West London NHS Trust

Mental health crisis services and health-based places of safety

Inspection report

Trust Headquarters
1 Armstrong Way
Southall
UB2 4SA
Tel: 02083548354
www.westlondon.nhs.uk

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Mental health crisis services and health-based places of safety

Inspected but not rated

We carried out this short-notice announced focused inspection to follow up on concerns raised about the safety and quality of the service being provided. In February 2021 the local coroner published a Regulation 28 Prevention of Future Deaths Report following the death of a patient being cared for by the Hammersmith and Fulham crisis, assessment and treatment team (CATT). This inspection focused on specific areas of concern raised by the coroner, recommendations made following the serious incident investigation and the actions taken by the trust in response to this death.

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic. Three inspectors visited the CATT service on 26 and 27 May 2021 to complete essential checks. The remainder of our inspection activity was conducted off-site. This included staff, patient and carer interviews over the telephone and analysis of evidence and documents. Our final telephone interview with a staff member was completed on the 17 June 2021.

Hammersmith and Fulham crisis, assessment and treatment team (CATT) is part of West London NHS Trust's mental health crisis services and health-based places of safety core service. This core service was last inspected in 2018 with a rating of requires improvement in the safe domain and good across the effective, caring, responsive and well led domains. The core service was rated good overall.

The trust has two other CATTs which cover the London Boroughs of Ealing and Hounslow. The CATTs provide initial assessments for patients in crisis referred to secondary mental health services, as well as providing brief interventions for periods of up to three months. The service refers to these different functions as (tier 1) crisis support and (tier 2) brief intervention therapy. The CATTs also support patients who are being discharged from hospital and gate-keep all inpatient admissions.

We did not rate this core service at this inspection. The previous rating of good remains. We found:

- The service assessed and managed individual patient risk appropriately. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients, family and carers to develop crisis plans.
- Changes had been made to risk management processes and clinical risk training. Twice daily handovers took place and arrangements for out-of-hours handovers were now set up. Twice weekly multidisciplinary meetings had been introduced where all patients on the crisis caseload were reviewed. Missed and cancelled appointments were reviewed daily and appropriate follow up action taken.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health CATT regularly reviewed the effects of medicines on each patient's physical health.
- Staff developed care and treatment plans informed by a detailed assessment and, usually, in collaboration with families and carers. They provided a range of treatments that were informed by best practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff supported, informed and involved patients, families or carers appropriately. Work was being undertaken by the team to further embed the Triangle of Care standards to improve patient and carer involvement.

Our findings

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Governance systems to ensure the effective running of the service were in place. The trust had effective systems for identifying risks and managing and reducing these. Leaders had recognised the issues with the service and had developed an action plan which was reviewed regularly at both the team and service line clinical improvement groups.
- Work was in the process of being undertaken to improve the quality of record keeping and address any gaps identified.

However:

- Whilst staff were assessing and managing patient risk well through regular handovers and MDT meetings, recorded risk assessments were not always updated regularly. We identified this as a breach of regulation at our last inspection. At this inspection we found the provider continued to be in breach as the required improvements had not been made.
- For two patients the risk management plans were not clear. Decisions made at handover meetings were not always recorded in the patient care and treatment record.

Is the service safe?

Inspected but not rated

We inspected elements of the safe domain during this focused inspection but did not re-rate it.

Mandatory training

The service provided mandatory training to staff and made sure everyone completed it. Changes were made to clinical risk training, which is mandatory for all clinicians, following the incident and coroner's report. The trust had developed bespoke training for the CATTs and the trust's single point of access (SPA) team on clinical risk. This was led by a Clinical Risk Practice Development Clinician. Staff confirmed that changes had been made to clinical risk training and that there was much more of a focus on risk formulation. Seventy three per cent of staff in the Single Point of Access (SPA) and 83% of staff in the Hammersmith and Fulham CATT had completed the training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health.

The CATT worked closely with the trust's Single Point of Access (SPA) team to ensure patients had access to the service in a timely manner. Changes had been made to the SPA triage assessment tool and referral management document following the serious incident investigation. This ensured that the decision-making process for referrals to the CATT was clear.

Our findings

Staff had a good understanding of patient risk and the arrangements in place to assess patient risk. Individual patient risks were assessed when patients were referred and accepted by the service. Staff used a recognised risk assessment tool.

