Good

East London NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWK62	Adult Mental Health Services – City and Hackney Directorate	Home Treatment Team – City and Hackney	E9 6SR
RWK46	Adult Mental Health Services – Newham Directorate	PACT (Psychiatric Acute Community Treatment) – Newham	E13 8SP
RWK61	Adult Mental Health Services – Tower Hamlets Directorate	Home Treatment Team – Tower Hamlets	E1 4DG
RWKJE	Weller Wing	Bedfordshire Crisis Team	MK42 9DJ
RWKW1	Luton and Bedfordshire Community Mental Health Services	Luton Crisis and Home Treatment Team	LU4 0FB

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding
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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Overall summary

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

- There were good levels of staffing in all the services. There were procedures in place for managers to follow when demand for the service increased. Many staff had worked in the teams for a number of years and knew some of the patients well. The teams made very limited use of temporary staff which promoted good consistency of care.
- Staff managed cases through daily handover meetings. Everyone in the team participated in these meetings at which patients were reviewed, risks were assessed and patient visits were co-ordinated. There was a clear system for rating the risk patients presented and this was reviewed every day.
- We observed interactions between staff and patients that were consistently caring, respectful, responsive and included both practical and emotional support. Staff demonstrated a very detailed understanding of individual patient's needs. There was a collaborative approach to care planning with patients. Care plans focused on patients self-defined needs and objectives. There was a strong focus on recovery in all the care plans.
- Psychological therapies were available and psychological approaches formed part of the daily professional practice of nurses. Staff reviewed patients' physical healthcare, including support with blood monitoring for patients with diabetes.
- Morale, team working and mutual support were strong in all of the teams. Staff spoke very positively about their work and the support they received from colleagues. Staff were supervised regularly and appraisals were carried out annually. There was clear evidence of supervision taking place each month and appraisals took place once a year. Records of appraisals included many positive comments about the employee's progress and development. There were opportunities for leadership development and career progression.
- Staff safety was carefully considered. There were good protocols in place for lone working. A new alarm system had been introduced that incorporated an emergency call button to the police and global positioning system (GPS) tracking.
- The target time for teams to respond to referrals was 24 hours in 80% of referrals. All teams exceeded this target. In some areas, the person being referred was contacted by telephone within four hours. The team responded promptly and adequately when patients contacted the service. There was a dedicated phone line for current patients.
- Staff took active steps to engage people who may have felt reluctant to use the service. There was a focus on understanding the individual needs, preferences, and context of people's lives. Staff offered practical support if this was the patient's priority. Staff were proactive in contacting patients when they did not attend appointments or when they were not in when staff visited. There was a clear procedure for further visits, contacting family or friends with the patient's consent, contacting the GP and asking the police to conduct a welfare visit.
- The teams met the individual needs of patients. For example, the use of interpreters was an integral part of service delivery. In one team there were two bi-lingual support workers who spoke the primary community language.
- Two teams had been accredited by the Royal College of Psychiatrists through the home treatment accreditation scheme since 2012.

However:

- Patients using the service were sometimes being brought by the police to the health based place of safety from their home, rather than from a public place which was contrary to section 136.
- Patient records were poorly kept in the health based places of safety which made it hard to know how quickly they were assessed and whether their rights had been explained to them.
- Home treatment teams were not meeting to share good practice.

Summary of findings

- Whilst risk was managed well, the risk assessment records were not always stored consistently.
- One home treatment team was not learning from serious incidents.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- All the premises we inspected were clean and well-maintained. Clinic rooms were clean and well-equipped.
- There were good levels of staffing in all the services. It was very rare of staffing levels to fall below the established level, and this only occurred when caseloads were low.
- Average caseloads were generally between 20 and 40. When caseloads did rise above 40, cases were more closely managed to ensure that the service still operated effectively. In one team, there was an established 'safer staffing' system in place to manage high caseloads which included senior nurses moving from managerial to clinical roles.
- Cases were managed through daily handover meetings. Everyone in the team participated in these meetings at which patients were reviewed, risks were assessed and patient visits were co-ordinated.
- Leave and sickness was covered by the existing staff team or by bank staff. Agency staff were not used in these services.
- There was access to a psychiatrist within all the teams between 9.00am and 5.00pm. Outside these hours, staff had access to the duty doctor within their local in-patient mental health service.
- Compliance with mandatory training was 90-95%, including training in safeguarding.
- Teams responded promptly when a patient's health deteriorated.
- There were good protocols in place for lone working. A new alarm system had been introduced that incorporated an emergency call button to the police and global positioning system (GPS) tracking.
- There was good medicines management.
- There was frequent recording of incidents. Staff knew how to report incidents. Staff apologised to patients when incidents occurred.

