



Central and North West London NHS Foundation
Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV3Y1	Campbell Centre	<ul style="list-style-type: none">Milton Keynes home treatment teamMilton Keynes Psychiatric Liaison teamMilton Keynes health-based place of safety	MK6 5NG
RV3AN	Hillingdon Hospital Mental Health Centre	<ul style="list-style-type: none">Hillingdon home treatment team	UB8 3NN

Summary of findings

		<ul style="list-style-type: none"> • Hillingdon Psychiatric Liaison team • Hillingdon health-based place of safety 	
RV383	Northwick Park Mental Health Centre	<ul style="list-style-type: none"> • Harrow home treatment team • Northwick Park Psychiatric Liaison team • Harrow health-based place of safety 	HA1 3UJ
RV312	Park Royal Centre for Mental Health	<ul style="list-style-type: none"> • Brent home treatment team • Brent health-based place of safety 	NW10 7NS
RV320	St Charles Mental Health Centre	<ul style="list-style-type: none"> • North Kensington home treatment team • Urgent advice line 	W10 6DZ
RV346	The Gordon Hospital	<ul style="list-style-type: none"> • South Westminster home treatment team • Health-based place of safety 	SW1V 2RH
RV3EE	Stephenson House	<ul style="list-style-type: none"> • Chelsea and Westminster Psychiatric Liaison team 	NW1 2PL

This report describes our judgement of the quality of care provided within this core service by Central and North West London NHS foundation trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Central and North West London NHS foundation trust and these are brought together to inform our overall judgement of Central and North West London NHS foundation trust.

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

In general, the teams were well managed. Staff supported people with complex needs in a caring and supportive manner. Staff received mandatory training and were appraised and supervised, incidents were reported and investigated, staff participated in audits, and safeguarding and Mental Health Act procedures were followed. Staff knew about the whistle-blowing process.

Staff morale was high in most of the teams we visited. Many staff told us they were proud of the job they did and felt well supported in their roles.

However in the responsive domain we found that:

- People who were assessed as requiring inpatient beds experienced long delays before being admitted. The delays in accessing inpatient beds meant that some people received care that did not meet their needs.

- The places of safety at the Gordon hospital and Park Royal had no separate access. This meant that people had their privacy compromised as they arrived at the places of safety.
- In the North Kensington team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

At the Gordon Hospital the two place of safety rooms both contained ligature points. The toilet for use of people was also not ligature free. Although staff could manage risk through observation, the environment meant people could not be supported safely without compromising their privacy. The trust had agreed to the refurbishment of the place of safety and work was starting in April 2015.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

Systems, such as daily handovers, were in place to discuss and manage risks for people. However, risk assessment documentation on the electronic notes system was sometimes simplistic and did not reflect updated risks.

Staffing was safe and met the needs of people, although the Milton Keynes psychiatric liaison team was stretched. Sickness rates across all of the teams were low. Staff were trained in safeguarding and knew how to make a safeguarding alert.

There were good medicines management practices including transport, storage and dispensing across all the teams.

Staff were aware of how to report incidents. All teams were able to identify learning from incidents and how they had implemented this in their work. There was variation between the teams in how they managed the risks associated with lone working. Most teams had robust systems in place, although in some the system was not as clear.

However at the Gordon Hospital the two place of safety rooms both contained ligature points. The toilet for use of people using the service was also not ligature free. Although staff could manage risk through observation, the environment meant people could not be supported safely without compromising their privacy. The trust has agreed to the refurbishment of the place of safety and work was beginning in April 2015.

Good



Are services effective?

We rated effective as **good** because:

Across all of the teams assessments were completed quickly with referrals being assessed promptly. There were effective handovers within each team, with risks being discussed appropriately.

Staff across all teams received mandatory training, supervision and appraisal and had access to team meetings.

Staff followed NICE (National Institute of health and care excellence) guidance when prescribing medication. Staff had received training in the Mental Health Act and had an understanding of the requirements of it. Staff completed mandatory training in the Mental Capacity Act but application was mixed across the teams.

Good



Summary of findings

However there was a variable standard of care records across the teams with care plan information being limited in some of the teams. The Brent and Harrow teams' care plans were more detailed. Records in other teams were less detailed.

Are services caring?

We rated caring as **good** because:

In all the teams we observed the staff to be kind, caring and compassionate. Feedback from people using the service was generally positive.

People received a welcome pack with information about the service. This was more detailed in some teams than others. Advocacy services were available if people required them.

The mechanism for collecting feedback and the response rates varied between teams. The teams should consider ways to ensure they collect regular feedback from people who have used their services.

Good



Are services responsive to people's needs?

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

- People who were assessed as requiring inpatient beds experienced long delays before being admitted. The delays in accessing inpatient beds meant that some people received care for extended periods in the places of safety that did not meet their needs.
- The places of safety at the Gordon hospital and Park Royal had no separate access. This meant that people had their privacy compromised as they arrived at the places of safety.
- In the North Kensington team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

People received timely assessments. The home treatment teams were responsive to people's individual needs. Most of the home treatment teams were not 24 hour. Four of the psychiatric liaison teams were 24 hour.

The trust had an urgent advice line that was available out of hours. Information was available for people. This was predominately in English across all the teams although there was access to additional languages on request. Interpreters were available to staff if they needed them to support their work.

Requires improvement



Summary of findings

People were given information on how to complain and assisted to do so via contact with PALS (patient advice and liaison service) and advocacy services. Learning was identified from complaints and this was shared with the teams.

In Milton Keynes the trust had developed a pilot street triage service to try and reduce the usage of section 136. Initial results have shown a reduction in admissions to the health based place of safety.

Are services well-led?

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

Staff members across all services knew the trust values and were able to describe how these were reflected in the work of the team.

In general, the teams were well managed. Staff received mandatory training and were appraised and supervised, incidents were reported and investigated, staff participated in audits, and safeguarding and Mental Health Act procedures were followed. Staff knew about the whistle-blowing process.

Staff morale was high in most of the teams we visited. Many staff told us they were proud of the job they did and felt well supported in their roles. However at the time of the inspection there was no formal process for home treatment teams to meet with each other and share good practice. Some staff within teams undergoing a consultation on merging felt they had not been listened to or supported appropriately.

Good



Summary of findings

Information about the service

The trust has eight home treatment teams, which largely correspond to borough boundaries. The teams are Brent, Harrow, Hillingdon, Milton Keynes, North Kensington, South Kensington, North Westminster and South Westminster.

