Requires improvement

Central and North West London NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

Stephenson House
75 Hampstead Road
Kings Cross
London
NW1 2PL
Tel:020 32145700
Website: www.cnwl.nhs.uk

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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)
RV3EE	Stephenson House	Brent North Community Mental Health Team	NW6 6BX
RV3EE	Stephenson House	Brent South Community Mental Health Team	NW6 6BX
RV3EE	Stephenson House	Brent Early Intervention Service	NW6 6BX
RV3EE	Stephenson House	Harrow West Community Mental Health Team	NW6 6BX

Summary of findings

RV3EE	Stephenson House	Harrow East Community Mental Health Team	HA3 5QX
RV3EE	Stephenson House	Hillingdon Community Mental Health Team West	UB4 8EW
RV3EE	Stephenson House	Hillingdon Community Mental Health Team North	HA4 8NQ
RV3EE	Stephenson House	Recovery and Rehabilitation Team –Milton Keynes	MK4 4EN
RV3EE	Stephenson House	North Kensington and Chelsea Community Mental Health Team	W10 6BS

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

Following this inspection, we rated community-based mental health services for adults of working age provided by Central and North West London NHS Foundation Trust as **requires improvement** because:

During this most recent inspection, we found that the services had addressed most the issues that had caused us to rate safe and effective as requires improvement following the February 2015 inspection. However at this inspection we found areas where further improvement was required.

- Since the last inspection in February 2015 improvements in risk assessment had been made in East and West Harrow CMHTs. At this inspection we identified that not all patients in the Brent and North Kensington and Chelsea teams had comprehensive risk assessments in place.
- The teams had either no or little input from a clinical psychologist. Patients either had no access to specialised psychological therapy had to wait a long time. This meant they were not receiving care in line with best practice.
- There was a large turnover of staff. The resulting high use of temporary staff meant there was a risk that patients' identified needs were not met and they did not receive consistency in care. In the Brent CMHTs, this was impacting on the regularity that care co-ordinators met with patients.
- Although staff had developed care plans for patients, many of these were not patient centred.
- Whilst all patients had a crisis plan, further work was needed in some teams to make them reflect the needs of individual patients.
- In some teams, less than 75% of staff had received recent training on basic life support (non-clinical staff) and fire safety training.
- Protocols to support lone working and staff safety were not being consistently used across all teams. At Milton Keynes CMHT staff did not have access to an appropriate alarm system when seeing patients.
- Staff did not always give patients who were subject to a Community Treatment Order an explanation of their rights.

However:

- The trust had made a number of improvements following recommendations made at the previous inspection in February 2015.
- The trust was reviewing service delivery and had employed peer support workers in teams to engage with patients and support access and discharge from CMHTs.
- There were systems in place to ensure that patients consistently received their medicines safely and as prescribed.
- Staff demonstrated a good understanding of how to recognise potential safeguarding issues and how to act on concerns. However the Milton Keynes team needed to to ensure they knew the outcomes of alerts and investigations.
- Staff were well supported, appropriately trained and able to develop their roles. Multidisciplinary teams were consistently and proactively involved in patient care, support and treatment.
- Most patients and carers spoke positively about the care and treatment received in all of the services. Staff actively involved people in developing and reviewing their care and maintained people's confidentiality. Staff were kind and respectful to people using the services.
- Morale of staff was good across the teams inspected despite staffing and recruitment challenges
- The service supported patients with a range of diverse needs appropriately.

Summary of findings

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

Are services safe?

Requires improvement

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

- The Milton Keynes CMHT did not have an alarm system and staff did not carry personal alarms. This meant that there was a risk to their personal safety and accessing help when needed.
- In February 2015, some patients in the Harrow community recovery team did not have a current risk assessment in place. At this inspection some improvements had been made and patients at the East and West Harrow CMHTs had a current risk assessment. However, further improvements were required to ensure patients were safe and had their needs met. Some patient risk assessments in the Brent and the North Kensington and Chelsea CMHTs were not detailed and risk management plans did not always address identified risks.
- In February 2015, we recommended that patients in the Harrow Community Recovery Team should have crisis plans that reflect their individual circumstances. At this inspection, improvements had been made within the East and West Harrow CMHTs and crisis plans were now co-produced with patients and person centred. However, further improvements were required in this area in the North Kensington and Chelsea and the Brent CMHTs where crisis plans were not person-centred.
- There was a large turnover of staff and high use of temporary staff. This meant there was a risk that patients' identified needs were not met and they did not receive consistency in care. In the Brent CMHTs, this was impacting on the regularity that care co-ordinators met with patients. Also some temporary and new staff, especially in Brent did not have prompt access to the essential patient record systems in order to carry out their work.
- Not all staff had completed mandatory training in basic life support and fire training.
- Staff at the Milton Keynes CMHT did not have arrangements in place to track the number of safeguarding concerns raised with the local authority, the progress of alerts, investigations and outcomes.

However:

Summary of findings

- In February 2015 not all services had a properly maintained automated external defibrillator (AED) machines. At this inspection all teams had an AED machine which had been serviced.
- In February 2015, we found that there were insufficient staff available to work as care co-ordinators which meant that duty workers in Harrow, Brent and Hillingdon CMHTs were responsible for supporting a number of patients. At this inspection we found that arrangements for duty work was going well and when staff were doing this role they had time to focus on this task.
- In February 2015, we recommended that staff be supported to learn about incidents from other services within the trust. At this inspection we found this had improved and learning from incidents in other services took place.
- There was an effective incident reporting system in place and staff knew how to report incidents. All incidents were reviewed and discussed within the teams so that learning was shared and improvements made. However, there was scope to do more joint learning with other care providers.
- There were systems in place to ensure that patients consistently received their medicines safely, and as prescribed.
- Staff understood their responsibilities under the duty of candour and apologised to patients when things went wrong.

Are services effective?

Requires improvement

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

- In February 2015, we recommended that where patients were supported by a lead professional clinician (LPC) their care plans should aim to be more person-centred. At this inspection, improvements had been made and patients supported by a LPC had a care plan which met their identified needs. However, for some teams we found that further work was needed to ensure care plans were person-centred and reflected their identified needs.
- Patients were often not able to access any or sufficient input from a clinical psychologist. This meant that their treatment was not in line with best practice. Whilst the trust was working to introduce alternative arrangements for patients to access talking therapies, there was still more to do.

Summary of findings

- Staff did not always give patients who were subject to a Community Treatment Order an explanation of their rights.

However:

- In February 2015, we identified in the Harrow community recovery team some patients had not been referred for a physical health check in the previous year. During this inspection, we found that patients had received physical health checks in the previous year.
- In February 2015, we recommended that the trust support staff who were working with patients with a personality disorder. At this inspection, this had improved and some staff in the East and West Harrow CMHTs had undertaken specific training on supporting patients with a personality disorder. Input from a consultant psychiatrist with specialist knowledge of personality disorders was available.
- In February 2015, we recommended that staff in all services fully understand the Mental Capacity Act 2005 (MCA) and code of practice. At this inspection improvements had been made and staff had a good understanding of the MCA.
- Staff used outcome measures to assess the effectiveness of interventions with patient care.
- Staff supported patients with their housing, employment and benefits
- There were effective multi-disciplinary teams working so that referrals, risks, treatment and appropriate care pathways were considered for each patient.
- Staff were appropriately qualified and able to undertake continuous professional development and specialist training to their role.

Are services caring?

Good

- The majority of patients were positive about the care and treatment they received and said staff were respectful and kind.
- Patients were involved in making decisions about their care and treatment.
- Staff offered carers assessments and provided support.
- Patients were involved in the way the service operated, this included involvement in staff recruitment and co-production of information leaflets.