However:

- Whilst staff had a very good understanding of the risks for individual patients, the recording of risk assessments was inconsistent. Risk assessments were sometimes recorded in the

Summary of findings

progress notes rather than using the specific risk assessment tool on the electronic patient record. Therefore, it was not always clear where to find the risk assessment in the electronic patient record.
- Whilst most teams had arrangements in place to share learning from incidents, for example through discussing this at team meetings, one London team where there had been some incidents did not appear to be doing this well.

Are services effective?

Good

We rated effective as good because:

- A comprehensive assessment was carried out for all patients in a timely manner.
- Care records were up to date, personalised, holistic and recovery focused
- Records were stored securely on the electronic patient record.
- Staff followed national institute for health and care guidance.
- Psychological therapies were available and psychological approaches formed part of the daily professional practice of nurses.
- Staff considered physical healthcare, including support with blood monitoring for a patient with diabetes.
- Outcome measures were in place in some of the teams
- There were effective multidisciplinary meetings and handovers at which patients were discussed and risks reviewed. Four of the five multidisciplinary teams included a psychologist.
- Staff were regularly supervised and appraisals were carried out annually. New staff received an adequate induction, including a two week supernumerary period in which they could shadow existing staff.
- Staff were experienced and qualified. Staff had specialist training for their role. Some staff had qualified as approved mental health professional training. Some staff had completed training in poly-pharmacology and non-clinical prescribing.
- Staff visited the inpatient wards regularly and were involved in decisions about patients being discharged to home treatment teams. When patients were discharged to community mental health services, a joint visit took place with a home treatment team nurse and the new care co-ordinator.
- Statutory documents relating to the Mental Health Act were in order.
- Staff had had training sessions on the Mental Capacity Act and appeared familiar with its requirements

However:

Summary of findings

- Six records stated that patients had been bought to the health bases places of safety by the police from their own home and had not been in a public place. This was potentially an inappropriate use of section 136. This matter had not been identified by the trust, the police or the local authority, indicating limited audit and oversight.
- Many of the records of patients assessed in the health based places of safety were incomplete and so it was not possible to know how long they had waited to be assessed.
- There were no records of patients' rights being discussed when they were on leave and under the care and supervision of home treatment teams. Records of patients being informed of their rights in health based places of safety were often incomplete.

Are services caring?

Good

We rated caring as **good** because:

- Observations of interactions between staff and patients were consistently caring, respectful, responsive and included both practical and emotional support.
- Reports by patients were consistently positive.
- Throughout our observations and attendance at handovers staff demonstrated a very detailed understanding of individual patient's needs.
- Confidentiality arrangements were agreed at the initial meeting with the home treatment team.
- There was active involvement in care planning, with care plans focused on patients self-defined needs and objectives.
- There was routine involvement of family and carers through home visits.
- There was a centralised system across the trust for patients to be involved in decisions to recruit staff at a senior nurse level and above.
- Feedback was consistently sought from patients. Results of this feedback were reviewed every three months and discussed in team meetings. Overall, feedback was positive.

Are services responsive to people's needs?

Outstanding

We rated responsive as outstanding because:

- The trust target was for 80% of referrals to be seen in 24 hours. All teams exceeded this target. In two teams, patients were telephoned within four hours of being referred.
- Urgent referrals were dealt with quickly.

Summary of findings

- Staff were available to assess patients immediately if this was required. In two teams there was a target for assessing patients in the accident and emergency department within two hours of referral.
- The team responded promptly and adequately when patients telephoned the services. There was a dedicated phone line for current patients.
- There was a clear criteria for the services. Patients were not excluded from using the health based places of safety if they were intoxicated due to drugs or alcohol, unless they required medical assistance and an admission to the accident and emergency department was more appropriate.
- Staff took active steps to engage people that focused on understanding the individual needs, preferences, and context of people's lives. Practical support was offered if this was the patient's priority, such as help with finances or housing. This was done in partnership with other third sector providers.
- Staff were proactive in contacting patients when they did not attend appointments or when they were not in when staff visited.
- Appointment times were flexible. Appointments were rarely cancelled and patients were kept informed if staff were running late. Staff worked pro-actively with patients to arrange appointments in the best location for them.
- There were a full range of rooms. Interview rooms were sound proofed.
- There were leaflets for patients on their rights and how to complain. Leaflets could all be translated on request.
- Use of interpreters was an integral part of service delivery. In one team there were two bi-lingual support workers who spoke the primary community language.
- Patients knew how to complain and formal complaints were dealt with appropriately and the teams discussed and learnt from the complaints.