The trust has six health based places of safety. These are provided at Brent, Kensington and Chelsea, Westminster, Harrow, Hillingdon and Milton Keynes.

Trusts liaison psychiatry services are provided on a 24 hour basis at the Chelsea and Westminster, Hillingdon, Northwick Park, and St Mary's hospitals. Day liaison services are also provided at the Central Middlesex, Royal Brompton and Royal Marsden hospitals.

These services have not been directly inspected previously. There were no outstanding compliance actions relating to them.

Our inspection team

The team that inspected the mental health crisis services and health based places of safety consisted of eight people: an approved mental health professional, two inspectors, two Mental Health Act reviewers and three nurses.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people using the service.

During the inspection visit, the inspection team:

- Visited all six health-based places of safety run by the trust located at Brent, Kensington and Chelsea, Westminster, Harrow, Hillingdon and Milton Keynes.

- Visited or spoke with staff from psychiatric liaison services at the Chelsea and Westminster hospital, Milton Keynes hospital, Hillingdon hospital and Northwick Park hospital.
- Visited seven of the home treatment teams: Brent, Harrow, Hillingdon, Milton Keynes, North Kensington, South Kensington and South Westminster.
- Visited the trust's urgent advice line.
- Shadowed staff members whilst they were visiting people.
- Spoke with 21 people who were using the service.
- Spoke with the managers or acting managers for each of the teams.
- Spoke with 60 other staff members; including doctors, nurses and social workers.
- Attended and observed hand-over meetings at each of the home treatment teams.
- Attended three multi-disciplinary meetings.

Summary of findings

We also:

- Looked at 41 treatment records of patients.
- Carried out a specific check of the medication management at each of the home treatment teams.

Looked at other relevant records such as records of checks of resuscitation equipment, staff rotas, and policies.

What people who use the provider's services say

Feedback we received from 21 people using the service that we spoke with was generally positive. They found the teams to be supportive and that they treated them with respect.

When we reviewed feedback collected by teams, this was mostly positive. For example, from January – December 2014 of the 26 responses the Hillingdon home treatment team had received to its questionnaire 19 people had rated it 'very good' or 'good'; one person had rated it 'poor'.

Prior to the inspection we collected the views of people using the service. Some people fed back to us that they were disappointed with the support they had been offered by the urgent advice line. They felt their expectations had been raised by this being referred to as a crisis line when it only offered support and signposting rather than full crisis support.

Good practice

In Milton Keynes the trust had developed a pilot street triage service to try and reduce the usage of section 136. In this scheme, which has been in operation since

beginning of January, a nurse is based with the police for four nights a week, Thursday to Sunday. Initial results have shown a reduction in admissions to the health based place of safety.

Areas for improvement

Action the provider MUST take to improve mental health crisis services and health based places of safety:

- The trust must ensure that when a person is assessed as requiring an inpatient bed that they are able to access a bed promptly.
- The trust must ensure that the access to the trust's places of safety promotes the patients' dignity and privacy by the provision of a separate entrance.

The trust must ensure people's private conversations cannot be overheard in adjoining interview rooms at St Charles hospital.

Action the provider SHOULD take to improve mental health crisis services and health based places of safety:

- The trust should ensure the building work to make the Gordon Hospital places of safety is completed.
- The trust should ensure people's risk assessments are updated on the trust's electronic records system to accurately reflect their changing risk.
- Arrangements for lone working should be reviewed to ensure that all teams have robust systems in place.
- Where appropriate, staff should record when they have assessed a person's capacity to make a decision within the written records.

Summary of findings

- The teams should consider ways to ensure they collect regular feedback from people who have used their services.

Central and North West London NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Milton Keynes home treatment team	The Campbell Centre
Milton Keynes Psychiatric Liaison team	The Campbell Centre
Milton Keynes health-based place of safety	The Campbell Centre
Hillingdon home treatment team	Hillingdon Hospital Mental Health Centre
Hillingdon Psychiatric Liaison team	Hillingdon Hospital Mental Health Centre
Hillingdon health-based place of safety	Hillingdon Hospital Mental Health Centre
Harrow home treatment team	Northwick Park Mental Health Centre
Northwick Park Psychiatric Liaison team	Northwick Park Mental Health Centre
Harrow health-based place of safety	Northwick Park Mental Health Centre
Brent home treatment team	Park Royal Centre for Mental Health
Brent health-based place of safety	Park Royal Centre for Mental Health
North Kensington home treatment team	St Charles Mental Health Centre
South Kensington home treatment team	St Charles Mental Health Centre
Urgent advice line	St Charles Mental Health Centre

Detailed findings

South Westminster home treatment team	The Gordon Hospital
Westminster health-based place of safety	The Gordon Hospital
Chelsea and Westminster Psychiatric Liaison team	Stephenson House

Mental Health Act responsibilities

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

The documentation in respect of the Mental Health Act was generally good. Paperwork regarding assessments was

generally in place and showed assessments were completed promptly. When people were being supported by home treatment teams whilst on section 17 leave, the timescale for the leave was monitored.

The environment within the health based places of safety at the Gordon and Park Royal hospitals was not appropriate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff completed mandatory training in the Mental Capacity Act (MCA) but the application with individual patients was mixed across the teams. Most staff we spoke with demonstrated a good knowledge regarding the principles of the MCA. Some of the teams, such as Harrow, had undertaken specialist training to improve staff knowledge of the MCA. However, some staff in other teams told us they did not feel confident and would like more training with regards to the act.

When we shadowed staff and through our observations of multi-disciplinary meetings we saw that staff were aware of the need to assess someone's capacity to consent. However, there were variations in the records we reviewed. In Milton Keynes most of the patient records showed that where needed capacity to consent had been considered. However, in other teams there was less information.

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 **good** because:

Systems, such as daily handovers, were in place to discuss and manage risks for people. However, risk assessment documentation on the electronic notes system was sometimes simplistic and did not reflect updated risks.

Staffing was safe and met the needs of people, although the Milton Keynes psychiatric liaison team was stretched. Sickness rates across all of the teams were low. Staff were trained in safeguarding and knew how to make a safeguarding alert.

There were good medicines management practices including transport, storage and dispensing across all the teams.

Staff were aware of how to report incidents. All teams were able to identify learning from incidents and how they had implemented this in their work. There was variation between the teams in how they managed the risks associated with lone working. Most teams had robust systems in place, although in some the system was not as clear.

