Requires improvement

Central and North West London NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV3EE	Stephenson House	Brent Assertive Outreach Team	NW6 6BX
RV3EE	Stephenson House	Brent Assessment and Brief Treatment Team	NW6 6BX
RV3EE	Stephenson House	Brent Early Intervention Service	NW6 6BX
RV3EE	Stephenson House	Brent Community Recovery Team	NW6 6BX
RV3EE	Stephenson House	Harrow Assessment and Brief Treatment Team	HA7 1AT

Summary of findings

RV3EE	Stephenson House	Harrow Community Recovery Team	HA1 4DH
RV3EE	Stephenson House	Hillingdon Community Recovery Team	UB4 8EW and HA4 8NQ
RV3EE	Stephenson House	Milton Keynes Assessment and Short Term Intervention Team	MK6 5AZ
RV3EE	Stephenson House	North Kensington and Chelsea Community Recovery Team	W10 6BS
RV3EE	Stephenson House	North Westminster Assessment and Brief Treatment Team	W9 2NW
RV3EE	Stephenson House	North Westminster Community Recovery Team	W9 2NW

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

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

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

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

Contents

Summary of findings

Overall summary

We gave an overall rating for community based mental health services for adults of working age **requires improvement** because:

- Not all services had properly maintained automated external defibrillators (AED) machines to be used in the event a person had a cardiac arrest.
- The standard of some risk assessments was poor. They were out of date and lacked detail. Important information was not included.
- There were insufficient staff available to work as care co-ordinators which meant that duty workers in some services were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk.
- Patients were not always referred for regular physical health checks when they should have been.

However, overall the quality of care and treatment was good. Staff were respectful, compassionate, caring and committed to their work. Learning from incidents and complaints led to improvements in care. Urgent referrals were prioritised and urgent assessments took place promptly. Most patients felt involved in their care. Services used a variety of strategies to meet the needs of a very diverse population particularly in Brent and North Westminster.

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:

- Not all services had properly maintained automated external defibrillators (AED) machines to be used in the event a person had a cardiac arrest.
- The standard of some risk assessments was poor. They were out of date and lacked detail. Important information was not included.
- There were insufficient staff available in the Brent, Hillingdon and Harrow CRT's to work as care co-ordinators which meant that duty workers in some services were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk.

In all services patients had prompt access to a psychiatrist when required. Staff in all services minimised the risks of lone working. Medicines were stored and given to patients in line with best practice. Serious incidents were discussed and reviewed in the services. Learning from serious incidents led to new ways of working.

Are services effective?

Requires improvement

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

- Patients were not always referred for regular physical health checks when they should have been.

Assessments of patients needs were generally comprehensive and detailed. There was a range of training available to staff. Staff regularly attended such training. There was good multi-disciplinary working and frequent opportunities for professionals to meet and discuss patients' care and treatment. Staff had an understanding of the Mental Health Act and Mental Capacity Act. The teams were working to improve the use of the MCA where needed.

Are services caring?

Good

We rated caring as **good** because:

Most staff were caring and compassionate. There was widespread use of personal budgets which allowed patients to choose the kind of care and support they wanted. Patients were able to be engaged with the service, through being involved in developing their care plans, attending forums, providing feedback through surveys and helping with staff recruitment.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

All services prioritised urgent referrals and urgent assessments took place promptly. The timing of appointments was flexible to meet patients' individual needs. Services used a variety of strategies to meet the needs of a very diverse population particularly in Brent and North Westminster. Most patients knew how to complain and services dealt with complaints effectively.

Are services well-led?

Good

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

Staff were well supported. They all said they were able to raise concerns. Ways of working changed in response to serious incidents and learning from complaints. Teams were committed to service improvement.

Summary of findings

Information about the service

Central and North West London NHS Foundation Trust (CNWL) provides a range of community-based mental health services for people of working age.

Assessment and brief treatment/assessment and short term intervention teams (ABT/ASTI):

these services assess patients needs. They work to support patients for a brief period of time. They may also refer patients on to the most appropriate service.

Assertive outreach teams (AOT): work with patients who experience psychosis and have complex needs. They work with patients who find it difficult to remain in contact with services.

Early intervention services (EIS): work with people aged 14-35 years who are experiencing a first episode of psychosis. They provide specific support and treatment.

Community recovery teams (CRT): support patients who have complex mental health and social care needs. They provide patients with longer term support.

We inspected the following services:

- Assessment and brief treatment teams/assessment and short term intervention teams (ABT/ASTI) – in Brent, Harrow, North Westminster and Milton Keynes.
- Assertive outreach team (AOT) – Brent
- Early intervention service (EIS) – Brent
- Community recovery teams (CRT) – in Brent, Harrow, Hillingdon, North Kensington and Chelsea, and North Westminster.

