answered swiftly and effectively.

The involvement of people in the care they receive

- Most patients and carers felt listened to and included in their care. They felt they were offered choices in relation to their care and treatment. Some patients had copies of their care plans but others said they had not seen a care plan for a long time. Patients in the early intervention service were encouraged to complete their own care plans. A patient of one of the recovery teams said they had been assisted to make an advance directive, which included their wishes should they need to be admitted to hospital in the future.

- On one occasion we observed a doctor assessing a patient and the doctor did not involve the patient in planning their care, did not explain treatment options and ignored the carer who was also present at the assessment. However, we also observed other sessions between doctors and patients and found that patients were encouraged to ask questions about their condition and their treatment plan whilst being shown kindness, dignity and respect. We observed two appointments where pregnant women had a lot of questions about how their condition and treatment might affect their unborn babies. The doctor had pre-empted some of the questions that the patients might have, and had

Are services caring?

Good ●

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prepared information about medication side effects and breastfeeding. We noted that the patients left the appointment feeling reassured and more informed about their treatment.

- Most teams had a carers support worker who worked exclusively with carers. They carried out carers' assessments and sign-posted carers to additional sources of help and assistance. They also provided short term emotional support. A carers charter and contact numbers for the carer support workers were displayed in waiting rooms. The carers support workers attended local carer forums. We also noted that staff listened to carers and worked out ways to support them and the patient, even when they wanted different things.

- Patients had access to a variety of independent advocacy services and support services which were well displayed in patient areas.

- Patients were able to give prompt feedback about the service they had received via electronic devices available at the reception desks. Responses to patient

comments and suggestions were displayed in waiting rooms. Posters reported what patients had said and what staff had done in response. Patients were also encouraged to give written feedback via questionnaires and a number of patients told us that they had done this.

- There were a number of service user led organisations in the local area. The trust had recently provided funding to establish the West London Collaborative, a social enterprise which aimed to be a self-sufficient and independent local organisation committed to improving health and social care services in the area. The West London Collaborative aimed to involve patients in developing the service.

- Vocational support workers were based in the teams, some funded by the Richmond Fellowship. They listened to patients and supported them to achieve their goals. Ten patients had been supported into work and ten into training between April 2014 and March 2015.

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as **good** because:

- Patients were prioritised based upon their need and risk. Urgent referrals were seen promptly.
- Patients were able to move through the services as their needs changed, although there was a long waiting list in most areas for patients to see a psychologist.
- Staff were flexible wherever possible and appointments could be made to suit the patient.
- Staff actively monitored and supported patients who did not attend for their appointments.

However result of very high caseloads, doctors were not able to offer routine follow up appointments as quickly as they would have wished to. There were long waiting lists for some psychological therapies.

Our findings

Access and discharge

- All community-based services had a target time of 77 days from referral to assessment and were far exceeding their target times. The Ealing early intervention service had a mean of 20 days from patient referral to assessment, for Hounslow it was 15 days and Hammersmith & Fulham it was 12 days. The service target for new admissions to the early intervention service was 45 each year.

- About 60% of early intervention service patients were discharged to primary care within three years of being taken on by the service.

- The Hounslow assessment team received 180 referrals every month. The Ealing assessment service received an average of 137 referrals a month between February and May 2015. During the same 4 month period they discharged an average of 119 patients, transferring the remainder to other teams. The trust risk register dated June 2015 recorded that the team were not achieving their target for seeing new referrals (emergency - 4 hours; urgent - 24 hours; routine plus - 7 days; routine – 4 weeks). Whilst they took every effort to ensure that referrals deemed "emergency" or "urgent" were seen as

soon as possible, the service could not meet the target. This risk register recorded this as a red risk. It also recorded as a red risk that patients and other professionals were experiencing difficulties accessing the team by telephone during normal working hours. Referrals to the assessment teams were generally made by GPs and were prioritised according to risk. The teams aimed to keep two emergency appointments available every day so that patients could be seen promptly. Most assessments were carried out face to face. However, the service was flexible and assessments were sometimes completed on the telephone, especially if a person had not attended their agreed appointment. Assessments could also be carried out in a patient's home if this worked best for them.