Risk assessments had been completed for nine of the ten patients we reviewed. One patient did not have a risk assessment completed during the entire period they were being cared for by the crisis team. However, whilst no risk assessment had been completed for this patient, the progress notes detailed that a face-to-face assessment had been undertaken on referral and that daily visits were being carried out. For another patient there was a delay of 10 days before completion of the risk assessment, however, there was evidence their risks were being addressed in the progress notes. For two patients, the risk assessments did not clearly detail the risk management plans in place.

Recorded risk assessments were not updated regularly. Changes in risk and key information were documented in individual progress notes rather than updates to the risk assessment itself. This meant that here was a risk that staff working different shift patterns would need to look in more than one place for the required information. However, staff were managing patient risk well through regular handover meetings where actions were agreed and then allocated to a member of healthcare staff to complete.

The operational team were aware of these issues and were in the process of adding a clinical portal summary (CPS) to the electronic patient record. The CPS would allow all key information such as the risk assessment, risk formulation, care plan and crisis plan to be held in one place on the electronic patient record. Staff confirmed the trust was in the process of rolling out training on the CPS.

The trust had implemented a weekly audit of patient risk assessments. Audits showed that shortfalls were being identified with the risk assessment documentation. However, the audits did not detail with timescales the action required to address the shortfalls. The trust reported that concerns with risk assessment documentation were addressed through the team's clinical improvement group (CIG).

Management of patient risk

Following the serious incident and the prevention of future deaths report, the trust made changes to how they managed patient risk. The service had introduced twice daily and out-of-hours handover meetings, and a bi-weekly multidisciplinary team (MDT) meeting.

We observed one handover and one MDT meeting during the inspection. All members of the MDT participated in the morning handover meeting at which all patients under the crisis team were reviewed, risks assessed, management plans updated and patient visits co-ordinated. At the MDT meeting, all patients on the crisis caseload were discussed. Discussions included any emerging risks and changes in presentation.

The trust action plan required that discussions and decisions made in relation to risk at the handover meetings should be detailed in individual patient care and treatment records. Records we viewed did not always include this information. This meant that that there was potential for key information relating to risk to get lost.

Changes had been made to the reporting of missed and cancelled appointments. The team administrator provided daily reports to the team manager. Where patients had missed appointments, these were followed by telephone calls, letters and, where required, by a welfare visit check. When staff had to cancel home visit appointments these were followed up by the team manager and / or shift team leader who would ensure that staff had arranged an alternative visit.

Our findings

Staff identified and responded appropriately to changing risks to patients, including any sudden deterioration in a patient's health. Discussions took place at the handover meetings. Staff confirmed that consultant psychiatrists and senior practitioners were available to discuss any patients that were a cause for concern. For example, we saw that a Mental Health Act assessment was arranged for a patient where clinical risk levels had changed.

The one patient and five out of the seven carers we spoke with knew how to contact services if there was a crisis. All confirmed they were provided with a telephone number to contact. The two carers who did not know how to contact the service did not live with the individual patients.

Staff access to essential information

All care records were stored securely and were accessible to staff in the electronic patient records system, protected by passwords. Staff needed their own account to access this system. Staff were able to easily access relevant patient information from other community teams and inpatient services provided by the trust.

Medicines Management

The service had systems and processes in place to safely prescribe, administer and record medicines use, in accordance with the trust's policies. Staff regularly reviewed the effects of medicines on each patient's mental and physical health. These reviews were in line with guidance from the National Institute for Health and Care Excellence (NICE). Any changes to medicines were recorded in the patient records.

There was a system in place to assess medicines that patients were taking on admission, by way of a medicines reconciliation. The latest figures showed that at least 90% of patients had a medicines reconciliation carried out within the first 72 hours of admission to the service.

"When required" medicines (PRN) for the management of anxiety were monitored by the service and the use of a different system for ordering "when required" medicines minimised the risk of patients not receiving their medicines.

Systems were in place for reviewing the effects of medicines on patients' physical health.

Discharge summaries sent to individual GPs from the service requested reviews of physical healthcare, such as carrying out electrocardiograms (ECG), blood tests and monitoring for constipation. Where patients took Clozapine, staff followed up any concerns with the Clozapine clinic.

Where patients required a medical review, these were arranged to take place within 72 hours of referral.

Shared care guidelines were in place for the monitoring of patients on high dose anti-psychotics, this included use of additional medicines for addressing side-effects and physical healthcare monitoring.

A range of audits were carried out to ensure safe medicines management, these covered medicines reconciliation, safe and secure drug handling, oxygen, FP10 prescriptions, controlled drugs, storage temperatures, steroid cards and missed doses. Weekly medical diary audits were in the process of being implemented. An audit template had been developed but was not in use at the time of our visit. The team manager confirmed that these audits would commence from June 2021.