These services had not previously been inspected by the Care Quality Commission.

Our inspection team

The team included two CQC inspectors, one social worker, two nurses, a consultant psychiatrist and a senior analyst. For one day, there was one additional social workers and nurse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from users of the service, and carers at user groups.

During the inspection visit, the inspection team:

- visited all 11 community based services for working age adults
- spoke with 18 patients who were using the services
- spoke with one carer of a patient who was using a service

Summary of findings

- spoke with the managers or acting managers of each service
- spoke with 94 other team members; including doctors, nurses, administrative staff, social workers, occupational therapists, psychologists, peer support workers and employment specialists
- attended and observed three home visits of patients who use services
- attended and observed seven meetings between patients and team members
- attended and observed nine referrals, allocation, business and multi-disciplinary meetings

We also:

- looked at 73 clinical records of patients
- carried out a specific check of the clinic rooms at five services
- looked at a range of policies, procedures and documents relating to the running of the services

What people who use the provider's services say

We spoke with patients and their families. Before the inspection visit we met a number of user groups. We also received information from local organisations and individuals.

People from Somalia felt that the services in Brent did not always meet their needs. In Harrow people had a number of concerns including poor discharge planning, lack of access to talking therapies, staff not always monitoring of the side effects of medicines, lack of consistency of care, not receiving care plans, and care plans not being followed. In Milton Keynes there were concerns regarding how responsive the service was.

In North Kensington and Chelsea people had concerns about the high turnover of staff, and staff being late for appointments. In Westminster, patients were pleased with the staff and with the services they received.

Patients we spoke with during the inspection were generally very positive when talking about staff. They described them as caring and valued the support they were given. Patients' privacy and dignity were respected by staff.

Most patients were involved in developing their care plans. Several community services involved patients in interviewing prospective new staff members as part of the recruitment process. Most teams held regular forums for patients and carers to give feedback about the service.

Good practice

- A consultant pharmacist attended the North Kensington and Chelsea community recovery team every week. Patients could book appointments with them to discuss their medicines.
- The North Westminster assessment and brief treatment and community recovery teams provided very good care. They were particularly sensitive to the cultural background of patients. Patients received care and treatment specifically tailored to their own diverse needs.
- Almost all services had employed peer support workers, people who had used or were using mental health services, who were a positive addition to the teams.
- Several community services involved patients in interviewing prospective new staff members as part of the recruitment process.
- Most teams held regular forums for patients and carers to give feedback about the service.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that where automated external defibrillators (AEDs) are provided because there is a clinical need for this equipment, for example at Hillingdon community recovery team (Pembroke Centre), that they are maintained on a regular basis, accessible, and available for use. The provider must ensure that other teams also have resuscitation equipment if needed.
- The provider must ensure that all patient risk assessments in Harrow community recovery team are comprehensive, detailed and thorough. They must be reviewed regularly and updated after incidents. There must be a personalised crisis plan in place for each patient.
- The provider must ensure there are sufficient staff available to work as care co-ordinators so that duty workers in some services are not holding large numbers of patients which could potentially create a risk for the safety and welfare of patients.
- The provider must ensure that patients using community services are referred for regular physical health checks.

Action the provider SHOULD take to improve

- The trust should ensure that people using services have crisis plans that reflect their individual circumstances.
- The staff should be supported to learn about incidents from services in other parts of the trust so they can apply the lessons learnt to their work.
- Where people using the service are being supported by a lead professional clinician their care plans should aim to be more person centred.
- The provider should ensure that psychological therapies are available for patients using community mental health services that reflect NICE guidance.
- The trust should focus recruitment to fill posts where the vacancies mean that a team does not have internal input from a particular care professional.
- The provider should ensure that all staff in all services fully understand the Mental Capacity Act and code of practice.
- The provider should address with staff at the Harrow community recovery team how they approach and support patients with a personality disorder.
- The provider should ensure that the areas used by patients at Mead House (Hillingdon CRT) are refurbished so that it is a pleasant environment for patients to use.
- The provider should ensure that risk registers in Harrow and Hillingdon community recovery teams reflect all risks. Risk registers should be detailed, thorough and risk rated.

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 Assertive Outreach Team	Stephenson House
Brent Assessment and Brief Treatment Team	Stephenson House
Brent Community Recovery Team	Stephenson House
Brent Early Intervention Service	Stephenson House
Harrow Assessment and Brief Treatment Team	Stephenson House
Harrow Community Recovery Team	Stephenson House
Hillingdon Community Recovery Team	Stephenson House
Milton Keynes Assessment and Short Term Intervention Team	Stephenson House
North Kensington and Chelsea Community Recovery Team	Stephenson House
North Westminster Assessment and Brief Treatment Team	Stephenson House
North Westminster Community Recovery 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 members had a good understanding of the MHA and Code of Practice. There were approved mental health practitioners (AMHPs) in all services except Milton Keynes ASTI. This meant that team members with specialist knowledge were almost always available .