- About 40% of patients seen by the Hounslow assessment team were referred on to the recovery teams. The assessment team and early intervention teams reported delays in transferring patients to the recovery teams because of the pressure on the recovery teams caused by large caseloads. The Hounslow early intervention team described delays of between six and eight months waiting to transfer patients to the recovery teams. Between 30% and 40% of patients were transferred to the recovery teams from the early intervention service.

- Recovery teams triaged all referrals in order to determine who was at higher risk and should be seen quickly. Less urgent referrals waited four or five weeks to be seen by a doctor. The duty worker provided support to patients in the interim if they needed help. Doctors were also involved in supporting the duty system.

- Ealing recovery team west provided nurse led clinics at a satellite venue in order to improve access for patients. An additional 90 appointments had been created by the team.

This was set up in response to the anticipated transfer of 200 patients who were being held on the caseloads of doctors in the assessment team, which was considered inappropriate.

- As part of the 'shifting settings of care agenda' recovery teams were trying to move patients who had ongoing mental health conditions, but were stable enough, back to primary care so that they could be monitored and supported by their GP. Shifting settings of care aims to

Are services responsive to people's needs?

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

promote patients' independence, social inclusion and recovery and allow GPs to 'join up' physical and mental health care more effectively. For example, Hounslow recovery team east had a target to discharge 54 patients back to their GP or to the primary care plus team, who acted as a step down between primary care and the recovery teams, every month. Since 1 April 2015 they had been achieving this target. Links between the primary care plus team and the community teams were good.

- The Ealing recovery team west ran a 'virtual' clinic where they reviewed patients who had not been seen in the last six months and no future appointments had been set. The 'virtual' clinic included a doctor and decisions were made as to whether the patient should be discharged directly to primary care or primary care plus or whether they needed to be seen by the team. The team had discharged 38 patients in May 2015. Other teams also used the 'virtual' model.

- Many staff reported how useful it was to be able to refer patients with less complex needs to the primary care plus team prior to discharge back to their GP. Primary care plus acted as a step up or step down between recovery and assessment teams and GPs and supported GPs and patients as they moved between primary and secondary care. The majority of GP practices had signed up to primary care plus in the three boroughs. More nurses were being recruited to the primary care plus service which would enable more patients to be supported locally by their GP.

- The Hounslow assessment team sent a text message to patients seven days in advance to remind them about their appointment. This was part of an effort to reduce the number of patients who 'did not attend' (DNA) their appointment. The DNA rate for first appointments was 17%. The team was working towards reducing this to a target of 15%. Several other teams also told us they texted appointment reminders to patients.

- There was a safe discharge protocol in place outlining how patients should be discharged from secondary mental health care to primary care.

- All community teams could usually arrange urgent appointments for patients at short notice and most patients we talked to confirmed this.

- Before the inspection, people attending a local service user forum told us that appointments with the Hounslow recovery team east were sometimes cancelled and patients were not informed of the cancellation until they arrived. Some patients said they were 'told off' if they were late and felt there was a pressure on staff to discharge them from the service. One patient told us they had seen a different doctor at their last eight successive appointments. They had difficulty relating to new people and were frustrated by continually having to retell their history.

- The Hounslow recovery team west had responded to feedback from patients that they sometimes had to wait to been seen past their allotted appointment time because clinics were running late. The team had tried to improve waiting times. Data showed that 49% of patients were seen within 10 minutes of their appointment; 37% within 11-20 minutes; 8% within 21-30 minutes; and 6% were seen more than 30 minutes late. The trust risk register recorded a red risk on April 2015 because the telephone system was not working effectively. This posed a significant risk to patients who might be unable to contact the team when they needed support in a crisis. This was still showing as a red risk on June 2015.

- Waiting times for patients referred to psychology by the early intervention teams was four to eight weeks. In Ealing recovery team west the waiting time to see a psychologist was six months and there were 62 patients on the waiting list at the time of our visit. The waiting time for psychology was seven months in Hounslow recovery team east. The team had tried to shorten waits for psychological interventions by increasing the number of psychology led therapeutic groups provided. Hammersmith and Fulham ssessment Teams and recovery teams reported that patients had to wait between one and two years to see a psychologist.