However:

- Two places of safety did not have a separate entry. Patients were required to be escorted along hospital corridors and travel to the first floor of the building.

Are services well-led?

Good

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

- Staff knew the organisation's values and team objectives reflected these values

Summary of findings

- Senior managers visited the teams regularly. This was valued by the staff.
- There were key performance indicators for referral times and reviewing referrals for admission to hospital. These performance indicators were consistently achieved.
- Team leaders all had administrative support and felt they had sufficient authority.
- We reviewed risk registers in each team. Staff could contribute to these through monthly business meetings.
- Sickness rates were low.
- Staff knew about whistle blowing. Notices about whistle blowing were displayed and staff said they could raise concerns without fear.
- Morale, team working and mutual support was strong in all of the teams. Staff spoke positively about their work and the support they received from colleagues.
- Staff were open and transparent.
- There were examples of improvement methodology such as clozapine titration at the crisis house and improving discharge letters to GPs.
- Two teams had been accredited by the Royal College of Psychiatrists through the home treatment accreditation scheme since 2012.

Summary of findings

Information about the service

East London NHS Foundation Trust provides mental health crisis services across Bedfordshire and Luton and three London boroughs of City and Hackney, Newham and Tower Hamlets. These services have separate commission arrangements and are managed within borough-based directorates. Consequently, the arrangements for the delivery of the service were different in each area.

In London, home treatments teams (HTTs) operated between 8.15am and 9.30pm in Hackney, from 9.30am to 8.00pm in Newham and from 8.30am to 10.00pm in Tower Hamlets. Outside of these hours, people were able to receive support from a mental health nurse through locally operated crisis lines. In Newham, a day hospital for up 25 patients was available as an alternative to in-patient admissions. This hospital was on the same site as the HTT and formed part of the crisis service. In Tower Hamlets, a crisis house was available for up to ten patients as an alternative to hospital admission or to enable some patients to move gradually from acute in-patient services to the community. On the day of the inspection, the HTT in Tower Hamlets was supporting five patients at the crisis house.

In Bedfordshire, both crisis and home treatment teams operated from 9.00am to 9.00pm. Support available through a crisis telephone line outside these hours.

The services all offered assessment and treatment to any person between the ages of 18 and 65 with a primary diagnosis of mental illness and experiencing symptoms of such severity that they were at risk of requiring inpatient treatment. The services also facilitated patients' early discharge from hospital. The aim of the services was to provide assessment and where appropriate intensive support for a limited period within the person's own home. Where the clinical risks indicated that a hospital admission was needed the team will arrange this. The teams accepted referrals from community mental health teams, local GPs, inpatient wards as well as from psychiatric liaison services based in local acute trusts.

The trust had five health-based places of safety located at Newham Hospital, Homerton Hospital in Hackney, the Royal London Hospital in Tower Hamlets, the Weller Wing at Bedford Hospital and at Luton Mental Health Centre. These provided facilities for the support and assessment of people under sections 135 and 136 of the Mental Health Act who were thought to be in immediate need of care or control in a safe environment.

Our inspection team

The team inspecting services in East London consisted of two CQC inspectors and two specialist advisors. Both specialist advisors were nurses with experience of providing crisis services. Two Mental Health Act reviewers inspected the East London health based places of safety.

The team inspecting services in Luton and Bedfordshire comprised of an inspector and two specialist advisors. One specials advisor was a psychiatrist and one was a social worker and therapist.

Why we carried out this inspection

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

Summary of findings

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.