A small number of patients were subject to community treatment orders (CTOs). Where patients were subject to CTOs their rights were explained to them. This happened on a regular basis. Staff sought appropriate advice about CTO's when they had any concerns. CTO paperwork was up to date, completed and stored properly.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had attended Mental Capacity Act (MCA) training which was mandatory. However, staff members knowledge of the MCA was variable. Some staff had excellent knowledge of the MCA. This was particularly evident in North Kensington and Chelsea CRT.

The majority of staff were aware of the process for assessing patients' capacity to consent. However, some staff had limited knowledge of the best interests checklist to be used to support the process for making best interest decisions where the patient was assessed as lacking capacity. There was uncertainty regarding the role of the independent mental capacity advocate (IMCA). This meant patients were not always adequately safeguarded when decisions were made about their care.

There were very few entries in clinical records concerning patients' capacity. At Harrow CRT attempts were being made to improve this and standard statements were included in doctors clinical records. These statements recorded whether, where needed, capacity assessments had taken place particularly in relation to decisions regarding medication.

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

Summary of findings

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

- Not all services had properly maintained automated external defibrillators (AED) machines to be used in the event a person had a cardiac arrest.
- The standard of some risk assessments was poor. They were out of date and lacked detail. Important information was not included.
- There were insufficient staff available in the Brent, Hillingdon and Harrow CRT's to work as care co-ordinators which meant that duty workers in some services were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk.

In all services patients had prompt access to a psychiatrist when required. Staff in all services minimised the risks of lone working. Medicines were stored and given to patients in line with best practice. Serious incidents were discussed and reviewed in the services. Learning from serious incidents led to new ways of working.

Our findings

Safe environment

- All of the services had accessible and working alarm systems.
- At the Brent services (ABT, AOT, EIS and CRT), tables and chairs in areas patients used had been specifically made for the service. They could not be used to harm people or to damage property.
- The clinic rooms in services were clean and tidy. Appropriate equipment was available for patients' physical health checks.
- At Hillingdon CRT (Pembroke Centre), the emergency equipment bag was in reception. The automated external defibrillator (AED) machine, used to restart a persons' heart, had not been serviced since 2013. This meant that the machine may not have worked in an emergency. There was no AED machine at the North Kensington and Chelsea CRT. An AED machine had been ordered.

Safe staffing

- Care co-ordinators were nurses, social workers and occupational therapists. They provided regular and ongoing support to patients. They also co-ordinated care for patients under the care programme approach (CPA). In Brent EIS care co-ordinators were supposed to support 15 patients. They were supporting up to 35 patients.
- In the previous year some services had experienced high levels of staff sickness. At the time of our inspection this had improved and most services had low levels of sickness. However, Hillingdon CRT and Brent EIS continued to have high levels of sickness. This included team members who were long-term sick. In Brent EIS a nurse, a social worker and a senior administrator were on long-term sick leave. No replacements for these team members had been obtained.
- Some team members had taken maternity leave or 'acted up' into more senior positions. During these times the team member was usually not replaced. When there was a replacement worker they did not necesarily cover all of the hours worked by the staff they were replacing. Where there were vacancies in services locum staff were used the majority of the time. In some services full-time posts were covered by part-time locums.
- Overall services responded promptly when patients' health deteriorated. This included staff undertaking urgent home visits. When a care co-ordinator was was on leave the duty worker in each service responded to urgent issues. In some teams there were two duty workers every day. There was always a senior team member available to support the duty worker. In Hillingdon CRT (Pembroke Centre) the duty worker undertook a range of activities. They supported patients waiting to be allocated a care co-ordinator. They also supported patients whose care co-ordinator was away. Their work included a regular assessment appointment every day. Two duty workers were supposed to be

Requires improvement

Are services safe?

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

available on Mondays and Fridays. However, sometimes only one duty worker would be available on these days. Recently, on some days, the demands on the duty worker had been very high and there was a risk that a prompt response to patients was not always possible. At Harrow CRT recent sickness had meant that there was no duty worker some days. This meant there was a high risk that a prompt response to patients would not be possible.