However:

Summary of findings

- At the North Kensington and Chelsea CMHT six care records did not clearly record patients involvement and none of the patients or carers who we spoke with had their own copy of a care plan.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Systems were in place to see patients who had been referred for urgent assessment in a timely manner.
- Staff kept patients needs under continuous review to ensure they had access to support when needed.
- Patients who did not attend their appointments were followed up.
- In February 2015, we recommended that the areas used by patients at Hillingdon West CMHT (Mead House) be refurbished. At this inspection, we found this had improved and refurbishment had been completed.
- Information was available to people and accessible in varying formats such as easy read and alternative languages as needed.
- Staff supported patients to access local community groups that met their diverse needs.
- Most patients using the service knew how to complain and staff learning from complaints was discussed within teams.

However:

- The trust was missing the agreed timescales to offer an initial routine appointment for an assessment following a referral to the CMHT. This was being closely monitored and was improving so in most areas the target was achieved or only narrowly missed.
- There were difficulties with the telephone systems at the East and West Harrow and North Hillingdon CMHTs and patients found it difficult to make contact with the teams. The trust had put in measures to manage this situation while the telephone systems were being repaired.
- Patients' discharges were delayed in the Brent CMHTs because not all GPs were willing to administer a depot injection. The service had established additional capacity in 'depot clinics' and was in discussion with commissioners about proposals to support transfer of this service into primary care.

Summary of findings

- There were privacy issues at the reception area at the East and West Harrow CMHTs. Patients said that other patients could hear them when they discussed confidential matters with the reception staff.

Are services well-led?

Good

We rated well-led as good because:

- In February 2015, we recommended that Harrow and Hillingdon team risk registers reflect all identified risks and include the risk rating. At this inspection, we found this had improved and all identified risks were recorded, scored and rated according to severity.
- Staff knew the trust's vision and values and felt these were embedded into service delivery
- All teams were well managed and benefitted from effective support from the service managers and senior management team.
- Staff morale was mostly good and the team culture was supportive and inclusive. Some staff across the teams told us that morale could sometimes be low due to high caseloads and staff turnover.
- Governance arrangements were in place within each division that supported the delivery of the service, identified risk, and monitored the quality and safety of the services. The senior management team within the trust had good oversight of the risks and challenges within the community services.
- Staff participated in regular audits to identify areas of improvement and monitor standards of care and treatment, although a few needed clear action plans to ensure they were followed up.

However:

- Care plan audits in the Brent CMHTs did not have specific action plans to ensure that issues identified were addressed by the team.

Summary of findings

Information about the service

Central and North West London NHS Foundation Trust provides a range of community based mental health services for people of working age in North West London and Milton Keynes.

The services are provided by community mental health teams (CMHTs) which aim to provide

secondary care to patients whose mental health needs cannot be met in the primary care setting. People who present with ongoing and complex mental health needs are managed under the care programme approach (CPA) which aims to ensure the person receives co-ordinated care to promote their recovery. People who do not require intensive support are seen by a psychiatrist or other health specialist from within the CMHT on an outpatient basis to receive a period of support and treatment.

Early intervention services (EIS) work with people who are experiencing a first episode of psychosis. The aims of the service is to engage promptly and reduce the length of time from onset of symptoms to treatment and support. They provide care co-ordination support and treatment up to a three year period.

We inspected the following services:

Brent North Community Mental Health Team

Brent South Community Mental Health Team

Brent Early Intervention Service (EIS)

Harrow West Community Mental Health Team

Harrow East Community Mental Health Team

Hillingdon Community Mental Health Team West

Hillingdon Community Mental Health Team North

Recovery and Rehabilitation Team – Milton Keynes

North Kensington and Chelsea Community Mental Health Team

This service was last inspected in February 2015 where it was part of the comprehensive inspection of the trust.

When the CQC inspected the trust in February 2015, we found that the trust had breached regulations within the community based services for adults of working age.

We issued the trust with three requirement notices. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation12 - Safe care and treatment
- Regulation 18 - Staffing

Our inspection team

Why we carried out this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

Summary of findings

- Visited eight community teams and the Brent Early Intervention Service
- Accompanied staff on nine home visits
- Spoke to 30 patients and 15 carers who were using the service
- Spoke with the team managers, service managers and service directors covering each of the services. We also spoke with 66 other members of staff including doctors, nurses, social workers, student social workers, employment advisors and occupational therapists
- Interviewed two members of the Hearing Voices group in Hillingdon
- Observed one clinic appointment with the consent of the patient involved
- Attended one Brent Pathway meeting which is a meeting between teams across teams to ensure issues arising across the patients' pathway are discussed.
- Attended one feedback meeting following assessments
- Attended and observed four 'zoning' meetings where patient risk and priority was discussed.
- Attended and observed one multi-disciplinary team meeting, one team meeting, one pathway meeting and one bed management meeting
- Attended and observed one handover meeting
- Attended and observed two Clozapine clinics
- Collected feedback from 27 comments cards
- Looked at 72 records including risk assessments, care plans and progress notes.
- Carried out a specific check of the medicine management in the Brent, Harrow and Hillingdon community teams
- Looked at a range of policies, procedures and other documents relating to the running of the service

This inspection was a short-notice, announced inspection.

What people who use the provider's services say

We spoke with 30 patients and 15 carers during our inspection.

We collected feedback from patients on 27 comment cards. Feedback from these was positive and included comments about staff friendliness, respect and kindness of staff.

Overall patients and carers were positive about the care and support they received. They told us they were treated with kindness, respect, dignity and were involved in their care planning. Patients told us they felt listened to in decisions relating to their care.

Patients and carers told us that they had been provided with a range of leaflets and other information and had good access to the recovery college and employment advisors.

Most patients, except those seen in the North Kensington and Chelsea and Milton Keynes team told us they knew how to make a complaint. Complaints posters and leaflets were available in reception areas for patient information in all of the services.

Good practice

- The occupational therapists in the Brent CMHTs were introducing a new approach to patient contact called 'Making Every Contact Count' (MECC) to support patients to make positive changes to their physical and mental well-being through day to day interactions.
- Peer support workers were employed within the CMHTS providing a truly holistic approach to care involving the lived experience of people who have used services. This development in service provision encouraged a collaborative, meaningful engagement process breaking down the stigma of mental illness and promoting patient engagement.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff working in the Milton Keynes CMHT have access to an appropriate alarm system.
- The trust must ensure that risk assessments are comprehensively completed and reviewed.
- The trust must ensure that all non-clinical staff undertake basic life support training and all staff undertake fire safety mandatory training to enable them to fulfil the requirements of their role.
- The trust must ensure that each patient has a care plan which is person-centred and that needs identified in the care plan are met or there is a clear indication of why they cannot be met.
- The trust must ensure that patients in the service have access to psychological therapies in line with best practice guidance.
- The trust must ensure that care co-ordinators regularly contact patients on their caseloads.

Action the provider SHOULD take to improve

- The trust should continue to ensure that lone working practices in the North Kensington and Chelsea and Milton Keynes CMHTs are followed.
- The trust should continue to focus recruitment strategies in the areas where there are the highest need of permanent staff particularly for nurses and social workers to work towards a more stable staff teams especially in Brent and Hillingdon.
- The trust should support patients to have crisis plans and contact details that reflect their individual needs.
- The trust should ensure that safeguarding referrals in the Milton Keynes CMHT are tracked so that progress of alerts, investigations and outcomes are known.
- The trust should ensure that locum staff and new permanent staff, especially in Brent have prompt access to essential patient record systems to perform their roles.
- The trust should ensure that patient rights are explained consistently when patients are on a CTO in accordance with the MHA Code of Practice.
- The trust should ensure that privacy issues identified in the reception area at the East and West Harrow CMHTs are addressed.
- The trust should ensure that patient involvement is clearly recorded in the care records and each patient provided with a copy of their care plan.
- The trust should continue to work at reducing the average referral to assessment time.
- The trust should ensure that all audits have an action plans to address any shortfalls identified.
- The trust should ensure that agreements are in place with local GPs in Brent so that patient discharges are not delayed.
- The trust should continue to ensure that patients waiting for an assessment or their first appointment are engaged with and monitored to support their risk management.
- The trust should ensure that casework discussions are detailed in staff supervision records.