However at the Gordon Hospital the two place of safety rooms both contained ligature points. The toilet for use of people using the service was also not ligature free. Although staff could manage risk through observation, the environment meant people could not be supported safely without compromising their privacy. The trust has agreed to the refurbishment of the place of safety and work was beginning in April 2015.

- Not all teams had facilities for meeting with people. Some of the teams, such as the South Westminster team, would meet with people in interview rooms elsewhere in the hospital in which they were based. Most people were seen in their own homes.
- Rooms used by the teams either had their own alarm system or staff carried personal alarms. The Harrow team could see people in rooms within the mental health centre. These rooms were connected to the building's alarm system. The Milton Keynes team's room was accessed via its own buzzer-controlled door. Staff carried personal alarms when meeting people. At the North Kensington team, based at St Charles hospital staff carried their personal alarms when meeting people here.
- Some of the teams, such as Hillingdon, had access to their own clinic room. We checked these rooms and they were well stocked and contained all necessary equipment. At other sites, clinic rooms were available for conducting any physical examinations that were required.

Safe staffing

- The number of nurses matched the establishment number for most shifts. Staff members did not report concerns about staffing numbers. Staff we spoke with told us they felt that caseloads were generally manageable, although they did have concerns sometimes. When caseloads were higher they could escalate this as a concern.
- Each team had a minimum staffing it aimed for per shift. In most cases this was being achieved. In the North Kensington team the minimum staffing was three staff per shift (including establishment number of nurses) and maximum of five.
- Staff in the Milton Keynes team told us that staffing had been difficult in the last year. The team had had a high turnover of staff. However, they felt the situation had improved by the time of the inspection.
- Sickness rates across all of the teams were low. In data supplied by the trust there were no team in which the sickness rate was higher than 2.7%.

Our findings

Home treatment Teams

Safe environment

Are services safe?

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

- The cover arrangements for sickness, leave, vacant posts ensured people's safety. There were no concerns raised by staff teams. In most of the teams there was limited usage of agency staff, with staff undertaking extra shifts or regular bank staff covering.
- There was appropriate use of locum and bank staff, with limited agency staff used. Where agency staff had been used they were on a longer term basis.

Assessing and managing risk to people using the service and staff

- All of the teams had daily handovers where each person on the caseload was discussed. At these 'whiteboard' meetings the individual risks for a person were discussed and plans put in place to address these risks.
- The quality of formal recorded risk assessments varied across the teams. Initial risk assessments were undertaken at the initial assessment, triage stage. However, risk assessments did not always contain details on the risk history. For example, in the North Kensington team risk histories were not always present on current risk assessments and the content of risk assessments was limited. For example, staff identified one person as being too great a risk to visit at home but this was not recorded on a risk assessment. There were similar examples across most of the teams.
- In the records we reviewed for the Milton Keynes team risk assessments were in place and up to date.
- In the London teams staff told us the risk assessment document used on the electronic notes system was too simplistic. They said it was difficult to use from an audit trail or incident investigation perspective. There were only seven areas of risk identified on the top of the form. Staff members found this limiting and suggested other fields like 'medication concordance' or an 'other risk' section.
- Crisis plans were in place across the teams to protect people using the service. In the North Kensington team there were relapse indicators and actions for staff. These were written in the first person. People using the service were provided with crisis cards. Staff formulated crisis plans on the electronic patient record system and the plans were reviewed regularly with people using the service.
- Staff members across all teams responded promptly to sudden deterioration in people's health. In Brent staff members reported that if they observe deterioration in a person's presentation they would assess the person's capacity, contact the team and bring the person to the unit where the bed manager would try and locate a bed. The staff member also stated that there was the option to increase visits to a maximum of twice daily. People could call or page when in distress. They were seen within an hour.
- Staff were trained in safeguarding and knew how to make a safeguarding alert. All staff across the teams reported that they would raise the 'alert' which was then forwarded to the safeguarding manager. All teams identified safeguarding leads and all staff spoken to were able to make alert. Staff received training in safeguarding as part of their mandatory training.
- There was variation between the teams in how they managed the risks associated with lone working. All teams were aware of the risks and had systems in place, although there were differences. The South Kensington team used personal alarms whilst in the trust building and alternative personal alarms in the general hospital. The team also recorded who they intended to visit on the white board but there was no specific times recorded. In Brent, Harrow and Hillingdon the teams used a movement board to let other staff know their whereabouts. The Milton Keynes team had a shift co-ordinator who monitored people's movements. The Brent team had a business plan for lone working devices as this had been identified as a need to ensure staff safety. The North Kensington team did not have a movement sheet or recording on the white board. Neither did it have lone worker devices. Some staff stated there was no lone working policy.
- There were good medicines management practices including transport, storage and dispensing across all the teams. The Harrow team had recently invested in new boxes for carrying medications. Medication charts we checked had been completed correctly. In Brent and in the North Kensington team the pharmacist visited the teams at least daily, sometimes several times a day. They used a communications diary regarding medication. Other teams, such as at Milton Keynes, did not have direct pharmacist support, although received support from pharmacists in the attached inpatient

Are services safe?

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

wards. Medication storage was satisfactory. All teams kept medications in locked cupboards. Most teams were monitoring temperatures regularly, although there were some variations. For example, in Brent there was one medication cupboard which was temperature monitored and checked monthly. Where controlled drugs were being stored, such as at Hillingdon, the correct procedures were being followed.

Track record on safety

- Data supplied by the trust recorded that from September 2013 to December 2014 there had been 10 serious incidents in Hillingdon community services, 10 in Milton Keynes and one in Brent. The teams had partial involvement in a number of these serious incidents, although the people were not always under the care of the team at the time of the incident. In the Hillingdon team there had been no serious incidents directly affecting the team in the last year. In the previous year to this, there had been a cluster of incidents. The team was able to explain clearly how these had been responded to and learning which had been identified.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report incidents. In most of the teams this was through the electronic reporting system. In Milton Keynes the team was still using an old system, but was about to change to join the rest of the trust. Improvements in safety were discussed at team meetings and in staff in supervision sessions. There was evidence of knowledge on how to report incidents, including the process for escalation, including out of hours.
- Information was available to all teams about improvements in safety. Staff across teams reported information about improvements in safety. This was disseminated by the trust and easily available on the shared drive.
- All teams were able to identify learning from incidents. For example, the Hillingdon team had made changes in the escalation process when a bed was needed and in the process for discharging people following incidents. In Brent they had changed their working practices following a recent incident. They had introduced a

process of two staff double checking letters for people taken on and discharged. Staff now checked a person's name, NHS number and their GP to ensure they were correct.