- The week of the inspection we found the number of people using the service who were waiting to be allocated a care co-ordinator varied. In Kensington & Chelsea and Westminster there were 2 or 3 people. Whereas in Harrow there were 16, Brent 35 and Hillingdon 40. Whilst these people were reviewed weekly and there were plans to allocate them to senior staff, and help being received from other teams, their lack of a named care co-ordinator could impact on their care.
- In all of the services staff could quickly access a psychiatrist when required. In Hillingdon CRT (Pembroke Centre) there was not always a psychiatrist on Fridays, but a psychiatrist was available by telephone.

Assessing and managing risk to people and staff

- There was an expectation that when patients were assessed by a service, a risk assessment would be completed. This was due to be completed within 24 hours of the assessment of the patient. A new risk assessment was also expected to be completed by staff within seven days of a Care Programme Approach (CPA) meeting.
- There were many examples of excellent risk assessments in clinical records. These assessments were thorough and detailed. They addressed all of the identified risks. Patients' own view of their risks were also recorded. The crisis plan was thorough and specific to the patient. We also observed that many risk assessments were updated after risk incidents. However, at Harrow CRT one patient did not have a risk assessment. Two patients' risk assessments had been completed by the home treatment team. One of these had been completed in early 2013. Another patients' risk assessment was from when they were in hospital many months previously. A number of patients risk assessments were over one year old. Two risk assessments were over two years old. This meant that the nature and level of current potential risks had not been recorded. If a team member did not know the patient well they may not have known the risks affecting them.
- There were some very detailed risk assessments at Harrow CRT. There were also risk assessments that had been barely completed. There was a lack of detail in some. Dates of incidents were not recorded. Factors leading up to a risk incident were not always recorded. This meant it was difficult to fully understand the risks and what led to them.Patients' risk assessments were not always updated at Harrow CRT. Recent safeguarding concerns and referrals were not always recorded. Recent risk incidents were not always recorded. These included serious risk incidents. This meant important recent information was not always recorded in the risk assessment.
- At Harrow CRT some crisis plans were not always specific to the patient. They often consisted of who to contact or where to go for help. One patients' risk assessment did not have a crisis plan. There was no information of who they should contact in an emergency.

All staff in the services had received safeguarding training. In each service there were safeguarding leads who were senior members of the team. Staff understood the circumstances that would lead to a safeguarding referral. They knew how to make a safeguarding referral to the local authority. Appropriate safeguarding referrals were made frequently. Safeguarding issues were discussed regularly in meetings in all of the services.

- All staff were aware of the providers' lone working policy. Each service had a system to ensure the safety of staff conducting home visits. This included two staff visiting when there were high risks.
- Some patients attended services to receive injectable medicines. Other patients attended to have blood testing for medicines. Medicines were managed well in services. They were stored securely and at the right temperature. There was enough stock of all of the medicines and they were within their expiry date.

Track record on safety

Requires improvement

Are services safe?

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

- Staff had a good understanding of incidents which had occurred within the service.
- When serious incidents occurred a thorough investigation took place. Following the investigation an action plan was made to address the learning identified.
- Changes occurred following serious incidents. At Hillingdon CRT a 'duty tracker' system was developed following an incident. In Harrow CRT patients on injectable medicine had regular physical health checks. These checks were audited.

Reporting incidents and learning when things go wrong

- All staff knew how to report incidents and the type of incidents they should report.
- When things went wrong staff explained this to patients. This was often done by a senior staff member.
- When serious incidents had occurred in the service this was shared with the team. Serious incidents were a standing agenda item at team meetings. They would always be discussed, including any associated action plan. However, this was not always the case when serious incidents occurred in other parts of the trust.
- Services adopted new ways of working following serious incidents. On some occasions team training had occurred after a serious incident.
- All team members attended a debriefing following a serious incident.

Are services effective?

Requires improvement

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

Summary of findings

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

- Patients were not always referred for regular physical health checks when they should have been.

Assessments of patients needs were generally comprehensive and detailed. There was a range of training available to staff. Staff regularly attended such training. There was good multi-disciplinary working and frequent opportunities for professionals to meet and discuss patients' care and treatment. Staff had an understanding of the Mental Health Act and Mental Capacity Act. The teams were working to improve the use of the MCA where needed.

Our findings

Assessment of needs and planning of care

- Assessments addressed patients' health and social needs. They were generally comprehensive and detailed. These assessments were undertaken when patients were referred to services. However, at Harrow ABT assessments were a list of how the patient presented. There was no evidence of attempting to understand the patient or their individual needs.
- Care plans were up to date and were reviewed regularly. Where patients had a care co-ordinator the quality of care plans was consistently good. Care plans were detailed, personalised and had recovery goals.
- In community recovery teams not all patients had a care co-ordinator. A significant number of patients were supported by a lead professional clinician (LPC). These patients did not require CPA. They also did not require a number of different professionals to support them. The support these patients received from the LPC consisted of regular appointments. These appointments generally ranged from twice to four times per year. Almost all LPCs were doctors. Care plans for patients supported by a LPC usually consisted of a letter for the patients' GP. 'This letter consistutes a care plan' was written at the top of the letter at Harrow CRT. There was minimal difference between these letters and standard GP letters. Technical language was sometimes used which meant they were not easy for patients to understand. At the end of the letter was a section entitled 'care plan'. In many cases the care plan was to continue medication and the time of the next appointment. When more details were added they were for requests such as a doctor's letter.