Central and North West London NHS Foundation 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
Brent North Community Mental Health Team	Stephenson House
Brent South Community Mental Health Team	Stephenson House
Brent Early Intervention Service	Stephenson House
Harrow West Community Mental Health Team	Stephenson House
Harrow East Community Mental Health Team	Stephenson House
Hillingdon Community Mental Health Team West	Stephenson House
Hillingdon Community Mental Health Team North	Stephenson House
Recovery and Rehabilitation Team –Milton Keynes	Stephenson House
North Kensington and Chelsea Community Mental Health Team	Stephenson House

Detailed findings

Mental Health Act responsibilities

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

- Staff in all the teams we visited had a good understanding of the Mental Health Act (MHA) and the MHA Code of Practice in relation to their practice in a CMHT. They had accessed training and were aware of how to access advice. There were approved mental health professionals (AMHP) based in the community mental health teams. However, information provided by the trust showed that MHA training completed by staff was less than 75% for each team.
- Staff received support from the trust's MHA office and approved mental health professionals (AMHP) based in the community mental health teams.
- We checked eight community treatment orders (CTO). Required documentation was in place and the majority of patients had their rights explained to them. For one patient at the Milton Keynes CMHT we saw that their rights were not explained consistently as required by the MHA Code of Practice.
- In the Brent EIS team we saw good use of a CTO tracker which ensured that any reviews and renewals were completed in a timely manner.
- The MHA office carried out audits of MHA documents.
- Patients had access to an Independent Mental Health Advocacy Service (IMHA).

Mental Capacity Act and Deprivation of Liberty Safeguards

- In February 2015, we recommended that staff in all services fully understand the Mental Capacity Act 2005 (MCA) and code of practice. At this inspection improvements had been made. Staff had a good understanding of the Mental Capacity Act and assessed patients' capacity when there was a reason to do so and involved family members where appropriate.
- The provider carried out regular audits of MCA documentation. For example, an audit carried out in April 2017 within the East and West Harrow CMHT identified shortfalls with the recording of capacity and an action plan was in place to address this.
- Across the service 95% of staff had undertaken MCA training. Within the Brent EIS staff had undertaken specific training in relation to consent for under 16 year olds.
- Staff had access to a MCA leads within the trust for advice when needed.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- All the services we visited were clean, tidy and well maintained. Hillingdon and Harrow CMHTs had recently been refurbished.
- Five of the nine teams had interview rooms that were fitted with alarms so that staff could call for help if they needed it. However, at the CMHT in Milton Keynes there was no alarm system at the premises and staff did not carry personal alarms. This meant that if there was an incident in the clinic room or one of the interview rooms it would be difficult for staff to call for help. At the Harrow East and West CMHTs' interview rooms were not fitted with alarms, however staff had personal alarms on them when they were with patients. Checks had been carried out at regular intervals to ensure the alarms were working correctly and staff knew how to respond when the alarm went off.
- Clinic rooms in all services were well equipped. Staff had the equipment they needed to carry out physical health examinations, which included weighing scales and blood pressure monitors. Records of equipment checks and calibration details were kept. Sharps boxes, for disposing of needles, were available in clinic rooms. However, at the CMHT in Milton Keynes there was no record to show when the weighing scales were last calibrated. This meant the scales may give an inaccurate reading.
- In February 2015 the North Kensington and Chelsea CMHT did not have an automated external defibrillator (AED). During this visit a defibrillator was present and easily accessible to staff. Records showed that it was checked daily. Also at the February 2015 inspection we identified that the AED machine at the Hillingdon North CMHT had not been serviced since 2013 and there was a risk that the machine may not have worked in an emergency. At this inspection we found that all AED machines at the teams we visited had been serviced.
- Cleaning records were up to date and demonstrated that the environments were regularly cleaned. Practices were in place to ensure infection control. Staff had access to protective personal equipment such as gloves and aprons. Hand gel dispensers were available throughout each service for staff to sanitise hands to reduce the spread of infections.
- Infection control audits were completed and up to date, which meant that each service monitored that infection control measures were in place.

Safe staffing

- The trust had re-designed the community services for adults of working age in March 2016. Staffing was a challenge and there were high levels of vacancies across the service. At our inspection in February 2015 we identified that there were insufficient staff available to work as care co-ordinators, which meant that duty workers in Harrow, Brent and Hillingdon CMHTs were responsible for supporting a significant number of patients. At this inspection we found that this was not the case and duty workers did not have appointments or assessments with their regular patients when they were on duty so that they could concentrate solely on urgent and duty enquiries.
- The care co-ordination role was carried out by nurses, social workers and occupational therapists. They provided regular and on-going support to patients. The teams had occupational therapy input but in the North and South Brent CMHT, this had been separated from the care co-ordination role to ensure that a specific occupational therapy focus could be retained for all patients.
- All teams had staff vacancies. North Hillingdon CMHT had the highest vacancy rate at 36% followed by Brent South and Hillingdon West CMHT at 33%. The provider had a number of initiatives in place to address the challenges of vacancy rates and staff retention in Brent and Harrow. This included the introduction of the 'golden hello'. This is a payment given to all new recruits, given at intervals through their first year of employment. Relocation packages were offered to newly appointed staff and the trust was in the process of developing an apprenticeship programme for band 3 and 4 support workers as well as a new band 5 nurse 'first destination' role for newly qualified nurses.

Requires improvement

Are services safe?

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

- Staff in all the teams told us that staff turnover was a particular challenge, particularly as some locum staff did not stay on in the team for a long period, leading to increased disruption. This sometimes impacted on care delivery. For example, in Brent we saw one care record where the need for a carers' assessment had been identified 10 months prior to our inspection visit and had not taken place. For another patient we saw that they had been referred from the single point of access to the community team in January 2017 and at the time of our visit, in May 2017, they had not been contacted or there was not a record of any contact made. We raised this during the inspection and the team manager made contact.
- Some of the feedback from staff in the Brent CMHTs included concerns for patients when there were a lot of changes in care co-ordinators. At the North and South Brent CMHTs we heard that this was impacting on the regularity of contact with patients. We asked the trust to provide information about how many patients allocated within the service had not had any contacts with the Brent CMHTs for over 4 months. In Brent, 19% of patients had had no contact with the team for over 4 months and 62% of patients had their last contact with the team between 1 and 3 months previously. A contact included visits for routine depot injections and medical review meetings as well as regular meetings with a care coordinator. This meant that some patients had not had regular contact with a care co-ordinator for a significant period of time. The Brent operational policy for adult community mental health teams indicated that there is an expectation that all people being held either on CPA or with a lead professional, would be seen a minimum of once a month. This meant that for the majority of patients, this was not the case and people were at risk of not having their assessed needs met. Staff also described the difficulties of keeping records up to date due to the volume of work.
- Sickness rates across the service varied. This was the highest at Brent South CMHT at 4%, 3% at North Kensington and Chelsea and the lowest at Hillingdon North at 0%.
- The average total turnover rate for the 12 months leading up to our inspection across the service was14%. This was the highest in the Hillingdon North CMHT at 29% and Brent North CMHT at 24%.
- Caseloads varied between teams based on a number of factors such as referral rates and the impact of low staffing levels. Overall staff across all the CMHTs said caseloads were between 35 – 40 over the past 12 months but were now reducing to approximately to 30. Brent South CMHT and Harrow West CMHT had the highest caseloads at 35. In the Brent Early Intervention Service (EIS) the caseload limit was 25 to support engagement work with patients. Staff we spoke with told us that these limits were generally maintained. Senior practitioners had reduced caseloads to accommodate other tasks such as staff supervision.
- Team managers were aware of staff caseloads and adjustments were made to take account of the complexity of patients. Across the teams we inspected, caseloads were managed through regular supervision and review.
- All teams managed, reassessed and prioritised caseloads regularly in daily zoning meetings. Staff collaboratively reviewed patients on a case by case basis and rated the complexity and needs of individual people. Zoning meetings included discussion of high risk patients, those categorised as red and amber and the plans and actions needed to keep them safe.
- There were 16 patients at the North Kensington and Chelsea CMHT and 18 patients at the West Hillingdon CMHT where at the time of the inspection the care co-ordinator had left and they were in the process of being re-allocated.
- Each team had arrangements in place to cover sickness, leave and staff vacancies. This included the use of duty, agency and locum staff.
- Each CMHT operated a duty service to ensure patients received a safe service. Identified staff leads in teams rotated as the senior duty worker. The duty role involved covering enquiries for staff who were absent due to leave, sickness or training, carrying out any urgent assessments and seven day follow ups. Staff within all the Brent CMHTs and EIS also had a buddy system in place which meant when an allocated member of staff was off work, another member of staff would provide back-up cover for them with information about their

caseload. The receptionist and administrators were also considered part of the duty team as they took messages for the duty team when duty team staff were meeting patients or completing assessments.