The facilities promote recovery, comfort, dignity and confidentiality

- Several teams told us they had difficulty accessing rooms where they could see patients. This was a particular problem in the Hounslow assessment team. Staff at Hammersmith & Fulham recovery team were concerned that this would be a major problem for them when the Old Oak Road site closed and all consultations would need to take place at the Claybrook Centre

Are services responsive to people's needs?

Good 🟢

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because they felt there were not enough rooms to see all of the patients that needed a consultation. Staff described rooms in the Ealing recovery team west premises as very hot in summer. Portable fans had been purchased to make the rooms more comfortable. A workplace assessment conducted at the Ealing early intervention service premises in March 2015 identified that heating levels in the team premises were 'often unbearably hot'. It was reported that the issue was well known and no action to address it had been planned. There were no rooms to see patients at the Hammersmith and Fulham early intervention service so staff used rooms in the nearby Claybrook Centre, which meant a 5-6 minute walk from their offices, across the hospital site.

- Staff at the Ealing early intervention service had raised concerns about the safety and comfort of the premises a number of times over the past two years but nothing had changed.

- Information on local services, particular mental health conditions and the performance of the community teams was on display in waiting areas at team premises. All sites displayed a wealth of local information for patients regarding advocacy services, social activities, employment support opportunities, and support groups. The trust recovery college was advertised and up to date prospectuses were available for patients and carers to take away. There were some out of date CPA leaflets in the Claybrook Centre, dating from January 2008 which were no longer relevant following changes to CPA in October 2008.

- Early intervention teams supported patients to take part in activities and ran regular outing groups such as visits to the coast, the cinema, museums and the theatre. There were regular hobby and music groups. One patient we spoke with said that activity groups run by the early intervention service could be better. They reported the groups did not always go ahead because of staff shortages. The patient really valued the group but had not felt involved in choosing the activities. Other patients told us that there were a lot of group activities that they really enjoyed and benefited from.

- The occupational therapist at Hounslow recovery team west provided gardening activities, cooking groups and anxiety management groups to patients. Patients were linked with community based activities and existing groups in the local area.

Meeting the needs of all people who use the service

- People with mobility issues and who used wheelchairs could access most community team venues. Consultation rooms were available on the ground floor. Except at the Ealing early intervention service where access to the office was via a spiral staircase. Staff could see patients at alternative venues if it was better for patients. Group therapy sessions and psychology appointments were held upstairs at Ealing recovery team east and there was no lift but staff said most patients with mobility needs could be seen in a ground floor consultation room if necessary. However, staff also said that there were limited consultation rooms at the site.

- Medicine information leaflets and leaflets about different mental health issues were available in a range of different languages. Staff used the trust intranet to locate and print out the version the patient required. Staff were able to obtain interpreters when they needed them to facilitate appointments with patients who did not speak English or were not confident in English. Care plans and clinic letters were translated in other languages when needed. Some waiting areas displayed welcome signs which displayed the word welcome in many different languages.

- Teams worked with a variety of local groups to support patients. These included cultural groups, groups supporting victims of domestic violence and rape, and a youth counselling service.

- Information on spiritual and pastoral care was displayed in waiting rooms. There was a multi-faith room available for patients at Lakeside mental health unit where the Hounslow assessment team and Hounslow early intervention service were based.

- The trust had produced information for staff on how to provide care and treatment to transgender patients more effectively.

Are services responsive to people's needs?

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

- Staff were culturally aware and understood the needs of their local communities. Training was also available for staff to enable them to gain a greater understanding of the different cultural beliefs that were held about mental health.

- Patients using the community services were representative of the local population.

- Patients could choose the gender of their care co-ordinator. Where staff spoke the same language as a patient this was taken into account when allocating them a care co-ordinator. Some teams were able to offer psychological interventions in the patient's first language without using an interpreter. For example, a psychologist in the Ealing recovery team west was fluent in Hindi, a language which was widely spoken locally.