During the inspection visit, the inspection team:

- Visited the five home treatment teams in Hackney, Newham, Tower Hamlets, Luton and Bedford.
- Visited the five health-based places of safety located at the Royal London, Homerton, Newham and Bedford hospitals and at Luton inpatient mental health service.
- Interviewed the five team managers with responsibility for the home treatment teams.
- Interviewed the five managers or senior duty nurses with responsibility for the health based places of safety.
- Spoke with 47 other staff members: including doctors (consultant psychiatrists, staff grade and GP trainees); nurses, including senior nurse practitioners; psychologists; pharmacists; social workers; associate mental health workers; community support workers; administrative staff; and a dual diagnosis worker.
- Attended and observed five hand-over meetings.
- Shadowed seven staff members across ten home visit appointments with people who used the service.
- Spoke with 13 people who were accessing the home treatment teams.
- Received two comment cards
- Looked at 35 care records of patients receiving support from home treatment teams.
- Looked at 36 records of patients who had been in the places of safety.
- Looked at 45 prescription charts of patients.
- Looked at 15 supervision records of staff.
- Carried out specific checks of the medication management at Luton crisis and home treatment teams.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Across the services, patients told us that staff were caring a compassionate. A number of patients said that staff were professional, respectful and polite. None of the patients we spoke with raised any concerns about the staff they had worked with.
- We received two comment cards from patients who gave mixed views of their experiences within one team. They said that whilst some staff had been caring, they were concerned about the competency and attitude of others.

Good practice

- Staff in the home treatment teams took active steps to engage people with a focus on understanding the individual needs, preferences and context of people's lives. Practical support was offered if this was the patient's priority. When needed staff would support patients to access third sector organisations.
- For patients supported by the home treatment team there was time given to ensure people had active involvement in their care planning, with care plans focused on patients' self-defined needs and objectives.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure there is a consistent approach to recording and storing risk assessments to improve the safe care and treatment of patients.
- The trust should ensure that serious incidents and the lessons from them are discussed in the Tower Hamlets home treatment team similarly to the other teams.
- The trust should ensure that all records relating to patients admitted to health based places of safety are completed in full to ensure that the care of people using this service can be accurately monitored.
- The trust should ensure that records relating the patients admitted to health based places of safety are regularly audited to identify potentially unlawful practice and practice that is inconsistent with the Mental Health Act 1983 Code of Practice and that this is raised where needed at crisis care liaison meetings.
- The trust should ensure that patients receive information about their rights under the Mental Health Act when they are on leave under the care of home treatment team.

East London NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Home Treatment Team – City and Hackney	Adult Mental Health Services – City and Hackney Directorate
PACT (Psychiatric Acute Community Treatment) – Newham	Adult Mental Health Services – Newham Directorate
Home Treatment Team – Tower Hamlets	Adult Mental Health Services – Tower Hamlets Directorate
Bedfordshire Crisis Team	Weller Wing, Bedford Hospital
Luton Crisis and Home Treatment Team	Luton and Central Bedfordshire Mental Health Unit

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.

- Training in the Mental Health Act 1983 was not mandatory for all staff. Most staff had had some training in the Mental Health Act and felt confident that advice was available from approved mental health professionals within their team if it was required.
- At the time of our visits there were six patients subject to the Mental Health Act. All six were detained under section three of the Act with leave granted under section 17. The inpatient consultant retained the role as responsible medical officer. We were told that it was rare for patients to be subject to community treatment orders.

Detailed findings

- We reviewed the statutory documents for all six patients who were liable to be detained. These documents were filled out correctly, up to date and stored appropriately.
- Patient records showed that information was given to patients about how the Mental Health Act applied to their situation when they were first detained. However, this was not repeated when they were placed on leave under the care of the home treatment team.
- At health based places of safety we found that paperwork was not always completed in full which made it difficult to reach a judgement about the timing of visits by AMHPs, the method of conveying the patient, whether relatives were contacted, whether patients were told about rights and arrangements after the initial assessment had taken place.
- Most of the forms did not confirm that the patient had been found in a public place. One form failed to give any details of where the patient been taken from or why they had been taken.
- On six records, it was clear that the person had been unlawfully taken from inside their own property, not from a public place. There appeared to have been no recognition of this from police, the local authority or the trust. We found no evidence of paperwork relating to patients subject to section 136 of the Mental Health Act being audited to check legal compliance. These concerns had not been raised at any multidisciplinary meetings.
- We did not see any evidence to show that patients were given information about their rights and how the relevant section of the Mental Health Act applied to them.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received training on the Mental Capacity Act within their team. Information about the Act, including the principles, was displayed on notice boards throughout the teams' offices. All staff had a credit card sized guidance booklet entitled 'Ten Point Guide to the Mental Capacity Act.' This included the principles of the Act, the components of decision making and advice on supporting people to make decisions.
- Staff told us that the Mental Capacity Act may be used in their professional practice if a patient's mental health deteriorated and they were no longer able to make decisions about taking medication, where they were staying or interaction with mental health services. Staff told us that they would usually contact a doctor to assist with an assessment of mental capacity and that action could be taken through using either the Mental Health Act or Mental Capacity Act, as appropriate.