Our findings

Is the service effective?

Inspected but not rated

We inspected elements of the effective domain during this focused inspection but did not re-rate it.

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient and had a good understanding of individual patient needs.

Staff worked in collaboration with patients and their carers to develop individual care and treatment plans which they reviewed regularly through multidisciplinary discussion and updated as needed. Progress notes detailed regular contact with patients and the care delivered.

Best practice in treatment and care

Staff delivered care in line with best practice and national guidance. The service used the CORE Fidelity Model standards for crisis and home treatment.

Staff completed regular clinical audits on care plan documentation, risk assessments, medicines and Triangle of Care. Actions were identified in these audits for staff to follow up, for example a recent audit against the Triangle of Care standards showed that, whilst there was involvement with patients and their carers, there were shortfalls with discharge planning and signposting to other services. An improvement action plan had been developed which was being monitored through the trust's service user and carer experience committee.

Is the service caring?

Inspected but not rated

We inspected elements of the caring domain during this focused inspection but did not re-rate it.

Involvement in care

Involvement of patients

Staff in the mental health crisis team involved patients in care planning and risk assessment.

Records showed that patients were involved in their care and treatment plan, for example a care plan detailed a risk discussion that had taken place with the patient and the family member.

One patient and a carer reported that frequent changes of staff carrying out home visits meant that there was a lack of consistency in care.

Our findings

Staff we spoke with discussed patients and carers with respect.

Involvement of families and carers

Staff supported, informed and involved families or carers appropriately. Five of the seven carers we spoke with confirmed that staff clearly explained the care and treatment plan, gave information on medicines and on the individual condition of the patient. They confirmed that they were listened to, respected and had their views considered. Staff supported carers to complete carer assessments where appropriate.

The CATT used the Triangle of Care model to engage with and support patients and carers. The model enabled staff to support carers and patients, through practical information, working collaboratively to support individual patients to promote safety, recovery and providing some emotional support to carers. The service now had a carer lead within the team.

Is the service well-led?

Inspected but not rated

We inspected elements of the well-led domain during this focused inspection but did not re-rate it.

Leadership

Leaders had the skills, knowledge and experience to run the service. They understood and managed the priorities and issues the service faced. They were visible in the service and approachable for patients and staff. Staff reported the team manager; consultants and clinical leads were approachable and provided support to the team. The team manager had previous management experience of working in another CATT.

Culture

Overall staff were positive about the organisation, their team and their work. Staff reported that they could raise concerns without fear of retribution. Most staff described recent improvements in morale and noted that work within the team had been hard during the COVID-19 pandemic and following the serious incident investigation. Staff described the team as being hardworking and resilient. Staff received support through regular reflective practice and individual supervision.

Governance

Our findings from the other key questions demonstrated that governance processes within the CATT team operated effectively and that performance and risk were managed well. Monthly team and service line clinical improvement group meetings took place and were attended by members of the MDT. However, concerns identified with risk assessment documentation were similar to the concerns identified at our inspection in 2018. This was a breach of regulation at that time and remains a continuing breach. Actions to strengthen systems to ensure risk assessment, patient documentation and patient and carer involvement were in development at the time of our inspection.

Management of risk, issues and performance

Our findings

Managers of the service had oversight of the key risk areas and were sighted on the performance of the team. The team and service managers confirmed that concerns were escalated when required. Senior leaders confirmed there had been challenges in implementing the action plan in full with the pressure of the pandemic.

The local risk register correlated to staff concerns, such as the need for improvement to the office environment and interview rooms. The team was part of the crisis transformation programme being rolled out throughout the trust. Managers were sighted on the risks involved in this change process and were taking steps to make sure all patients were cared for safely during the transition.

Staff had implemented recommendations from reviews of deaths and incidents. For example, an action plan had been developed following the serious incident investigation and prevention of future deaths coroner's report. Regular reviews of the plan were taking place to ensure that actions were being implemented and improvements made.

Our findings

Areas for improvement

- The trust must ensure that staff in the CATT record risk consistently so that all staff can quickly gain a clear understanding of current patient risk.

SHOULDS

- The trust should ensure that all actions arising from the serious incident are fully embedded within the Hammersmith and Fulham CATT.

- The trust should ensure that all staff working in the Single Point of Access team undertake clinical risk training.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, a Mental Health Act Reviewer and pharmacist inspector.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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