Best practice in treatment and care

- Medicines were prescribed in accordance with NICE guidance. We observed that side effects of medicines were discussed with patients.
- Patients could access a range of psychological therapies in most services. Family therapy was available in most services. In Milton Keynes ASTI, interventions were mapped against NICE guidance.
- In Harrow CRT patients were referred for psychological treatment. The patient was sent a letter and then had to contact the psychology service. This was to inform the psychology service that they wanted treatment. This was a barrier to patients accessing treatment. Patients who self harmed were not accepted for psychological treatment. This was not in accordance with NICE guidance. The psychology service provided cognitive behavioural therapy (CBT). There was also a psychotherapy service which provided mentalisation based therapy (MBT). Mindfulness and dialectical behaviour therapy (DBT) were not offered. This was not in accordance with NICE guidance. Specific funding had to be sought for patients to have DBT treatment.
- Patients were given support in relation to employment, housing and welfare benefits. Employment specialists were based within services.
- Patients were generally referred for physical health checks annually. This was in accordance with NICE guidance. The service would send a letter to the GP for this check. In some cases team members supported patients and accompanied them to see their GP. However, referrals for annual physical health checks were not always made in all services. In Hillingdon CRT 27 patients had recently been identified as requiring an annual physical health check, but there was no record that they had been referred for this. In Harrow CRT six people had not been referred for a physical health check in the last year. There were other patients who had not been referred for a physical health check since 2011, 2012 and 2013.

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.

- All services used HoNoS (Health of the Nation Outcome Scales) to monitor the outcomes for patients.
- Services conducted ongoing clinical audits. These audits were specific to the service. In Harrow CRT there were very few ongoing clinical audits. Most audits were conducted for brief periods.

Skilled staff to deliver care

- All services had a multi-disciplinary team. This meant that there was a range of professionals in each team. At Milton Keynes ASTI four social worker posts were currently vacant. This meant that there was no social work expertise in the service. In Brent EIS a psychology post became vacant in August 2014. There had been no replacement and the post was not being recruited to. This meant there was no psychological input specifically for the service.
- At North Kensington and Chelsea CRT a consultant pharmacist was available. They attended the service every week. Patients had appointments to discuss their medicines.
- All permanent team members had attended an induction. In North Westminter services four locums had received a local induction.
- Staff in most services had attended mandatory training. This included long-term locum staff.
- Most staff received regular supervision. This was usually monthly.
- Staff had received an annual performance appraisal within the last 12 months.
- Staff almost always had access to regular team meetings. However, at Harrow CRT staff grade doctors had not been invited to attend regular meetings. This meant that they had not been aware of important information. During the inspection visit a decision was made to invite these doctors to meetings in future.
- Locum staff had access to trust training. Staff frequently attended additional training. This meant team members were regularly updating their skills or learning new ones. Staff in Harrow ABT spoke highly of the self harm training they had received.

Multi-disciplinary and inter-agency team work

- All services held weekly multi-disciplinary meetings. In these meetings patients' care, treatment and support was discussed. Services also had team or business meetings on a regular basis. These meetings highlighted changes to procedures and operational issues. They also reviewed actions to be taken following serious incidents. Complaints were also discussed.
- At Harrow CRT there were also monthly meetings. These were attended by the consultant psychiatrists, the manager and senior team members. At these meetings service improvement was discussed.
- In addition to team and multi-disciplinary meetings some services had additional meetings. In Harrow (ABT and CRT) there was a daily morning meeting. Patients who had not attended appointments were discussed in the ABT. In the CRT the duty worker from the day before updated the team on significant events. Patients who had been seen or who had contacted the duty worker were discussed. In Hillingdon CRT team members had 'catch up' meetings twice a week. Care co-ordinators attended this meeting with senior team members. The purpose was to discuss patients support and to highlight concerns. In Milton Keynes ASTI the consultant psychiatrist conducted a daily 'walk round'. They spoke with team members and identified any concerns.
- Overall, services had good links with other services and agencies. In some services there were link workers. These staff worked in the service some days and in another service other days. This meant that communication between the services was good. Where different services were on the same site communication was very good. There were good links with social services and housing organisations. The citizens advice bureau held clinics in a number of community mental health services. Some services had good relationships with the local diabetic clinic.
- Relationships with individual GP practices varied. North Westminster ABT and Brent ABT had strong links with GPs. Harrow CRT experienced a more difficult relationship with GPs. Primary care mental health services called primary care plus were being introduced in Harrow and Hillingdon which it was hoped would improve links between services.