- In February 2015, we identified that there were insufficient staff available to work as care co-ordinators which meant that duty workers in Harrow, Brent and Hillingdon CMHTs were responsible for supporting a number of patients. At this inspection we found that the arrangements for managing duty work had improved and were working well. When staff were doing duty work they did not have appointments or assessments with their regular patients so that they could concentrate solely on the duty role.
- Across the CMHTs staff and patients could access a psychiatrist when they needed. The Brent Early Intervention Service had two consultants, one who worked in the service full time and another who was specifically a CAMHS consultant who attended the team one day per week and were contactable on other days if necessary. Staff were able to refer patients promptly and each psychiatrist had daily emergency appointments available. Staff said they were able to access advice or input from a psychiatrist easily.
- As at 1 May 2017, the training compliance for all CHMT's across the trust was 89% against the trust target of 95%. However we found that at North Kensington and Chelsea, Hillingdon North and Harrow CMHT's basic life support training was below 75% for non-clinical staff which meant that there was a risk that staff may be in situations where they need to provide immediate support and their training would not be up to date. All staff with a clinical role undertook emergency life support training which was above 75% for eight of the nine services inspected. At the Brent South CMHT this was 72%. Staff who had not completed their mandatory training were scheduled to attend and training shortfalls were followed up with individuals at one to one supervision.

Assessing and managing risk to patients and staff

- In February 2015, some patients in the Harrow community recovery team did not have a current risk assessment in place. At this inspection, we reviewed 24 care records across both East and West Harrow CMHTs and found that all had risk assessments in place which were current.
- At the Brent CMHTs we identified five risk assessments where concerns identified were not reflected specifically in risk management plans and one care record where no risk assessment had been completed. For example, we saw a risk assessment which identified physical health risk but did not include any risk management plan relating to this need. At the Hillingdon West CMHT we saw one risk assessment where important risk information had not pulled through onto the most current risk assessment. This meant that there was a risk that key information about current risks may not be available to staff working with that patient.
- At the North Kensington and Chelsea CMHT three of the 11 records that we viewed did not contain a risk assessment. A further four records contained a risk assessment, but not all risks in the patients case notes and history were included in sufficient detail in the risk assessment. These four cases did not have plans in place detailing how the individual should manage themselves to minimise the identified risks and were not personalised. For example, we identified individuals who had existing safeguarding issues that did not pull through onto their risk assessments. In one case, the patient had a history of domestic violence and had a family living at home with them. There was a lack of detail about this history and how to manage this risk to protect family members at home. Staff within this team had already identified this as an area which required improvement following a care records audit in February 2017 and work was in process to improve the quality of risk assessments and risk management.
- Overall, the risk assessments reviewed across the other CMHTs were comprehensive and detailed. Risk assessments included information about patient's mental and physical health, substance misuse history, compliance with medicine and a long term crisis and risk management plan. Risk assessments contained information about patients who were vulnerable to harm or exploitation, harm to self and harm to others and staff had assessed each individual risk. Staff also

recorded events of risk in the patient's progress notes. Risk events we reviewed demonstrated that staff gave context and outcomes to the event and included patient feedback and involvement.

- At the North and South Brent CMHTs we saw that where substance misuse had been identified as a risk, a specific risk assessment tool, known as the Bromley Tool, which screens alcohol use had been used.
- Staff assessed and managed patient risk through daily zoning meetings. Risks were given a risk rating of red for high risk, amber for increased concerns and green for low risk. At these meetings staff discussed the plans and actions needed to keep patients safe.
- In February 2015, some crisis plans in the Harrow community recovery team were not always specific to the patient. At this inspection, patients care records at the East and West Harrow CMHT's contained crisis plans which were co-produced with patients and their families. These were person-centred and included triggers for crisis, techniques and support methods which had worked in the past to resolve individual crisis and the role of family and carers in crisis management. Patients and carers knew who to contact if their mental health was deteriorating and in a crisis situation.
- In the other CMHTs most patients' crisis plans contained standard information on the local emergency contact numbers and emergency facilities in the community. The trust provided crisis cards with details of the out-of-hours urgent advice line and the telephone numbers of other crisis services. Most crisis plans outlined what patients should do and who they should contact in an emergency. For example, one care plan included the arrangements for looking after the patients' children if the patient had to go into hospital. However, at North Kensington and Chelsea CMHT nine of the 11 records reviewed contained crisis plans which were brief and not person centred. At the Brent CMHT one crisis plan we saw did not have contacts for an emergency listed and one care record did not have a crisis plan in place.
- The duty worker at each CMHT could respond promptly to any sudden deterioration in a patient's health. This included staff undertaking urgent home visits.
- Senior team leads kept in telephone contact with people who had been assessed and were waiting for allocation to a care co-ordinator. This enabled staff to assess whether patients risk levels had changed whilst they were waiting for allocation. Staff rated these cases according to their risk after assessment. This informed how soon they would be allocated and how often the duty worker would make contact with them whilst they were waiting. Patients were also provided with telephone numbers to call if they were in crisis, and were made aware that they could see a duty worker at any time if they wished.
- The provider had systems in place to identify, report and act on signs or allegations of abuse. Staff had undertaken training around safeguarding adults and children and knew how to raise a safeguarding alert. Staff were familiar with the different types and signs of abuse and could describe these and the action they would take if a referral needed to be made. There was a safeguarding lead identified for each CMHT where staff could obtain advice and support. Staff were able to give examples of the safeguarding referrals they had made. However, at the Milton Keynes CMHT we found that whilst staff raised safeguarding concerns with the local authority appropriately, they did not have arrangements in place to track the number of concerns raised, the progress of alerts, investigations and outcomes. This meant there was a risk to the care and treatment of patients because the team did not know how many safeguarding alerts had been raised, whether there were any trends and any follow up actions required following investigation.
- The trust had a lone working policy in place to support staff working alone in the community and help ensure their safety. However, we identified that lone working procedures in the Kensington and Chelsea and Milton Keynes CMHTs were not robust. At the North Kensington and Chelsea service staff did not record when they were expected back from a visit or when they had returned. Staff in this team told us that in an emergency they would use specially provided mobile phones to call colleagues for help using a code word, but they did not know what the code word was.
- At the service in Milton Keynes there was no local policy for lone working. Staff did not carry alarms. When staff considered patients to present a heightened level of risk, staff visited patients in pairs. Staff did not leave details of the visit or the patient they were visiting. There was no system to check that their visit had ended safely. This meant that if there was an incident during a home

visit the member of staff may be unable to call for help and no one would be aware of the incident. Concerns around lone working had been identified by the team and a working group led by a consultant psychiatrist to improve the arrangements for staff safety had been set up. We saw that this was discussed at the weekly business meeting. However, this was insufficient to address the immediate risk. We informed the team manager of these concerns during the inspection. Following the inspection the trust told us that a more robust daily monitoring system managed by the duty workers in each team had been implemented including the requirement for staff to contact the office following a home visit.