- Staff in teams told us of a recent suicide of a long standing client. The team responded to the initial incident and following this suicide were given debriefing, supervision, and 1:1 sessions with a psychologist.
- Staff received feedback from investigations of incidents both internal and external to the service. Feedback was provided from other incidents affecting other teams. Copies of reports, such as inquests after patient death, were made available to all staff with the key learning points highlighted.

Psychiatric Liaison Teams

Safe staffing

- Most of the teams had adequate staff to deliver support for people. For example, the Northwick Park team had two consultants, a middle grade doctor, a manager, a team leader and nine nurses (with a further three vacancies).
- The team in Milton Keynes had been commissioned to have 4.6 WTE nursing staff. This had been increased by winter pressure money to provide 7 staff members. However, staff told us they felt stretched having to provide the 24 hour, seven day a week service with so few staff.

Assessing and managing risk to patients and staff

- Risk assessments and initial assessments were completed to a high standard in the examples we reviewed.
- At Northwick Park, the staff had an alarm system that was linked to the mental health unit.
- Staff were trained in safeguarding and knew how to make a safeguarding alert. All staff across the teams reported that they would raise the 'alert' which was then forwarded to the safeguarding manager.

Track record on safety

- At Chelsea and Westminster the manager e-mailed reports about adverse events to the team and incidents were discussed in handover.

Are services safe?

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

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report incidents. When learning from incidents had been identified this was shared between teams.
- Where shared learning was required, with the emergency department and other teams within the trust, the teams were involved in this.

Health-based places of safety

Safe environment

- In the six places of safety we visited we found variations in the quality of the physical environment.
- At the Gordon hospital the two place of safety rooms contained ligature points. The toilet was also not ligature free. Although staff could manage risk through observation, the environment meant people could not be supported safely without compromising their privacy. The trust has agreed to the refurbishment of the place of safety and work will begin in April 2015.
- The Milton Keynes place of safety became operational the day before our inspection. The new facility contained an inner room from which people could be observed. The room had been designed to be ligature free. The room was accessed through its own separate entrance.

Safe staffing

- The places of safety were either staffed by staff from the wards at the locations they were based or by the

psychiatric liaison services. Each London place of safety had a bed manager who was responsible for ensuring staff covered the place of safety. At night, the duty senior nurse or bleep holder would arrange staffing for the units. In the examples we reviewed staff had always been sourced promptly to support people in the places of safety.

- The process for accessing assessments by approved mental health professionals (AMPH's) varied between the sites. In some places the teams were based on site, so could be accessed quickly. At others they were not. In the places of safety we visited AMHPs were generally undertaking assessments promptly.

Assessing and managing risk to patients and staff

- A clear system was in place for requesting assessments by an AMHP. In the records we reviewed we saw appropriate physical and mental health assessments had been undertaken.

Reporting incidents and learning from when things go wrong

- Incidents were reported through the trust's incident reporting system. Staff we spoke with were aware of the need to report incidents. These were reviewed by the managers responsible for the service.
- In the months prior to the inspection there had been a number of incidents regarding delays in people being admitted. In response an escalation protocol had been developed to try and ensure people could access a bed where required.

Are services effective?

Good 

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

Summary of findings

We rated effective as **good** because:

Across all of the teams assessments were completed quickly with referrals being assessed promptly. There were effective handovers within each team, with risks being discussed appropriately.

Staff across all teams received mandatory training, supervision and appraisal and had access to team meetings.

Staff followed NICE (National Institute of health and care excellence) guidance when prescribing medication. Staff had received training in the Mental Health Act and had an understanding of the requirements of it. Staff completed mandatory training in the Mental Capacity Act but application was mixed across the teams.

However there was a variable standard of care records across the teams with care plan information being limited in some of the teams. The Brent and Harrow teams' care plans were more detailed. Records in other teams were less detailed.

up to date, holistic and person centred with an onus on focused, time limited work towards crisis resolution. In other teams, care plans were briefer. For example, the North Kensington team care plans were in a blue leaflet style document with five lines of hand written entries. In the South Kensington team the initial care plan was written on an information leaflet. Any changes were updated via a letter to the GP which the person using the service was offered a copy. People were offered their initial care plan, which was collaboratively formulated with the person using the service who signed the documents.

- The information needed to deliver care was available on electronic notes system, including paper documents which were scanned onto the electronic system. It was easily accessible to staff when people moved between teams. However, there was variation between teams in how they recorded the information. In Harrow, all discussions in the daily meeting were updated onto the system. Other teams, such as South Westminster, recorded changes on the team whiteboard. Information and care plan changes recorded here were not always updated immediately on the system.

Best practice in treatment and care

- Staff followed NICE (National Institute of Health and Care Excellence) guidance when prescribing medication. In the Brent team there was direct reference to NICE guidance in the consultant's clinical entries in people's care and treatment records. People using the service had access to psychological therapy as recommended by NICE. When we spoke with consultants they told us that they were kept up to date with guidance by the trust and through their professional networks. The consultant in Milton Keynes had written a blog regarding NICE guidance and how it related to the team's work.
- The teams worked hard to successfully meet the physical health care needs of the people using the service. In records we reviewed they had ensured that all people using the service received an annual health check. We observed good discussion and monitoring of physical health in multi-disciplinary meetings, such as in South Westminster.
- The teams used outcome measures to rate severity and outcomes. In the Brent and Harrow team there was clear

Our findings

Home treatment Teams

Assessment of needs and planning of care

- Across all of the teams assessments were completed quickly with urgent referrals being assessed within an hour. All of the teams held daily meetings where the team discussed people's care and the support they required. Staff were aware of the needs of people and were putting plans in place to address these needs.
- There was a variable standard of care records across the teams with care plan information being limited in some of the teams. The Brent and Harrow teams care plans were more detailed. In Brent the clinical entries in both the care plans and daily records were completed to a high standard. The initial assessments and care plans were detailed and were regularly updated to include information from follow up visits by all team members including community support workers, nursing staff, social workers and medical staff. The information was

Are services effective?

Good 

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

use of outcome measures by using the Mental Health Clustering Tool, with all records within their cluster review date. In the other teams there were some examples of measures that had exceeded their review dates.