Adherence to the MHA and the MHA Code of Practice

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.

- Team members had a good understanding of the MHA and code of practice. There were approved mental health practitioners (AMHPs) in all services except Milton Keynes ASTI. This meant that team members with specialist knowledge were almost always available.
- A small number of people were subject to community treatment orders (CTOs). Where patients were subject to CTOs their rights were explained to them on a regular basis. Where there were concerns regarding a CTO appropriate advice had been sought by staff. CTO paperwork was current, completed and stored properly. This included patients' consent to their treatment.

Good practice in applying the MCA

- All staff had attended Mental Capacity Act (MCA) training which was mandatory. However, staff members knowledge of the MCA was variable. Some staff had excellent knowledge of the MCA. This was particularly evident in North Kensington and Chelsea CRT.
- The majority of staff were aware of the process for assessing patients' capacity to consent. However, some staff had limited knowledge of the best interests checklist to be used to support the process for making best interest decisions where the patient was assessed as lacking capacity in making a specific significant decision. There was uncertainty regarding the role of the independent mental capacity advocate (IMCA). This meant patients were not always adequately safeguarded when decisions were made about their care.
- At Harrow CRT attempts were being made to improve the use of the MCA where needed and standard statements were included in doctors clinical records. These statements recorded whether where needed capacity assessments had taken place particularly in relation to decisions regarding medication.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

Most staff were caring and compassionate. There was widespread use of personal budgets which allowed patients to choose the kind of care and support they wanted. Patients were able to be engaged with the service, through being involved in developing their care plans, attending forums, providing feedback through surveys and helping with staff recruitment.

Our findings

Kindness, dignity, respect and compassion

- When staff spoke with patients they showed warmth and understanding. Patients were treated with dignity and respect. They were also provided with emotional and practical support.
- Patients were generally very positive when talking about staff. They described caring staff and valued the support they received. In Brent ABT patients were particularly pleased with the care they received. At Hillingdon CRT (Mead House) most patients were very positive about the staff. However, some patients thought some staff were not always caring and compassionate.
- A number of patients in CRTs told us that they never saw the same doctor twice. These were patients supported by a Lead Professional Clinician (LPC). They felt that they had to keep repeating the same information about themselves every time they saw a doctor, which they found frustrating.
- We saw evidence in progress notes that staff understood patients needs. We also observed staff meeting with patients and it was clear they understood the needs of patients they cared for.
- In Harrow CRT we heard some negative views expressed by junior and senior staff about patients with a personality disorder and how they were not able to meet their needs.
- Staff in all services undertood the importance of confidentiality. Consent was obtained from patients before sharing information.

The involvement of people in the care they receive

- Where patients had a care co-ordinator, most patients were involved in developing their care plan. There were isolated examples in a number of services where this was not the case. However, in Harrow ABT care plans were generally written about the patient and there was little evidence of patient involvement in developing the care plan.
- Approximately 70% - 80% of patients in most teams were offered a copy of their care plan. In Brent ABT and Harrow CRT the percentage was lower with about 55% of patients being offered their care plan.
- In a number of services patients were supported to access a personal budget. This meant that patients could choose aspects of their care and support.
- In almost all services peer support workers were a member of the team and were a positive addition to the teams. Peer support workers were people who were using or had used mental health services themselves.
- In all services carers received a carers assessment. Carers and family members were involved with patients care when the patient wanted this. In almost all services there were regular forums for carers.
- Advocacy services for patients were available in all services. In Brent services (ABT, AOT, EIS and CRT) in particular, there was a strong presence of advocacy services. In Hillingdon CRT (Mead House) advocacy services were available but patients were not always aware of them.
- Several community services involved patients in interviewing prospective new staff members as part of the recruitment process.
- In several services there were regular forums for patients to discuss their views of the service. A recommendation for such a forum had recently been made to Harrow CRT where no forum was currently in place. There was also no patients forum at Hillingdon CRT.
- The provider obtained patient feedback regarding services through a range of surveys. In North Westminster ABT feedback was obtained regarding why patients did not always attend appointments.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated responsive as **good** because:

All services prioritised urgent referrals and urgent assessments took place promptly. The timing of appointments was flexible to meet patients' individual needs. Services used a variety of strategies to meet the needs of a very diverse population particularly in Brent and North Westminster. Most patients knew how to complain and services dealt with complaints effectively.