- There were systems in place to ensure that patients consistently received their medicines safely, and as prescribed. Appropriate arrangements were in place for obtaining, storing, administering and recording medicines. The community pharmacist in each borough visited the community teams monthly and we saw evidence that the prescription charts had been screened and appropriate clinical interventions had been made.
- Each CMHT had a local clozapine clinic run by a community psychiatric nurse (CPN). At these clinics there was point of care testing for a patient's blood test which meant there were immediate blood test results so patients did not have to return for a second time to collect their medicine. Each time a patient visited the clinic a range of physical health checks were completed which included a patient's weight and blood pressure. Each CMHT ran local depot medicine clinics.
- Patients who were on community treatment orders (CTOs) had their CTO forms reviewed by a pharmacist each month. We saw evidence that the pharmacy team contacted the Mental Health Act law team if there were any concerns about the prescriptions on these forms. Any changes to a patient's medicine was communicated to GPs via a standard form which was sent either electronically or by post depending on the GPs practice preference.
- The trust had systems in place to monitor the quality of medicines management. Regular audits took place and any medicine incidents were reported.
- The trust had an excellent range of medicine information available to patients in a variety of accessible formats such as easy read. Further information was available to patients from the 'Choices and Medication' website set up by the trust. The trust also had a medicines helpline for patients.
- Each location had an in date anaphylaxis kit for use in an emergency.

Track record on safety

- The trust reported that there had been 22 serious incidents involving locality team patients since April 2016.
- Staff had a good understanding of incidents which had taken place in the services they worked in and were able to report on recent incidents.
- Some changes and improvements had taken place following incidents. For example at the Hillingdon North team we saw that all zoning meeting minutes were documented with clear action points for staff to complete following an incident of self-harm.

Reporting incidents and learning from when things go wrong

- Staff knew what type of incidents they should report and how to report them. Managers described an open reporting culture. The trust quality and governance teams had copies of all incidents reported so that information could be collated and trends could be identified. Some senior staff in the service were trained to complete root cause analysis investigations of serious incidents requiring investigation. We saw that families were involved in investigations.
- At Milton Keynes CMHT there had been 12 deaths between April 2016 and May 2017. The clinical governance team assigned four deaths a rating that required investigation. The trust had investigated these incidents thoroughly. At the time of the inspection visit investigations into the other deaths were not required. This was because the deaths were either due to natural causes or the preliminary investigation carried out by the service did not identify concerns relating to care.
- Staff made improvements to the service in response to learning from incidents in order to reduce the risk of the same type of incident happening again. For example at

Requires improvement

Are services safe?

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

the East and West Harrow CMHTs we saw examples of lessons learned included ensuring all staff were reminded to record all contacts and records to reflect the care and treatment that patients had received from the service.

- In February 2015, we recommended that staff should be supported to learn about incidents from services in other parts of the trust. At this inspection we found this had improved and information regarding incidents in other services was shared.
- Staff received feedback from investigation of incidents through team meetings, individual supervision and multi-disciplinary team meetings. We observed feedback about an incident which was shared in the Brent pathway meeting we attended. The key theme of this incident related to communication between teams and ensuring that patients and carers do not fall between cracks in service provision. This involved a team manager giving feedback to their peers about an incident which they had investigated and highlighted both short term and longer term learning that each team could reflect on and work with to improve their own services
- Staff were open and transparent with service users when something went wrong. For example, at North Kensington and Chelsea CMHT a face to face meeting was arranged with a patient following a medicine error so that staff could provide an explanation and apology for what had gone wrong. At the East and West Harrow CMHTs we saw that staff had apologised in writing to patients who had their care plans or letters to GPs inadvertently sent to other patients.

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.

Our findings

Assessment of needs and planning of care

- Doctors and nurses carried out a comprehensive mental health assessment of individual patients when they were referred to the service, this was to determine whether the service could meet their needs. Assessments we reviewed were complete, comprehensive and included the patients' perspective and goals.
- Most care plans were holistic, related to individual needs, included patient views and were reviewed regularly through the CPA process. However, three of the records we reviewed at North Kensington and Chelsea CMHT did not have a care plan and three other care plans were brief and not person-centred. The team manager had already identified this as an area of improvement following a care plan audit in February 2017. For one patient at the Brent South CMHT we identified their care plan had not been updated following an inpatient admission and that the care co-ordinator had not actioned the recommendations made by the occupational therapist. Two other care plans we looked at did not indicate any information about patients' physical health care needs and two other care plans did not have clear discharge plans to explain how people would move on from the team. This meant that there was a risk that patients needs would not be met.
- In February 2015, we recommended that in Harrow community recovery team care plans for patients supported by a lead professional clinician (LPC) usually consisted of a letter for the patients' GP, some of which had technical language. During this inspection, we found that patients supported by a LPC at outpatient clinics had a care plan in their care records where needed which included patients' social needs and individual goals and were easy to understand.
- Staff used the trust database system to access records which were held electronically. However, in the Brent North and South CMHTs some staff raised a concern that when new locums and permanent staff started, they did not immediately have access to the records system which meant that this could place an additional burden on those staff in the team who accessed records on their behalf.

Best practice in treatment and care

- Prescribing of medicines were in accordance with National Institute for Health and Care Excellence guidance (NICE). Psychiatrists referred to national guidelines when prescribing medication and discussed medicine decisions with patients.
- In February 2015, we recommended that psychological therapies be available for patients which reflect NICE guidance. At this inspection, we found little improvement in this area. For example, at the Milton Keynes CMHT a clinical psychologist was not employed and none of the patients registered with the service were receiving a service from the psychological therapies team. Fifteen members of staff we spoke with across Brent North and South CMHTs, mentioned specifically how the low level of psychology provision had impacted on service delivery and also how many patients were having to wait long periods before receiving this input.
- Some of the teams were addressing the lack of one to one therapy. For example, the clinical psychologists and psychology assistants at Hillingdon West CMHT were developing a group that people on the waiting list could attend whilst they waited for one to one treatment. In addition the team at North Kensington & Chelsea CMHT were working with the local psychotherapy department to provide group based services for group therapies to support patients and reduce waiting times. This was in response to concerns raised by patients on the waiting list.
- Patients were supported with applications and reviews of their housing, employment and benefits. Most of the teams had an employment advisor based within each service, supporting patients with preparing CVs and interview preparation. At the Milton Keynes CMHT care co-ordinators supported patients with housing and employment matters. The service frequently referred patients to local community services such as the citizens advice bureau for specialist advice. These groups held a weekly drop-in service at a community venue specifically for people using mental health services. At the North Kensington and Chelsea CMHT a dedicated citizen's advice office operated on site for all patients to use. Patients told us that they had received help finding accommodation and completing benefits

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paperwork. There was an employment advisor who worked specifically in the Brent EIS team and liaised with local employers and colleges to access additional support and opportunities for patients.