- There was variation between the teams with regards to number and recording of audits. In the Brent and Harrow teams there were many audits in place. They were kept on the team's shared drive. Audits included an audit of the team's recording of allergies, an audit of discharge summaries, and an audit for use of anti-psychotic medication.

Skilled staff to deliver care

- Overall the teams had access to the range of mental health disciplines required to care for the people using the service. However, there were variations in the makeup of teams. Each team had access to a psychiatrist. The Hillingdon team received locum support for an extended period of time, but a permanent doctor was being recruited at the time of the inspection.
- Most teams had some access to a psychologist. This resource was being used mainly to facilitate reflective practice sessions. For example, in Hillingdon this took place every two weeks. People using the service could be referred to the trust's psychology service.
- Occupational therapy and social work resource differed between teams. In the teams where there was no social worker or occupational therapists, we were told this was due to their being difficult to recruit.
- Staff across all teams received mandatory training, supervision and appraisal and had access to team meetings. In some of the teams, such as the South Westminster team, records of formal supervision were limited, although staff told us they were well supported and had received supervision. Most teams had regular team meetings, although in some teams, such as Milton Keynes, these were less frequent. Most staff we spoke with felt well supported in their teams.
- Staff had access to specialist training for their role. In the North Kensington team staff reported they could easily access training. Nurses had completed additional safeguarding sessions and others had done training in how to undertake venipuncture procedures. In Brent

staff members described their supervisors as being very supportive of their professional development and training. One staff member was currently considering taking a course in counselling.

- Poor staff performance was addressed promptly and effectively. The managers were aware of the procedures to follow when poor staff performance was identified.

Multi-disciplinary and inter-agency team work

- All teams had regular and effective multi-disciplinary team (MDT) meetings. In Brent the MDT met weekly and the electronic notes system was projected onto the wall and updated live. Electronic notes were also updated during clinical handovers.
- There were effective handovers within each team. In all teams there were twice daily handovers. We observed full professional discussion of all cases. Changes were made to information on the white board. In some teams information was updated directly onto electronic records. However, in some of the teams, including South Westminster and South Kensington it was not always clear how information changes on the whiteboard were updated in the records.
- Staff told us the move to a borough management structure had helped as they now had closer links to the outpatient and inpatient services they worked closely with. For example, in Hillingdon the teams held a weekly meeting to discuss issues affecting people, including the pathway through the service.
- In Brent people who could be supported towards early discharge from the ward were clearly identified. The process of early discharge support, known locally as 'facilitated early discharge', was seamless with care planning being formulated whilst the patient was still an inpatient and the home treatment team worked to this care plan. There were good working relationships with community teams but the team's caseload held 15 extra people who would have been discharged to community teams but were awaiting allocation. The team kept people on their caseload until they were formally accepted by the community teams.

Are services effective?

Good 

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

- At the time of the inspection there was no formal process for teams to meet with each other. There had been a home treatment team forum, but this had not met for a number of months. This meant that opportunities for learning and sharing may be missed.
- There were good working relationships with external agencies across all teams. This was particularly evident in the Brent team where GPs were offered the option of a face to face meeting when a patient was being discharged from the care of the team. The team actively used summary care records to share with external agencies where patient consent had been given. The team were also piloting additional work with primary care. The South Westminster team had close links with the local homelessness team and homeless hostels.

Adherence to the MHA and the MHA Code of Practice

- Staff had received training in the Mental Health Act and had an understanding of the requirements of it.
- When people left inpatient services under section 17 leave the teams could support people whilst they were in the community. The number of people on section 17 leave varied between teams. In some teams there were no people on leave. In others, such as South Westminster, there were a high number of people. When people's section 17 leave expired this was recorded on the team board.
- Teams had access to approved mental health professionals should they need support in conducting a mental health assessment on someone.
- Staff across teams were aware how to access the mental advocacy services.

Good practice in applying the MCA

- Staff completed mandatory training in the Mental Capacity Act (MCA) but the application with individual patients was mixed across the teams. Most staff we spoke with demonstrated a good knowledge of the principles of the MCA. Some of the teams, such as Harrow, had undertaken specialist training to improve staff knowledge of the MCA. However, some staff in other teams told us they did not feel confident and would like more training.
- Staff were aware of the need to assess someone's capacity to consent. However, there were variations in

the records. For example, in the five records we reviewed in Milton Keynes, we found that capacity to consent had been considered in four records. However, in other teams there was less evidence to show this had been considered where needed.

Psychiatric Liaison Teams

Assessment of needs and planning of care

- Risk assessments and initial assessments were mostly completed to a high standard. When further interventions were required the team could refer on to other teams within the trust.
- Whilst a person was receiving care in the acute trust the team could visit and support staff to meet the needs of the person.

Best practice in treatment and care

- Some of the psychiatric liaison teams, including Hillingdon and Northwick Park, were undertaking accreditation with the Royal College of Psychiatrists as part of the psychiatric liaison accreditation network. At the time of the inspection they had undertaken their assessments and were awaiting the decision on their accreditation.
- All people receiving support from the teams were either in a medical ward or had been triaged in A&E. In Brent patients' physical health was discussed as part of the referral and then in the assessment. Base line observations were taken. There was also further physical examinations and review during the first medical review within the first week.

Skilled staff to deliver care

- The Northwick Park team had a reflective practice session every Monday where the team met to discuss recent work.
- The Chelsea and Westminster team members received supervision every four weeks and the team had reflective practice with the psychology service.

Multi-disciplinary and inter-agency team work

- The teams had developed working relationships with the acute services where they were based. For example, the Northwick Park team attended a daily meeting at 8.30am in the A&E. They also had a computer with access to the trust's patient records put in this area.

Are services effective?

Good 

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

- The Chelsea and Westminster team had effective multi-agency working practices. The team maintained good working links with the A&E and response time was generally within an hour of referral.

Adherence to the MHA and the MHA Code of Practice

- Staff could refer people for mental health assessments if required. If this was required, a referral would be made to an AMHP (approved mental health professional).

Good practice in applying the MCA

- Staff had undertaken training in the Mental Capacity Act and demonstrated a good understanding of it.
- At the Chelsea and Westminster Hospital the patient records indicated that capacity assessments were taking place where needed.

The teams provided training and support for the acute trust with any queries associated with either the Mental Health Act or the Mental Capacity Act 2005.