- One early intervention service manager had developed a series of workshops on spirituality, religion and culture: informing our mental health interventions and a cultural competency tool to help staff deliver interventions to a diverse patient and family group.

Listening to and learning from concerns and complaints

- The trust received 72 complaints relating to adult community services between January and December 2014. This was 20% of all trust complaints. Eleven complaints were made about the recovery and assessment teams in Hounslow. These were mostly about staff attitude, communication and treatment. Eight complaints were upheld or were still being investigated. Twenty nine complaints related to the recovery teams in Ealing and five were about Ealing assessment team. The majority of complaints were related to dissatisfaction with care and treatment. Twenty four of the complaints were upheld or were still open. In Hounslow there had been two complaints, one of which was upheld. The upheld complaint was about a delayed/cancelled appointment. There were a further 25 complaints about recovery and assessment teams. However, it was not clear from trust data in which particular borough these had been made. These complaints showed similar themes to the others.

- Managers had received training in how to conduct an investigation and complaint resolution.

- Team managers told us about complaints that had been made by patients and how they responded positively and used the experience to make improvements in the services. Some managers told us how formal complaints were averted because patients gave feedback which enabled staff to take positive action to remedy the situation.

- Information on how to complain was displayed in waiting rooms where patients visiting the premises could see it.

- The majority of patients we spoke with said they were unaware of the complaints process. Several thought they would be able to find this out or would contact the service manager. There were mixed views on whether staff would listen to and act on complaints. Some patients doubted their complaint would be taken seriously. Whereas one patient described how they had been assisted by their care co-ordinator to make a complaint. Some patients told us that although they had never had cause to make a complaint and did not know how to, they felt confident that they would be listened to if they did make a complaint.

- Some teams forwarded informal complaints to the patient advice and liaison service, once they had been resolved, where the themes of the complaints could be captured. Otherwise informal complaints from patients and carers were generally not recorded. This meant some staff teams might miss the opportunity to learn from them.

- Information was displayed on notice boards in service waiting rooms highlighting improvements that had been made to the service in response to complaints and suggestions from patients and carers. There were clear examples showing what patients had said and how things had improved as a result, such as changes to the chairs in the waiting room at Ealing assessment team and new furniture in the patient social area at Ealing recovery team east.

- We were shown six compliments for the assessment teams and six for the recovery teams. The compliments were from a variety of sources including: family; patients; other organisations who were pleased with the response times; and GPs who thanked the service for the support they provided to patients.

Are services responsive to people's needs?

Good ●

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

- We looked at 153 CQC comment cards that related to the service. We also looked at 14 trust comment cards that were left in the reception are of the Ealing assessment team. They were overwhelmingly positive: 142 positive; 14 negative; 11 mixed; and 3 blank. Positive comments often referred to the kindness and understanding shown to patients by staff. Negative comments described some buildings as not being clean or comfortable and some said staff had too many cases and it took too long to get any support.

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.

Summary of findings

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

- Staff were aware of the trust's vision and values.
- Local leaders were visible and accessible to staff.
- Lessons learned from incidents were widely shared throughout the teams.
- Audits were being used to monitor and improve the services.
- Morale was generally good within the teams, despite high caseloads and organisational change.

However ongoing staff engagement is needed as senior managers were trying to encourage more staff feedback by introducing initiatives for staff to speak out without fear.

Our findings

Vision and values

- Staff understood the vision and values of the trust.

Good governance

- Staff knew who the senior managers were in the trust and some were aware that senior managers had visited their work places. The chief executive had visited some of the teams. Most were positive that the new trust senior management team in the trust would be able to make the necessary improvements to services. Others were more cautious about the difference they would be able to make.

- The adult community teams were well led. Staff felt supported by their team managers who were well respected.

- Staff informed patients and carers when errors had been made or things had gone wrong and apologised. Managers provided examples of when this had happened. They were aware of the duty of candour and the need for openness when mistakes had been made. Ealing recovery team East openly displayed the number of CPA reviews that were overdue.

- Staff at band 7 and above were encouraged to attend leadership training. Many managers we spoke with had completed this training, which had been helpful. Mentors were provided for new managers who said they found this helpful.