- In February 2015, we identified that in the Harrow community recovery team some patients had not been referred for a physical health check in the previous year. During this inspection, we looked at 24 care records and found that all patients except one had received physical health checks in the previous year.
- Staff supported patients to attend for an annual physical health check at their GP surgery. Some staff at the Brent North and South CMHTs told us that this information was not always received back and that liaising with GPs was not always smooth. Referrals to specialists were made when needed. Physical health monitoring for patients prescribed lithium was carried out at the patient's GP surgery.
- We observed a review of physical health carried out a clozapine clinic at the Hillingdon West CMHT. Staff were knowledgeable, efficient and provided clear explanations to patients questions. Staff checked and recorded the weight, pulse and blood pressure each patient and discussed the side effects of medicine. Staff also discussed other physical health issues and advised patients to see their GP for this. Staff told us that any concerns relating to patients' physical health, identified at the clinics, was communicated to the duty worker or care co-ordinator without delay.
- The Milton Keynes CMHT had developed a specific project to promote the physical health of patients. The service provided staff with portable equipment to carry out health checks at the patient's home. In the North Kensington and Chelsea CMHT regular physical health checks had started to be rolled out for patients in-house, to prevent delays and inconsistencies with booking GP appointments. A physical health and wellbeing group was also led by the peer support worker at the North Kensington & Chelsea CMHT. This provided psychosocial support for patients to make healthy lifestyle choices and improved understanding and importance of healthy eating.
- Information and support was available to patients to improve their physical healthcare. Occupational therapists and peer support workers in some of the teams ran a health and wellbeing group. Patients could also access health and well-being courses at the recovery college such as healthy eating, managing stress and physical exercise.
- Plans were in place across all the teams to introduce the SHINE programme which was part of a quality improvement initiative within the trust. This aimed to improve patients' physical health assessment as part of the physical health implementation strategy of the trust. The SHINE programme aimed to improve routine assessment and detection of physical health problems and lifestyle risks in people with long-term mental health conditions. Staff within the Brent CMHTs told us that they had started to undertake some audits in order to identify physical health needs of patients in the community. For example, the Brent South CMHT were in the process of identifying patients who had a diagnosis of diabetes for a focussed piece of work to develop diabetes awareness for staff.
- In February 2015, we recommended that the trust support staff who were working with patients with a personality disorder. At this inspection, we found that most staff within the East and West Harrow CMHTs had completed specialist training to support people with a personality disorder. A full time psychiatrist who had a speciality on personality disorders worked within this team. This meant that staff could access support and expertise when they worked with patients with a personality disorder.
- Occupational therapists used recognised assessment tools and outcome measures including the model of human occupation screening tool (MoHOST) and INSPIRE which is a tool used to measure a patient's experience of the support they receive from a mental health worker and focusses on recovery. Staff throughout the service used the health of the nation outcome scales to record progress. Staff told us and records showed that a number of rating scales were also used to monitor the severity of symptoms. These included rating scales for depression, anxiety and alcohol use. At the Milton Keynes CMHT staff measured the severity of medicine side effects using the Glasgow Anti-psychotic Side-Effect Scale.
- Clinical staff regularly completed a range of audits to monitor the delivery of care and treatment. These included the auditing of staff recording patients' care

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notes and risk assessments, infection control procedures, environmental assessments, medicines, audits of assessment waiting times, an audit of physical health care needs and health and safety procedures.

Skilled staff to deliver care

- There was a range of staff disciplines within the teams including doctors, nurses, occupational therapists, clinical psychologists, social workers, consultant pharmacist, employment specialists and peer support workers. Staff working within the teams were experienced and qualified to carry out their roles.
- All new staff including temporary staff received an induction from the trust which provided staff with the relevant information required to commence their roles.
- All staff told us that they had access to regular supervision. We checked supervision records and saw that staff received supervision on every four to six weeks and had annual appraisals. At the North Kensington and Chelsea CMHT completion of staff supervision still required ongoing improvement. No supervision sessions had been recorded before January 2017. However, the team had introduced a new supervision structure to ensure that regular supervision took place. We reviewed five supervision records at this team. Three of these did not detail discussions about the employee's casework which meant that there was a risk that patients needs would not be met.
- The total number of non-medical staff who received an appraisal in the last 12 months was 84%.
- In February 2015, we recommended that staff at the Harrow CMHTs addressed how they supported patients with a personality disorder. At this inspection improvements had been made. For example, in the Harrow East and West team most staff had been trained in systemic therapy, cognitive analytical therapy, Eye Movement Desensitization and Reprocessing (EMDR) therapy, knowledge and understanding framework (KUF). These specialist training courses prepared and trained staff to support patients with a borderline personality disorder.
- Staff were appropriately qualified and able to undertake continuous professional development and specialist training to their role. Records showed staff had completed training that was relevant to their role. For example, two members of staff within the West Harrow CMHT had additional training and expertise to work with patients with a forensic background. This included training on suicide prevention in criminal justice and PREVENT training to support patients at risk of terrorism and extremism.
- Four nurses in the Milton Keynes CMHT were qualified as non-medical prescribers. This meant they could prescribe medication to patients under the supervision of a psychiatrist. One member of staff in the Brent EIS was trained to deliver family therapy. Doctors accessed a regular academic programme which was based within Brent.
- Peer support workers were embedded in the teams. Peer support workers have 'lived experience' of mental health. They empowered patients to have their voice heard, took part in MDT meetings and promoted recovery focused practice. Peer support workers had undertaken specific training for their role such as leading on therapeutic book clubs and carried a small caseload.
- The human resources department provided support to team managers to address any poor performance issues.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team meetings (MDT) were regularly held in each of the teams. Staff shared information and worked effectively to make informed decisions about patient care. We attended and observed a range of multidisciplinary team meetings and saw how well the different disciplines worked together.
- Staff attended zoning meetings, allocation meetings and complex case discussions on a regular basis.
- Each team maintained good working links with other agencies involved in individual patients' care, including the home treatment teams, crisis teams, drug and alcohol services, social services and probation teams.
- Nurses in the West and North Hillingdon and North and South Brent CMHT's reported that the working relationships with GPs in the boroughs was mixed. They highlighted some poor communication and GPs not wanting to engage in the CPA process.

Are services effective?

Requires improvement

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- Staff told us that they signposted patients to community groups and activities. Occupational therapists in the North and South Brent CMHTs had started a 'Give it a Go' group which took patients to local community groups and functions once a week. They told us about plans to start up groups to focus on discharge and a healthy living group specifically for people who took clozapine to address the side effects of the medicine such as weight gain. In the East and West Harrow CMHTs staff supported patients to access specialised services for example, deaf patients were supported to access the deaf adult's community team and the West Hillingdon CMHT staff worked closely with the local university to support students with a mental health condition.
- The Brent Early Intervention Service worked with local schools specifically in order to meet the support needs of patients in the service. They also linked in with colleges and universities. EIS had strong links with the community child and adolescent mental health service (CAMHS) services in Brent. One of the EIS consultants also worked in a Brent CAMHS service and attended the team weekly. This meant that there was a very good relationship between the services and that information was able to flow to the benefit of patients. EIS consultants across London met weekly to share good practice.

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

- Staff in all the teams we visited had a good understanding of the Mental Health Act (MHA) and the MHA Code of Practice in relation to their practice in a CMHT. They had accessed training and were aware of how to access advice. There were approved mental health professionals (AMHP) based in the community mental health teams. However, information provided by the trust showed that MHA training completed by staff was less than 75% for each team.
- Staff received support from the trust's MHA office and approved mental health professionals (AMHP) based in the community mental health teams.
- We checked the records of eight patients who were currently subject to community treatment orders (CTOs). A CTO is a legal order, which sets out terms under which a person must accept treatment whilst living in the community. Patient records included the required CTO documentation that patients had their rights explained to them. However, at the Milton Keynes CMHT for one patient we saw that there rights were not explained consistently when periods of CTO were being renewed, changes in treatment were being considered or when there was a care programme approach review. This meant the service was not acting in accordance with the requirement of the MHA Code of Practice.
- In the Brent Early Intervention Service EIS team there was good use of a CTO tracker which ensured that any reviews and renewals were completed in a timely manner.
- The MHA office carried out audits of MHA documents.
- Patients had access to an Independent Mental Health Advocacy Service (IMHA).

Good practice in applying the Mental Capacity Act

- In February 2015, we recommended that staff in all services fully understand the Mental Capacity Act 2005 (MCA) and code of practice. At this inspection improvements had been made. Staff had a good understanding of the Mental Capacity Act. Staff assessed patients' capacity when there was a reason to do so and involved family members in making decisions when patients lacked capacity. For example, a capacity assessment had been carried out in relation to treatment decisions and appointeeship at the Milton Keynes service.
- The provider carried out regular audits of MCA documentation. For example, an audit carried out in April 2017 within the Harrow team identified shortfalls with the recording of capacity and an action plan was in place to address this.
- Across the service 95% of staff had undertaken MCA training. Within the Brent Early Intervention Service staff had undertaken specific training in relation to consent for under 16 year olds.
- Staff had access to a MCA leads within the trust for advice when needed.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff interacting with patients in a positive and engaging way. Staff were skilled, knowledgeable, polite, caring and helpful. Staff spoke to patients in a respectful way, taking time to explain treatment options and listening to their concerns. Staff provided appropriate practical and emotional support.
- Staff spoke about patients respectfully and demonstrated a good understanding when describing the needs of individual patients.
- Staff we spoke with had a good understanding of how to protect confidentiality. Records were kept securely.
- Staff in the North and South Brent teams told us that there was a high turnover particularly when patients were allocated to locum care co-ordinators who left after short periods. This meant that there was a risk that staff would not build longer term relationships with patients.