Health-based places of safety

Assessment of needs and planning of care

- Initial assessments were completed in a timely manner. A clear assessment and physical health check was undertaken when people were brought in under police powers on a section 136.
- In the records we reviewed initial risk assessments, physical health assessments and referrals for mental health assessments were completed as appropriate.

Skilled staff to deliver care

- The places of safety were either staffed by staff from the wards at the locations they were based or by the psychiatric liaison services. Each London place of safety had a bed manager who was responsible for ensuring staff covered the place of safety.

- If required referrals could be made to AMHPs or section 12 doctors to undertake assessments.

Multi-disciplinary and inter-agency team work

- The trust had developed links with other services. The trust had a clear policy developed with the police. Regular police liaison meetings were being held to share information and develop the service. In Milton Keynes the trust had developed a street liaison service with the police.
- As part of the crisis care concordat work the trust had been working with the police to develop the protocols for the usage of places of safety.

Adherence to the MHA and the MHA Code of Practice

- At the Milton Keynes place of safety most assessments were carried out jointly by the doctor and the approved mental health professional.
- All sites kept good records, which recorded all the required information. This was later sent to a central point in the trust for auditing purposes.
- In Milton Keynes the place of safety room had moved the day before. When we visited there was no visible clock in the room although this was provided afterwards.

Are services caring?

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:

In all the teams we observed the staff to be kind, caring and compassionate. Feedback from people using the service was generally positive.

People received a welcome pack with information about the service. This was more detailed in some teams than others. Advocacy services were available if people required them.

The mechanism for collecting feedback and the response rates varied between teams. The teams should consider ways to ensure they collect regular feedback from people who have used their services.

- Staff demonstrated a good knowledge and understanding of people using the service. In the shadow visits we undertook, it was clear that staff had an understanding of people's needs.
- People's confidentiality was maintained by all the staff teams. When we accompanied staff on home visits the staff members asked if the person was happy for a CQC team member to be present prior to the visit. All staff spoken with were aware of the need to ensure a person's confidential information was kept securely. Staff access to electronic case notes was protected.

The involvement of people in the care they receive

- People received a welcome pack with information about the service. In Brent and Harrow the pack was very detailed and these included information on complaints, support groups and advocacy information.
- People were offered a copy of their care plan. When we shadowed staff, we saw that people had copies. When updates were agreed with a person's GP, letters were sent to them.
- Advocacy services were available if people required them. Information available on advocacy was mixed across the teams ranging from information in waiting rooms to information in the welcome pack and active discussion from the staff team.
- People were able to give feedback on the care they receive via surveys or community meetings. The mechanism for collecting feedback and the response rates varied between teams. Some team, such as the North Kensington and Milton Keynes teams had limited feedback from people using the service. This was acknowledged as an area for development.
- Some teams, such as the Hillingdon team, had involved people using the service in their recruitment of staff.
- Carers' assessments were offered to people when appropriate.

Psychiatric Liaison Teams

Kindness, dignity, respect and compassion

- Staff were observed treating people respectfully and with kindness.

Our findings

Home treatment Teams

Kindness, dignity, respect and compassion

- In all the teams we observed the staff to be kind, caring and compassionate. This was demonstrated by all the staff we shadowed. When we spoke with people receiving support they were generally positive about the support they had been receiving.
- In Brent the support workers and the consultant were particularly supportive of people using the service. The consultant made considerable efforts to engage with people on the phone and face to face. He made links with a person's GPs so he could meet with them and the patient to discuss any matters about discharge. Feedback from people we spoke with was very positive about the kind and caring attitudes of the staff team. People were given information about self-help groups and literature in their welcome pack to promote independence and learning.
- The mechanisms for collecting feedback from people were variable across the teams. However, where feedback had been sought, this was generally positive. For example, all the people who had responded to a survey by the Hillingdon team responded 'yes, definitely' or 'yes, to some extent' to the question, 'did the team treat you with respect and dignity?'

Are services caring?

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

- The teams worked with staff employed by the acute trust to develop their knowledge of mental health, including the care of people with dementia. This meant that people could receive more appropriate support.

The involvement of people in the care they receive

- People who had been supported and their carers were given a feedback form to complete. This information was gathered and reviewed by the teams
- In a recent questionnaire undertaken by the Northwick Park team 17 people responded that they were involved in discussions about their problems and the different treatments available.
- Advocacy services were available for people to access.
- An information pack was given by the team to people. This included information for carers on local support services.

- The Northwick Park team were planning to involve service users in teaching sessions where they explained their experiences of care and how they thought it could be improved.

Health-based places of safety

Kindness, dignity, respect and compassion

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

The involvement of people in the care they receive

- Advocacy services were available for people to access from the places of safety.
- The Hillingdon place of safety had received visits from the local user forum to provide feedback.

Are services responsive to people's needs?

Requires improvement 

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

Summary of findings

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

- People who were assessed as requiring inpatient beds experienced long delays before being admitted. The delays in accessing inpatient beds meant that some people received care for extended periods in the places of safety that did not meet their needs.
- The places of safety at the Gordon hospital and Park Royal had no separate access. This meant that people had their privacy compromised as they arrived at the places of safety.
- In the North Kensington team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

People received timely assessments. The home treatment teams were responsive to people's individual needs. Most of the home treatment teams were not 24 hour. Four of the psychiatric liaison teams were 24 hour.

The trust had an urgent advice line that was available out of hours. Information was available for people. This was predominately in English across all the teams although there was access to additional languages on request. Interpreters were available to staff if they needed them to support their work.

People were given information on how to complain and assisted to do so via contact with PALS (patient advice and liaison service) and advocacy service. Learning was identified from complaints and this was shared with the teams.

In Milton Keynes the trust had developed a pilot street triage service to try and reduce the usage of section 136. Initial results have shown a reduction in admissions to the health based place of safety.