Good

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

London home treatment teams

Safe and clean environment

- The home treatment teams (HTTs) in City &Hackney and Newham had facilities for patients to be interviewed at the team's offices. A premises inspection of the HTT offices in Tower Hamlets was not required as patients did not attend the offices. In Hackney, the interview rooms were not fitted with alarms, but all staff were provided with a personal alarm. Personal alarms were charged and tested on a regular basis. In Newham, all interview rooms were fitted with call buttons.
- In Hackney and Newham the clinic rooms well-equipped with facilities to carry out physical examinations. Fridges and cupboards were in good order with clear records of daily temperature checks. In Hackney, equipment for physical examinations had been put in bags so staff could take these to the patient's home and conduct examinations there.
- All areas used by the teams were clean. All staff carried alcohol gel, equipment was cleaned before and after use, gloves were worn by staff conducting physical examinations and designated yellow boxes were used for the disposal of sharp items. All furniture and decorations were well-maintained.

Safe Staffing

- Across the three boroughs, different commissioning arrangements meant that there were different shift patterns and different staffing levels in each area. The HTTs opened between 8.15am and 9.30am and closed between 8.00pm and 10.00pm. Newham and Tower Hamlets operated for a full seven days each week, whilst City & Hackney HTT did not operate between 4.15pm on Saturdays and 1.30pm on Sundays. Outside these times, telephone support was available through telephone 'crisis 'lines, staffed by qualified nurses from either the HTT or psychiatric liaison service. Staffing levels ranged from eight or nine staff on each shift in Hackney to four or five in Tower Hamlets. This reflected demand for the service. In each service there were no more than two health care assistants within the established staffing allocation for each shift.
- We reviewed the staff rotas in each team for the three months before the inspection and found that it was very rare for staffing levels to fall below the established allocation. For example, in Tower Hamlets there was one shift when the staff team was one post below the established allocation and another when they were half a post below. When this occurred, the workload was assessed and considered manageable on the basis of the number of patients and the risk they presented at the time.
- Caseloads were highest in Hackney where the service worked with around 50 patients, on average at any time. This figure fell to 35 in Newham and 30 in Tower Hamlets. None of the services had a waiting list.
- None of these services used agency staff. Bank staff were used to cover sickness and other routine absences. Bank staff were familiar with the staff team and had either worked in the service previously or worked in similar services.
- Each service had access to a psychiatrist within the team between 9.00am and 5.00pm from Monday to Friday. Outside these hours, the duty psychiatrist at the local hospital was available.
- Mandatory training involved 15 courses including safeguarding, prevention and management of violence and aggression and basic life support. Overall compliance with training requirements was 93%. The completion rate for specific courses within the mandatory training programme did not fall below 75%.

Assessing and managing risks to patients and staff

- We reviewed 23 care records across the three services. Risk assessments were consistently completed on referral or very shortly afterwards. The protocol for recording risk assessments varied. The team in Tower Hamlets completed a comprehensive risk assessment on the electronic patient record, whilst in Hackney and

Good

Are services safe?

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Newham these assessments were recorded in the progress notes. Recording in the progress notes meant that the risk assessment was more difficult to locate and the information recorded was not always consistent.