The involvement of people in the care that they receive

- Patients told us they were involved in decisions about their care and most care records we reviewed confirmed this. Patients attended care review meetings and were given copies of care plans. Care plans included a section that gave details of patients views. However, at the North Kensington and Chelsea CMHT six care records did not clearly record patients involvement and none of the patients or carers who we spoke with had their own copy of a care plan.
- At the Harrow East and West CMHTs we found that all care plans included the patients' voice. The teams completed an audit of person-centeredness in care plans for patients on a lead professional care plan and a CPA. This audit looked at collaborative decision making between patients and professionals, identifying goals and the individual perspective among other indicators.
- There was appropriate involvement of families and carers. The service routinely invited carers to care planning meetings in accordance with people's wishes. Most carers we spoke with gave positive feedback about the service. Carers told us that staff supported them. Some carers at the North Kensington and Chelsea CMHT fedback that they were not involved enough and often spent time chasing information as a result.
- Processes were in place for ensuring that carers received the assistance they were entitled to. Staff within the teams had a responsibility to undertake carers' assessments.
- Patients were able to access a range of advocacy services. Staff understood how to support people to access an advocate.
- Patients using the service were regularly involved in the recruitment of staff. Patients at the West Hillingdon CMHT had co-produced the information leaflet about the service.
- There were well established carer forums in the Harrow and Hillingdon CMHTs. At the time of our inspection, staff in the Brent CMHTs were planning to set up a carers' forum for the carers' of those who received services both in the community mental health teams and the EIS, however this was not yet running.
- Patients were invited to give feedback on the service through a 'friends and family' questionnaire. Results were collated and action plans developed to make improvements. Comments boxes were available in reception areas. We observed a 'you said' 'we did' board in the Harrow and Hillingdon services. At the West and North Hillingdon CMHTs we saw examples of where staff had taken action on issues service users were unhappy about. This included the consistency of staff, the external environment around the building at Hillingdon East and West CMHT and care plan involvement.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The majority of referrals to the teams were directed through the trust Single Point of Access team (SPA) based in the trust headquarters. Referrals were received via GPs, other agencies and self-referrals. The SPA team triaged urgent referrals within 24 hours to the home treatment team whilst the rapid response team accepted referrals needing to be seen within 4 hours. These referrals were then transferred to the local teams, where there were targets of 28 days to assess for routine referrals and 7 days for 'routine plus' referrals. Early Intervention Service referrals had a target of being seen for an assessment with 14 days.
- The trust aimed to have the service assess 95% of new referrals within the target time.
- Urgent referrals were discussed at the daily zoning meetings. Doctors within the teams could review urgent referrals. All the teams had a duty system to enable the team to respond to urgent telephone enquiries from health professionals and deal with emergency situations. The duty worker was also able to see patients quickly if required.
- The trust was not meeting the agreed target of 28 days for routine referrals to assessments, although this was improving. From November 2016 to April 2017 average routine referral to assessment waiting times was 31 days across all services. The average number of days was fluctuating between months. At the end of April 2017 the average waiting time was 31 days which was a drop from March 2017 where the average was 37 days. Across the eight services, North Hillingdon CMHT had the highest average waiting time over the six months at 47 whilst North Brent CMHT had the lowest average of 25 days. Breaches to the trust targets were monitored by each team and reported on at service and divisional level.
- From November 2016 to April 2017, Brent EIS had an average waiting time for referral to assessments of 14 days. At the time of our inspection, they were meeting that target 50% of the time. There was a waiting list for the employment support worker, however, the team had worked specifically on reducing this and while there was a waiting list of 2 to 3 months at the time of our inspection, it had been 4 months previously.
- Each team monitored the referral to assessment waiting times, where shortfalls were identified in meeting target times action plans were in place. For example, in the East and West Harrow CMHTs there was a management plan in place to address non-compliance with the target time by reviewing the teams' management referral process, training administration staff and telephoning new referrals before their appointment to confirm attendance. In the Brent CMHTs there had been an in-depth review of the non-compliance with the CCG urgent pathway targets. Improvements had been made in the North Kensington and Chelsea CMHT in the timeliness of assessments and 81.8% of routine referrals were seen within 28 days in April 2017, an increase from 25% in January 2017.
- Once patients were assessed, each team had arrangements to review new referrals in order to prioritise them for treatment. Non-urgent referrals were discussed at weekly allocation and team meetings. Staff looked at the complexity of cases and allocated based on staff capacity. For example, we observed one of the twice daily meetings held at the North and South Brent CMHTs where staff who had assessed new patients reviewed this information with other members of the team to decide the next steps. We saw that the teams made multi-disciplinary decisions relating to people who had not attended arranged appointments and the current and future care needs of patients who had been assessed.
- Teams responded appropriately and quickly when patients called the service. However, some patients at the East and West Harrow CMHTs told us that there were difficulties with the telephone system and they sometimes waited a long time for a response. At the East and West Harrow CMHTs most crisis plans contained details of the Harrow service telephone number to contact, which was difficult to get through to. Two crisis plans contained the direct telephone numbers of staff. This meant that some patients would not be able to access support during a crisis if, for example, those members of staff were on leave. The telephone system at North Hillingdon CMHT had similar

Are services responsive to people's needs?

Good

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

issues which were being addressed. Since our last inspection the telephone system had been upgraded and was integrated with the IT system. This issue was on the local and trust wide risk register. This had been escalated and senior leaders were having weekly meetings with the IT provider to address this and had arranged for additional staff to assist the reception staff at the service.

- Most patients who did not attend appointments or were difficult to engage were followed up appropriately. This included staff making telephone calls, sending SMS messages, reminder letters and home visits were made if appropriate.
- Patients were discharged from the service when they no longer needed clinical support or care coordination to support mental health, social or psychological needs. At the East and West Harrow teams we saw that patients who had been with the service for many years, or who had complex health problems, were supported to be discharged to the primary care mental health team (PCMHT). The PCMHT supported patients monthly for six months after discharge from the CMHT. The PCMHT acted as a bridge between the patient and their GP to make sure that the GP understood and was able to support patient's needs. The North Kensington and Chelsea CMHT were in the process of introducing the PCMHT to facilitate discharge and reduce caseload numbers within the team.
- Staff at the Brent CMHTs fedback concerns regarding the delay in discharging patients on team caseloads. The impact of this was that new work could not be carried out as efficiently. There was no agreement in place with local GPs to accept patients who needed depot injections to support their return to primary care which meant patients were remaining with the CMHT so their medication could be administered. In an effort to proactively manage discharges from the team, the Brent CMHTs had employed two nurses to work with people who were being held by lead professionals and were not subject to CPA to facilitate speedier discharges.
- We attended one pathway meeting in Brent which was a fortnightly meeting between the Brent community teams and the single point of access team including the home treatment team and psychiatric liaison service based at the local hospital. This allowed teams to feedback about any misunderstandings or particular issues in their services and for information and learning to be shared following incidents.
- Most patients we spoke with told us that appointments ran on time and if there was a delay or cancellation staff offered an explanation. Each CMHT operated during the normal working week. Teams where flexible about appointment times when this was necessary to meet peoples' needs.