Our findings

Access, discharge and transfer

- The ABT services and the ASTI service had a target time in which to assess patients. For the ABT services this was four weeks. Most services met this target. However, at Harrow ABT patients sometimes waited for five weeks. At Milton Keynes ASTI patients were to be assessed within 18 weeks of referral. Almost all patients were seen within 12 weeks.
- Brent EIS was required to provide a service to 65 new patients each year. Once a referral was made an assessment was undertaken within 14 days. Five patients in hospital were waiting for treatment with Brent EIS.
- CRTs accepted most referrals from other mental health services or hospitals. In almost all CRTs there was a waiting list for patients. This was for patients who required a care co-ordinator. In some cases patients were already receiving support in the service from a lead professional clinician. Patients on the waiting list usually remained in their current service until they were allocated a care co-ordinator in the CRT. In Hillingdon CRT 40 patients were on the waiting list. They were being supported by a duty worker until they could be allocated a care co-ordinator. This meant patients spoke about their needs to a number of different staff depending upon who was on duty on a particular day. This meant there was a risk to the continuity of care. Patients waiting to be allocated were reviewed weekly by a senior staff member.
- All of the services were able to assess urgent referrals. Urgent assessments were prioritised and there was minimal delay in these taking place.
- Overall services responded quickly and appropriately when patients called them. The exception was Harrow CRT where there were difficulties with the telephone system. Patients sometimes waited some time for a response. This issue was included on the service risk register and action had been taken to address it.
- Each team had clear criteria for patients who would benefit from their service.
- Some patients found it difficult to engage with services. Services actively attempted to engage with these patients. This included conducting home visits. Most services made attempts to engage with patients who missed appointments. In some services there were multiple attempts to engage with patients. Some services sent SMS reminders to patients, or contacted them by phone. In Harrow CRT there was a protocol for patients supported by a LPC. Patients who did not attend appointments would be sent another appointment, although this would only happen if the patient had a 'valid reason' for missing the appointment. This also applied when patients cancelled an appointment. The service would take action where there were identified risks. The protocol placed emphasis on the patient contacting the service. If they did not, one option was to discharge them to their GP. This meant some patients who still required treatment could be discharged. CRT staff told us there was a pressure to discharge patients from the services, although patients were not discharged unless it was safe to do so. In Harrow CRT some patients due to be discharged were offered individual occupational therapy. This therapy focussed on the patients' coping skills. In Brent CRT the peer support worker supported patients due to be discharged.
- The waiting list for psychological treatment was one year in Brent services (ABT, AOT, EIS and CRT). This meant patients did not receive treatment when they required it. In North Westminster services (ABT and CRT) there was a six month wait for psychology. This was also the case in Harrow CRT. Brent EIS service did not have a dedicated psychologist. This meant there was limited

Are services responsive to people's needs?

Good

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

family therapy or relapse prevention. Staff told us they wanted to undertake this work but they were only able to 'crisis manage'. Therefore treatment was not delivered in accordance with NICE guidelines.

The facilities promote recovery, dignity and confidentiality

- Most services were clean, well decorated, and well maintained. However, in Harrow CRT, a toilet floor had not been mopped. The waste bin was overflowing, with the bin lid on a window sill.
- At Hillingdon CRT (Mead House) some areas patients used were neglected. Paint on the walls was almost flaking off. The chairs in interview rooms were worn and appeared dirty. Patients told us that the service had been cleaned immediately prior to the inspection visit.
- At the Brent services (ABT, AOT, EIS and CRT), two interview rooms had a gap in the wall. This meant patients could be heard talking in the next room. This issue appeared on the service risk register and the problem was being dealt with.
- Most services provided a range of information leaflets on a variety of topics. These included information regarding medicines and treatment. There were very few of these information leaflets at Milton Keynes ASTI

Meeting the needs of all people who use the service

- All services were wheelchair accessible, and had a disabled toilet with appropriate hand rails.
- In North Kensington and Chelsea CRT there was information concerning services and community groups. This information was in different languages. At Hillingdon CRT (Mead House) there was some information in Arabic. In all of the other services information leaflets were in English only. Information in different languages was available on the providers' intranet.
- Patients were called on the telephone before an assessment at North Westminster ABT. Their specific needs were then identified. People who were transgender were called by their chosen name. Their care records were also in their chosen name.
- Patients appointment times were flexible in all services. This was so patients could attend college or work. It also meant, at certain times of the year, patients could fulfill their religious or cultural needs. In Brent services (ABT, AOT, EIS and CRT) links were being made with a Somali organisation. A culturally specific day service had also been identified. In Brent AOT patients were asked their preference for a male or female interpreter.
- The North Westminster assessment and brief treatment and community recovery teams provided very good care. They were particularly sensitive to the cultural background of patients. Patients received care and treatment specifically tailored to their own diverse needs.
- All of the services were able to access interpreters. Staff were aware of the procedure for doing so. In Brent ABT some letters from the service were translated. In Brent CRT the translation of care plans was being considered. In North Wesminster ABT staff were aware of potential difficulties with interpreters. Patients from a small community had concerns regarding confidentiality and interpreters. The team at North Kensington and Chelsea CRT were also aware of this.