- During the initial assessment, patients were given cards with information about crisis services, including the number of the local crisis telephone line. Confidentiality agreements were also made which provided details of friends or family members that the patient agreed the service could contact if they were concerned about the patient.
- Patients were reviewed at daily handover meetings. Patients were classified as presenting a red, amber or green risk rating. Patients classified as 'red' were new referrals or patients that presented a heightened level of risk. Patients who were 'amber' were considered to be making progress. Patient rated as 'green' had made progress in their recovery and were usually awaiting discharge. We saw that patients could have their risk rating increased at handover meetings, resulting in more frequent visits up to three times each day. For example, one patient had their risk rating increased due to high blood pressure. Another patient had increased visits after they began to take a new anti-depressant medication.
- All staff had completed their mandatory training on safeguarding adults and children. Staff showed a good awareness of how to raise safeguarding concerns about children, such as children whose parent was using the service and may be at risk if there was a deterioration in the parent's health. The services in City & Hackney and Tower Hamlets had both made one referral to the local authority safeguarding team in the three months before the inspection. In Newham there had been seven referrals in the nine months before the inspection following concerns about physical abuse, emotional abuse and domestic violence. Safeguarding concerns were discussed in daily handover meetings and multidisciplinary team meetings.
- The trust had updated its lone working policy in May 2016. The policy included a list a procedures to enhance safe working. This included a requirement for up to date risk assessments, having an agreed code word or phrase that staff use when phoning the office to indicate they are encountering difficulties, and ensuring there was a clear record of the times and locations of meetings. Across the home treatment teams we saw compliance with this policy. Staff routinely visited patients in pairs. Staff only visited patients alone if the patient was well known to the service and had been assessed as presenting a low risk. Staff had alarms fitted with global positioning systems (GPS) tracking and a call button that would immediately alert the police. Staff said they had never felt pressured in making a visit if they felt uncomfortable about the level of risk involved.
- There was good medicines management in the locations where medicines were stored. Medicines were stored appropriately and were all in date. We reviewed forty medication charts and found them to be in good order. A pharmacist visited once a week to reconcile medication. We interviewed the pharmacist in Hackney who said staff were quick to report any drug errors. The pharmacist said that they often attended to team meetings to discuss medicines management. Medication was taken from the pharmacy to patient's home in a bag with the medication card. Staff only travelled with small amounts of medication. Some patients were given daily medication and were supervised when taking this. Others were given weekly supplies.

Track record on safety

- There was significant variation in the number of serious incident recorded for each team. In Newham there had been no serious incidents in the year before the inspection. In Hackney there had been one death. However, in Tower Hamlets there had been six patient deaths and four serious incidents, of which three could have resulted in the patient's death. Of the six patient deaths, two were still being investigated at time this report was being written. We reviewed the reports of investigations into the other four deaths, three of which were entitled a 'Serious Incident Review' and one was a 'Level Two Review.' The serious incident reviews were thorough, providing an analysis of the root causes of the incident, highlighting good practice as well as problems in service delivery and provided a list of lessons learned. The level two review gave a detailed chronology of events leading to the patient's death and a summary of the incident. However, this report was far less detailed and lacked any meaningful learning.

Good

Are services safe?

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- The incident reports highlighted how it is difficult to predict the behaviour of patients when they are not know to services and that it can be difficult to develop a full risk history of patients who have recently arrived in the United Kingdom.

Reporting incidents and learning from when things go wrong

- Staff told us that they knew what to report and how to report it. Staff said they were able to discuss any concerns about incidents with colleagues and escalate matters to the team manager. All nurses could report incidents directly onto the electronic incident record.
- Staff familiarity with incident recording was reflected in the number and nature of incidents recorded. In City & Hackney, for example, 30 incidents were reported in the six months before the inspection. The incidents included medication errors, a delay in a patient being assessed and an incident of violence and aggression. In one month, there had been 10 incidents resulting in a specific staff meeting to review these concerns. This meeting was attended by 18 of the 20 members of staff. Incident reporting in Newham was lower with five entries on the incident record in the same period. These incidents included a medication error and a patient deliberately taking a significant overdose of medication.
- Incident reports showed that staff had been open and transparent with patient when things went wrong. Serious incident reports made specific reference to the actions taken to ensure the trusts duty of candour had been fulfilled. We saw that when medication errors occurred staff told patients this had happened and apologised. A presentation on the trust's duty of candour had been given to the Hackney team.
- Within the City & Hackney team, discussing incidents was a standing item on the agenda for fortnightly team meetings. In addition, there was a meeting every three months for all managers in the City and Hackney directorate to discuss what had been learned from incidents. Staff in other boroughs told us that incidents were discussed. However, when we reviewed the minutes of recent team meetings in Tower Hamlets we did not see any evidence of this. Staff across all three teams said that incidents were discussed in team meetings, although two nurses in Hackney said there had not been any incidents and none of the nurses in Tower Hamlets specifically mentioned the deaths and significant serious incidents that had occurred in the previous year. The psychiatrist in Tower Hamlets said there had been three or four incidents in the last two years when the electronic incident record showed there had been at least 10 incidents in the previous year.
- We saw evidence of changes as a result of incidents. For example, in one team the tray containing new referral forms was moved to a more prominent place in the office. In another team a system was introduced to check the patient's date of birth whenever medication was dispensed to avoid it being given to the wrong person by mistake. Following a serious incident, improved information was sent to GPs clarifying the most appropriate referral routes for patients, specifically addressing any confusion about whether the primary diagnosis was mental illness or substance misuse.
- The process that was followed after an incident involved de-briefing staff at two stages. An initial debrief with staff immediately involved in the incident, team doctors and the team leader took place as soon as factual evidence gathering began. A further de-briefing took place at multidisciplinary team meetings and handover meetings once the investigation had been completed. Staff said that support was available after serious incidents. One supervision record showed that an incident had been discussed and further support offered to the employee.