Access, discharge and transfer

- All the teams met their team performance indicator set by the Trust that all urgent referrals were assessed within an hour. People's care and treatment records confirmed assessments were timely.
- Skilled staff were available to assess people immediately. In Brent the service provided 24 hour cover. A member of staff was also allocated to cover assessments at the urgent care centre at the Central Middlesex hospital. These took 15 minutes from the time the patient was referred to team and the time they were seen by staff.
- Most of the teams did not provide 24 hour cover. During the hours the teams worked they would receive referrals directly. Out of hours, people would be referred to the psychiatric liaison teams.
- The trust had an urgent advice line that was available out of hours. This provided advice, support and signposting to other services. Some people raised concerns with us that this was called a crisis line, as the team could only signpost and support, rather than provide full crisis team support.
- The home treatment teams were responsible for 'gatekeeping' all admissions to inpatient beds. Most teams were achieving, or close to achieving, 100% for this indicator that all referrals that may need admission to hospital were seen by the team. If a person was admitted overnight they were referred to the team the next day.
- Staff in all the London teams we visited told us it was hard to find a bed for a person. They told us that they were able to escalate this concern, but there had been occasions when people who needed to be admitted had been delayed.
- Each team had clear criteria for offering a service. People were not excluded if they would benefit from treatment. No referrals were refused although those originating from a care coordinator were scrutinised and further work may be suggested prior to assessment being arranged.
- All teams had systems in place to ensure they responded adequately when people phoned in. For example, in the North Kensington team people who were known to the teams were put through to the

Our findings

Home treatment Teams

Are services responsive to people's needs?

Requires improvement 

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

individual worker or to another team, such as the early intervention service. If people were not known to the service they were offered initial assessments or if their request was more general then they were signposted to other services like their GP.

- The teams took active steps to engage with people who found it difficult or were reluctant to engage with mental health services. For example, the South Westminster team worked with the local homelessness team to ensure the needs of this group were met.
- Each team took a proactive approach to re-engaging with people who did not attend appointments. In the North Kensington team where there had been a failed visit repeat visits would be carried out. Risks were then considered prior to requesting a welfare check.
- In each of the teams we visited people were given flexibility in when they could see staff and where. Staff were responsive to people's individual requests and needs and tried to work around these. Appointments were cancelled rarely. Staff told us this may occur when there was a shortage of staff, but if this was the case they assessed the risk of doing so and would contact the person. Appointments mostly ran on time and people were kept informed when they did not.

The facilities promote recovery, dignity and confidentiality

- At the North Kensington team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

Meeting the needs of all people who use the service

- All sites where people were seen were wheelchair accessible. In Brent there were wide doors and ramp for easy access for wheelchairs and push chairs. Toilets for people with a disability were available on all sites.
- Information was available for people. This was predominately in English across all the teams although there was access to additional languages on request. Interpreters were available to staff if they needed them to support their work. Staff were aware of the need to

support people in a manner that respected their preferences. For example, if someone requested a visit from a female member of staff the teams tried to facilitate this.

- Some of the teams had developed links with local support groups, which they signposted people to. For example, in Milton Keynes the team had worked with local lesbian support groups.

Listening to and learning from concerns and complaints

- People were given information on how to complain and assisted to do so via contact with PALS (patient advice and liaison service) and advocacy services. People we spoke to said they knew how to complain and received feedback from the staff team.
- There were posters or information explaining the process in waiting rooms on each site. At Harrow information about complaints was included in the information pack people received at the initial assessment.
- The teams had received few complaints. Formal complaints were investigated in line with the trust's complaints procedure. We saw examples of people being satisfied with responses. For example, following a complaint to the Brent team the manager met with the complainant at their home and a positive conclusion was reached.
- Informal or verbal complaints were dealt with immediately by the staff team. There were entries in patient's daily records with a record of the outcome. Whilst the managers monitored formal complaints, there was no monitoring of the informal complaints. Therefore, it was not possible to check trends, analyse or learn from these complaints.

Learning was identified from complaints and this was shared with the team. For example, complaints were discussed at every team meeting for the Harrow team and any learning points were followed up as appropriate.

Psychiatric Liaison Teams

Access, discharge and transfer

Are services responsive to people's needs?

Requires improvement 

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

- The teams we visited responded to referrals promptly. For example, the Northwick Park team was meeting its target to respond to 80% of A&E referrals within an hour and referrals from wards within 24 hours.
- All teams working with A&E departments provided a service 24 hours, seven days a week.
- The teams worked with teams on wards to develop staff knowledge of mental health, including with regards to dementia. In this work they could also assist in supporting people to arrange social care placements.

The facilities promote recovery, dignity and confidentiality

- In Harrow the team provide staff for a 'transit' lounge. This room had armchairs and tea making facilities. It was designed to provide a quieter area for people to be assessed and supported in rather than the A&E. Staff we spoke with told us they found this facility useful as it enabled them to support people in a comfortable environment with more confidentiality. The trust opened a second 'transit' lounge in Hillingdon during the week of the inspection.

Meeting the needs of all people who use the service

- Staff could access interpreters if they needed to or other support to meet the individual needs of the patient.

Listening to and learning from concerns and complaints

- Few complaints had been received by the teams. When feedback was received this was discussed in the team meetings.

Health-based places of safety

Access, discharge and transfer

- From December 2014 till the end of January 2015 the places of safety were used 157 times. Of these, the length of stay was 6-10 hours in 31 cases and over 10 hours in 18 cases. Most of these (26) occurred at the Westminster place of safety. Staff told us that due to pressure in finding a bed within an inpatient ward, some people had to wait a long time prior to admission. We looked at the incident reports relating to the places of safety for January 2015. These showed that people were often having to wait a long time before being admitted. For example, one person had to wait 18 hours before

getting a bed, another spent two nights waiting for a bed and a third left the unit to sleep on an older people's ward at 23:10 before returning early in the morning. The delays in accessing inpatient beds meant that some people received care for extended periods of time in an environment that did not meet their needs.

- In Milton Keynes the trust had developed a pilot street triage service to try and reduce the usage of section 136. In this scheme, which had been in operation since beginning of January, a nurse was based with the police for four nights a week, Thursday to Sunday. Initial results have shown a reduction in admissions to the health based place of safety. For the first three weeks of January there were 20 contacts, only one of these lead to usage of the place of safety.
- Park Royal and Northwick Park could receive under 18 year olds if needed on behalf of the trust. We were told this would be less likely at other locations.

The facilities promote recovery, dignity and confidentiality

- The places of safety at the Gordon hospital and Park Royal had no separate access. Park Royal had its place of safety unit on the first floor and the toilet was reached by going through the nurses' office. The Gordon hospital place of safety was accessed through the front door for the hospital. This meant that people had their privacy compromised as they arrived at the places of safety. The trust had plans to redevelop both of these places of safety. The other places of safety had their own entrances and privacy could be maintained within the suites.

Meeting the needs of all people who use the service

- If a person did not speak English, interpreters would be sought to assist. This sometimes contributed to delays.
- At Hillingdon a multi-faith chaplaincy was available for people to access. Information leaflets were available for people in the service.