Listening to and learning from complaints

- Information on how to complain was displayed at most services except at Hillingdon CRT (Mead House) where no information was displayed.
- Team members in all services knew how to handle complaints. A senior team member would often discuss the complaint with the patient or carer. We found that when complaints were made they were dealt with appropriately.
- In Brent, patients were encouraged to express concerns and complaints.
- Once complaints were investigated feedback was given to relevant staff. There was evidence that changes were made following investigation of complaints.
- Some complaints could not be investigated by the manager of the service. This was due to a conflict of interest. In these situations the manager from another service investigated the complaint.

Are services well-led?

Good

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

Summary of findings

We rated well-led as **requires improvement** because:

- At Harrow and Hillingdon CRT the service risk registers were not detailed and did not identify all risks affecting the service. The severity and likelihood of the risks were not measured. Risk registers were not updated when actions were completed.

However, staff were well supported. They all said they were able to raise concerns. Ways of working changed in response to serious incidents and learning from complaints. Teams were committed to service improvement.

Our findings

Vision and values

- At North Kensington and Chelsea CRT team members were fully aware of the providers' values. This was also the case at Milton Keynes ASTI. In a number of other teams this was not the case.
- Some service managers had a clear vision of how they wanted to improve the service. Other managers knew that improvements were required but they did not always have a clear plan of how to achieve this.
- Some staff knew who the most senior managers were and had met them. Other team members did not. At Milton Keynes ASTI the senior manager operated a regular surgery. Staff could attend the surgery to discuss issues and concerns.

Good governance

- In most services there were effective systems to safeguard the safety and welfare of patients. Procedures were in place to ensure team members and patients safety such as supervision and training.
- Managers of services had a service risk register. This register highlighted the risks to the service which could affect the support provided to patients. Most risk registers were thorough and detailed. They indicated all of the risks to the service. Each risk was rated in a way that identified the severity and likelihood of the risk. There were action plans in place to reduce the risk.
- However, the Harrow CRT and Hillingdon CRT service risk registers did not provide enough detail. It was not clear how the risks identified affected the support patients received. Not all of the risks to the service were on the risk register. There were very few actions to reduce the risk, and where actions were identified these were not always specific. Risks were not rated. This meant it was unclear what the severity and likelihood of the risk was. The risk registers were not updated when actions had been completed.
- At Hillingdon CRT there were significant challenges managing a service on two sites. Each site effectively operated as a different team. This affected communication and continuity of care.
- The providers performance measures were reviewed at team business meetings. Performance measures developed by each service were also reviewed and discussed.

Leadership, morale and staff engagement

- Staff members knew about the providers' whistleblowing policy. They felt they would be able to use it. All staff in all services said that they were able to raise concerns.
- Almost all staff said they were satisfied in their job. In Brent EIS we were told morale was low.
- The provider operated a leadership development course. Some staff were undertaking this course.
- In all of the services staff felt supported by their colleagues. This included administrators, peer support workers and psychiatrists. Staff said they felt supported by their managers. When mistakes were made staff usually reported this to senior staff or the manager. Senior staff would then speak with the patient and carers or family.
- Staff were able to provide feedback to improve the services. This was undertaken in a number of ways including during team away days.

Commitment to quality improvement and innovation

- All team managers were committed to improving the service.
- Some services were taking part in wider research co-ordinated by the provider.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure that each patient was protected against the risks of receiving inappropriate or unsafe care or treatment. At the Harrow community recovery team patients' risk assessments were not thorough or detailed. They were not updated after risk incidents. The planning and delivery of care did not always protect the welfare and safety of patients. Several patients using Harrow and Hillingdon CRTs had not been referred for regular physical health checks. This is a breach of regulation 9(1)(a)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment use of unsafe equipment by ensuring the equipment is properly maintained and suitable for purpose. At the Hillingdon community recovery team (Pembroke Centre), the automated external defibrillator (AED) had not been properly maintained. As a result there was a risk to people from the use of unsafe equipment in an emergency situation.

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 16(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider did not take appropriate steps to ensure there were sufficient numbers of staff. There were insufficient staff available to work as care co-ordinators which meant that duty workers in the Brent, Hillingdon and Harrow CRT's were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.