- Local clinical improvement group meetings had been implemented in all of the teams. These meetings involved the whole team and focussed on operational issues, the results of audits, new research, safeguarding, and learning from incidents and complaints. Minutes of local clinical improvement group meetings were sent to more senior level clinical improvement groups. This helped facilitate communication between the frontline staff and senior management and the trust board. The clinical director for primary and planned care saw all minutes from clinical improvement groups. He acknowledged that the quality of the groups varied - some were excellent and some were quite poor.

- Service managers had access to "scorecards" that measured the team performance on a range of key performance indicators. These included complaints, incidents, seven day follow by recovery teams post-discharge and patients not attending appointments (DNAs). Where shortfalls were identified action plans were put in place to bring about improvements. For example, in the Hounslow assessment team there was an action plan in place to improve the rate of DNAs. The Hounslow recovery team east had missed three seven day follow ups of patients during the previous month. This was being closely monitored by the manager. The Ealing assessment team had a clear "action plan" but it did not show timescales for the planned steps to achieve the actions.

- Managers had access to a scorecard that included information on staff training. The system flagged when staff mandatory training was about to expire. Most staff in the community teams were up to date with mandatory training. Managers were also advised by the flag system when staff registration renewal and disclosure and barring checks were due.

- The clinical director for primary and planned care was responsible for the recovery teams and early intervention service. He was aware of the high caseloads and the number of patients who were not formally allocated to a named clinician. There were plans in place to review the patient care pathway to ensure

Are services well-led?

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seamless patient transfers between the early intervention services and recovery teams. Some progress had already been made on lowering caseload sizes and determining who required care and treatment from recovery teams.

Leadership, morale and staff engagement

- Staff sickness rates for Ealing recovery team west was (8%) and Hounslow recovery team east (9%) were slightly higher than the average sickness rate for all trust community teams, which was 6.5%.

- Staff were aware of how to raise concerns. However, they had different opinions as to whether they felt safe to admit mistakes or raise concerns within the trust without fear of blame and victimisation. Some staff were confident they could raise concerns. Two staff provided examples of where they had contacted the chief executive of the trust in response to the 'speak up Fridays' initiative that encouraged staff to raise concerns. However, other staff told us they were afraid to report incidents and mistakes in case it led to them being blamed or bullied. Some staff gave examples of having raised concerns but felt they were not treated fairly as a result which made them less comfortable raising concerns in the future. The clinical director monitored serious incidents and was aware that the tone of emails sent by senior managers in response to incident reports were not always helpful. He acknowledged the need to address this issue and restore trust amongst staff.

- Staff spoke of an improving culture within the teams. Staff were expressing increasing levels of respect for other disciplines.

- Most staff talked of good morale in their teams but some felt that a lot of recent organisational changes and high caseloads in the service made it difficult for them to maintain good morale.

Commitment to quality improvement and innovation

- The early intervention service was working closely with a London university on the development and demonstration of outcome measures for patients using the service.

- Peer support workers were based in most teams to bring an added element of support for patients. They had experience of using mental health services. A benefits clinic was also provided which patients could self-refer to. The Ealing recover team west held benefit and housing clinics to support patients with their wider needs.

- Vocational support workers were deployed in some teams. They supported patients to access employment and training opportunities. Between April 2014 and March 2015 ten patients had been successfully supported into employment and ten into training across the service.

- Early intervention service staff were encouraging patients to participate in a study called the 'circle study – cutting down or quitting cannabis' which was being run by a London university. There was a financial incentive for patients to participate in the study and for those who succeeded in giving up cannabis.

This section is primarily information for the provider
Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. • Patient crisis plans were not always kept up to date. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis. • Premises used by the community teams were not all safe to use for seeing patients and families. This was in breach of regulation 12 (1)(a)(b)(d)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems in place to ensure that accurate records of patients' care and treatment were maintained were not effective. This was in breach of regulation 17(1)(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough suitably qualified staff deployed in the adult community services to meet the needs of all patients on team caseloads safely and effectively. The staff need to be trained to support the specific needs of patients over the age of 65. This was in breach of regulation 18(1)