The facilities promote recovery, comfort, dignity and confidentiality

- In February 2015, we found that the areas used by patients at West Hillingdon CMHT (Mead House) required refurbishment. At this inspection the premises at West Hillingdon CMHT had been refurbished and this had improved the facilities for staff and patients. All of the premises were well maintained and furnished. Each team had access to a range of rooms including consultation, clinic and meeting rooms.
- The majority of patients we spoke with gave us positive feedback about the care and treatment they received from their care co-ordinators. Patients and carers told us that staff were friendly and approachable and would always welcome queries about medicine or treatment between appointments. However, some patients reported that there were dignity and privacy concerns in the reception area of the building which housed the East and West Harrow CMHTs. Patients said that other patients could hear them when they discussed confidential matters with the receptionists, because there was not enough space between the desk and the seating area.

Meeting the needs of all people who use the service

- Staff within the teams were able to access interpreters for initial assessments and follow up appointments and were able to give us examples of when they had done so.
- Services were accessible to people with physical disabilities. Where required staff would undertake home visits to people who were unable to attend the service due to their physical needs.

Are services responsive to people's needs?

Good

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

- A patient in the Hillingdon team told us that whilst on recent holiday in Cornwall the care co-ordinator had been in touch during the holiday. They had also provided details and set up contact with home treatment team in Cornwall if needed.
- All staff in the teams accessed online equality and diversity training.
- All waiting areas had notice boards and leaflets which provided a range of information such as local services, advocacy support and how to raise concerns and complaints. The leaflet sent to people who had been referred to the service was available in five community languages and further translation was available if necessary.
- In the Brent Early Intervention Service records detailed that written communication to a patient had been translated into their native language.
- Staff were aware of community groups who could offer support to patients from diverse backgrounds. In the North Kensington and Chelsea CMHT we saw that staff referred BME patients to a specific BME resource service at a local charity.

Listening to and learning from concerns and complaints

- Staff we spoke with were aware of the trust complaints procedure and how it could be accessed. Information about how to complain was on display in patient waiting/reception rooms in the services we visited.
- Most patients and carers knew how to complain. However, none of the patients or carers we spoke with at the North Kensington and Chelsea and Milton Keynes CMHT reported they did not know how to make a complaint.
- The community mental health services for working age adults had received 48 complaints from patients and carers in the 12 prior to the inspection. Nine complaints were upheld and 21 were partly upheld. Three complaints had been referred to the ombudsman and seven were still under investigation. The issues patients and carers complained about most were clinical care, communication and staff conduct which included staff attitude and complaints about individual clinicians.
- Staff actively reviewed complaints with the aim of improving people's experience of the service. Complaints were discussed at senior management and team meetings which meant lessons were learned and shared with others.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff knew and understood the trust vision and values. Staff demonstrated the vision and values in the way they worked with patients in all the community teams. The services had undergone a re-design since our last inspection in February 2015 where specialist teams were brought into more general community mental health teams. Some staff told us that there had not been widespread consultation although there had been communication about this to each of the teams. We were told that additional service developments were planned, however, it was not clear what impact this would have on staff morale.
- Staff knew who the senior managers in the trust were. Staff reported that the trust senior management team and board members visited the teams. Staff at the North Kensington and Chelsea team told us they felt that the most senior people in the trust hadn't fully recognised some of the positive changes that they had made in the months leading up to our visit.

Good governance

- The trust is divided into three separate divisions. Each division has a separate governance framework. Governance arrangements were in place within each division that supported the delivery of the service identified risk and monitored the quality and safety of the services provided. Each team monitored their performance in terms of compliance with commissioner targets and key performance indicators. This included performance and information on staff training, staffing, complaints, incidents, accidents, CPA reviews, referral and discharge information.
- The trust was very aware that they had a significant challenge with staff recruitment and there was an ongoing recruitment process to fill staff vacancies across the service. A number of initiatives were in place to address recruitment and retention difficulties such as the 'golden hello' and relocation packages. There was a high turnover rate in some of the teams in Brent. For example, in the North Brent CMHT, the average turnover in the year prior to the inspection was 24%.
- The services had systems in place to provide assurance as part of their governance processes. Staff participated in regular audits to identify areas of improvement and monitor standards of care and treatment. For example, following an audit at the North Kensington and Chelsea CMHT improvements were made to the duty worker rota, and using bank staff to improve the timeliness of assessments. The service was also considering employing nurse prescribers to minimise the number of patients waiting to see a doctor. In the Brent CMHTs staff were working with clear action plans developed from incidents, peer review programmes and audits. However, we saw some audits, such as the local audits of care plans, did not have specific action plans to ensure that issues identified were remedied by the team.
- Senior managers demonstrated a good understanding of the risks within the community services. We saw minutes from local and divisional governance meetings which indicated that the management team had a good overview of the risks, strengths and challenges in the services we visited. Some teams had recently started using a new business intelligence tool which would provide real time information such as individual case loads and waiting times. Where this was not in use team managers were in the process of being trained to use it.
- Team managers escalated risks related to the service via their line managers and in regular quality and performance meetings. A risk register was held at team level and service/directorate level.
- In February 2015, we found that Harrow and Hillingdon team risk registers did not reflect all risks. At this inspection we viewed, the risk registers at the Hillingdon and Harrow CMHT's. All identified risks were recorded, scored and rated according to severity, and there was evidence of some review of risks. Team managers were familiar with the local risk areas for their teams which included recruitment, poor IT systems including the telephones and not meeting referral targets.

Leadership, morale and staff engagement

- Overall staff across the CMHTs were positive about working for the trust. They said morale was mostly good and the team culture was supportive and inclusive. Some staff across all the teams told us that morale can

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.

be low due to changing caseloads and staff turnover. Staff reported that team and senior managers were supportive and had good oversight of the challenges that staff faced working in the community teams.

- Numerous staff and managers through the Brent CMHTs told us that they often worked beyond the 9am to 5pm Monday to Friday period for which they were employed and it was not unusual for staff in the team to come in early, go home late and work through their lunch hours. One member of staff described this as working on 'goodwill' with an assumption by the trust that this was expected in order to complete the work allocated to them. This meant that there was a risk that staff were not being remunerated for the hours which they were working with the potential for impact on their wellbeing and retention as well as ongoing morale in the team.
- There were no reported cases of bullying or harassment in any of the teams we visited. Staff said they knew how to raise concerns and felt they could do so without victimisation. Staff told us that they were aware of the trust whistleblowing processes. One member of staff in the Brent CMHT contacted us anonymously raising concerns about their service during the inspection. They raised concerns about staffing levels, workload and morale. However, generally, staff we spoke to during the visit across the Brent CMHTs were positive about the support they received from their managers and through the division, although many staff referred to the difficulties of working where there was a high turnover rate.
- Staff were open and transparent and explained to patients when things went wrong.

Commitment to quality improvement and innovation

- The occupational therapists in the Brent CMHTs were introducing a new approach to patient contact called 'Making Every Contact Count' (MECC) to support patients to make positive changes to their physical and mental well-being through day to day interactions.
- The SHINE project was being rolled out across all the community teams as part of the trusts improving physical health strategy for patients. This meant that the teams would have a greater focus on the physical health needs of patients.

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 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not provided in a way that ensured that assessments of needs and preferences of the service user were carried out and that these needs were met. Care plans were not person centred at North Kensington CMHT At Brent CMHT, care and treatment was not carried out in accordance with the care plan and care plans did not always include identified needs. Access to psychological therapies was limited which meant patients were not receiving care in line with best practice or having to wait a long time for this input. Some patients in the North and South Brent CMHTs had not had regular contact with a care co-ordinator for a significant period of time. This placed them at risk of not having their assessed needs met. This was a breach of regulation 9(1)(2)(3)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Care and treatment was not provided in a safe way for service users.

Risks to patients were not always assessed, risk assessments lacked detail and management plans did not address identified risks.

This was a breach of regulation 12

(1)(2)(a)(b)(c)(e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Premises and equipment used by the service provider were not suitable for the purpose for which they were being used.

Staff were at risk because the Milton Keynes CMHT did not have an alarm system and staff did not carry personal alarms when seeing patients.

This was a breach of regulation 15(1)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staff were not receiving appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The trust must ensure that all non-clinical staff undertake basic life support training and all staff undertake fire safety mandatory training.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 18(2)(a)