Listening to and learning from concerns and complaints

- Information about raising concerns and complaints was available to people who were assessed in the health based place of safety units.

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 members across all services knew the trust values and were able to describe how these were reflected in the work of the team.

In general, the teams were well managed: staff received mandatory training and were appraised and supervised, incidents were reported and investigated, staff participated in audits, and safeguarding and Mental Health Act procedures were followed. Staff knew about the whistle-blowing process.

Staff morale was high in most of the teams we visited. Many staff told us they were proud of the job they did and felt well supported in their roles. However at the time of the inspection there was no formal process for home treatment teams to meet with each other and share good practice. Some staff within teams undergoing a consultation on merging felt they had not been listened to or supported appropriately.

Our findings

Home treatment Teams

Vision and values

- Staff members across all services knew the trust values and were able to describe how these were reflected in the work of the team.
- Managers in all teams were aware of the team objectives. For example, in the North Kensington team staff stated that the team aimed to 'keep patients safe, independent and at home'. Staff across most of the teams told us the priority was preventing admission and facilitating people returning to the community.
- Staff know who the most senior managers in the organisation were and gave examples of when these managers had visited the teams.
- The trust was undertaking a consultation regarding the restructuring of bed management and home treatment teams in Westminster and Kensington & Chelsea. Staff told us they were concerned about this process and felt

that their views regarding the risks associated with this had initially not been fully listened to. Although they felt this had improved, many were still worried about this process and the risks associated with it.

Good governance

- Shortly before the inspection the trust had reorganised its governance structure to correspond to the London boroughs. This meant that the new structure was still being embedded. Each borough will have its own care quality meeting where information is reviewed, including complaints and serious incidents.
- At the time of the inspection there was no formal process for teams to meet with each other. There had been a home treatment team forum, but this had not met for a number of months. This meant that opportunities for learning and sharing may be missed.
- In general, the teams were well managed. Staff received mandatory training and were appraised and supervised, incidents were reported and investigated, staff participated in audits, and safeguarding and Mental Health Act procedures were followed.
- Staff could submit items to the trust risk register. Examples given included the need for safeguarding training and development of a lone worker policy.

Leadership, morale and staff engagement

- There were low sickness rates across the teams. None of the teams had a rate higher than 2.7%.
- Staff knew about the whistle-blowing process. There were posters in the reception areas and information provided on the trust intranet. Staff we asked about whistleblowing told us they had not seen any staff behaviours that caused them concerns. If they did then they would report it to their line managers.
- Staff across teams told us they were able to raise concerns either privately in one to ones or at staff meetings. Staff at Brent said there was an open door policy with the manager. However staff involved in the potential merger of teams in Westminster and Kensington & Chelsea, who were moving location and applying for posts in the merged team, expressed some concerns about the consultation process. Morale in these teams had been affected by this process.

Are services well-led?

Good 

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

- Staff morale was high in most of the teams we visited. Many staff told us they were proud of the job they did and felt well supported in their roles. Staff members told us that recruitment and retention was good because they felt empowered to raise any issues and promote service development and initiatives. The majority of staff spoken with were positive about working in the teams. Staff felt well managed and mostly had high job satisfaction.
- There were opportunities for staff to have leadership training and also gain professional qualifications.
- Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers. Staff at Brent identified a need for improvement in their linking risk assessments to care plans.

Commitment to quality improvement and innovation

- In Harrow the team had created a care plan folder and introduced it in May 2013 as a result of initial service user feedback. The pack included an initial care plan, self-help resources, and carers' information.
- Teams were working towards smoking cessation. In Brent there were two staff members trained in by national centre for smoking cessation and training. Patches and inhalers were kept in stock.

Psychiatric Liaison Teams

Vision and values

- Staff members across all services knew the trust values and were able to describe how these were reflected in the work of the team.
- All the managers were able to clearly describe the service they were delivering and the aim to move towards a full rapid, assessment, interface, discharge (RAID) model.

Good governance

- In general, the teams were well managed: staff received mandatory training and were appraised and supervised, incidents were reported and investigated, staff participated in audits, and safeguarding and MHA procedures are followed.

- Some teams had developed their own risk registers on which they had identified local risks. These were managed through ongoing monitoring by the managers.

Leadership, morale and staff engagement

- Morale in the teams was generally high. They were motivated, enthusiastic and proud of the job they did. The Milton Keynes team felt under pressure due to having fewer members of staff.

Commitment to quality improvement and innovation

- Some of the psychiatric liaison teams, such as the Northwick Park team, had been involved in a study to identify and provide supportive interventions for people who frequently attended emergency departments. People who were identified as frequent attenders were invited to attend a clinic appointment where an attendance plan was developed. Initial findings suggested a reduction in emergency attendance following this.
- The psychiatric liaison team at the Chelsea and Westminster Hospital was accredited as excellent with the psychiatric liaison accreditation network (PLAN) through the Royal College of Psychiatrists. The other teams had started a self review in September 2014.

Health-based places of safety

Vision and values

- As part of the crisis care concordat work the trust had been working with the police to develop the protocols for the usage of place of safety. All sites had a copy of the trust's policy for places of safety.
- Staff were aware of the values of the trust and how they related to their work.

Good governance

- Information on the usage of the places of safety was collated centrally and monitored by the trust. This audit was completed on an ongoing basis. When there were delays in assessing or admitting a person this was recorded on the trust's electronic incident reporting system.
- Although the head of social work and other senior staff had an overview of the service, the opportunities for sharing experience and learning between the places of safety was limited.

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.

Commitment to quality improvement and innovation

- The Milton Keynes team had developed a street liaison service to reduce the usage of section 136 places of safety. Initial findings indicated this had led to a reduction in the usage of these services.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities)
Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. Delays in accessing inpatient beds when required meant that people had to be supported in health based places of safety and bed management lounges for extended periods of time.

This was a breach of Regulation 9 (1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities)
Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities)
Regulations 2010 Safety and suitability of premises

People were not being protected against the risks associated with unsafe or unsuitable premises.

People using the place of safety at the Gordon Hospital and Park Royal had to pass through other parts of the hospital rather than accessing the service through a separate entrance which could compromise their privacy and dignity.

Interview rooms at St Charles hospital did not maintain the confidentiality of people using the service.

This was a breach of Regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities)
Regulations 2010 now Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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