Luton and Bedfordshire home treatment teams

Safe and clean environment

- At the Luton Crisis Resolution and Home Treatment (CRHT) team, the interview rooms were fitted with two alarm buttons. At the Bedfordshire Crisis Team patients did not come to the office.
- There was no clinic room at either of the offices we visited. If medicines were required urgently doctors wrote a prescription for patients for medicines dispensed at local pharmacies. Prescription pads were stored securely in the staff office and records were kept of their identification numbers.
- All areas were clean and well maintained.

Safe staffing

- The Bedfordshire Crisis Team operated from 9.00am to 9.00pm seven days a week. The service operated a day shift from 9.00am to 5.00pm and an evening shift from 1.00pm to 9.00pm. On both shifts, the established

Good

Are services safe?

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

staffing level was three nurses and two support workers. The Luton CRHT team also operated from 9.00am to 9.00pm, although staff in this team tended to work long days covering the whole shift. During the week the established staffing allocation was seven nurses and two support workers. This reduced to six nurses on Saturdays and five nurses on Sundays. Outside these times, telephone support was available through telephone 'crisis 'lines, staffed by qualified nurses from either the crisis and home treatment teams or the psychiatric liaison service.

- The higher staffing levels in Luton reflect the higher caseload. A typical caseload for the Luton team was 35 compared to an average of 20 in Bedford. The Luton team had an established procedure if the caseload went above 45 patients, involving the senior nurse moving from a managerial to a clinical role and extra bank staff being booked. In Bedford, extra staff were booked if there was in an increase in the number of patients requiring three visits each day. Neither service had a waiting list.
- Bank staff were used to cover sickness and other routine absences. Bank staff were familiar with the staff team and had either worked in the service previously or worked in similar services. The team in Bedford had used one nurse from an agency who was familiar with the service.
- Each service had access to a psychiatrist within the team between 9.00am and 5.00pm from Monday to Friday. Outside these hours, the duty psychiatrist at the local hospital was available.
- Mandatory training involved 15 courses including safeguarding, prevention and management of violence and aggression and basic life support. Overall compliance with training requirements was 95%. The completion rate for specific courses within the mandatory training programme did not fall below 75%.

Assessing and managing risk to patients and staff

- We reviewed 10 patient records across the two services. Each record showed that a risk assessment had been carried out at the initial assessment. Risk assessments included a statement of the patient's diagnosis, the current presenting risks and a history of incidents. We observed discussions with patients about risk. Risk assessments were routinely discussed at multidisciplinary reviews and updated if there had been a change in the nature and level of risk.
- At the initial assessment, patients were given information about crisis services, including the number of the local crisis telephone line. Confidentiality agreements were also made which provided details of friends or family members that the patient agreed the service could contact if they were concerned about the patient.
- Patients were reviewed at daily handover meetings. Patients were classified as presenting a red, amber or green risk rating. Patients classified as 'red' were new referrals or patients that presented a heightened level of risk. Patients who were 'amber' were considered to be making progress. Patient rated as 'green' had made progress in their recovery and were usually awaiting discharge. The rating determined the frequency of visits, with 'red' patients being visited at least once a day, 'amber' patients were visited up to three times a week and 'green' patient were visited twice a week or less. We saw that one patient had been admitted to hospital after a deterioration in their health.
- All staff had completed the mandatory training in safeguarding. Support workers had all completed level one training and nurses had all completed level two. In Bedford, there had been no recent referrals to the safeguarding team, although there had been eight referrals to the multi-agency safeguarding hub for children between October and December 2015. In Luton we reviewed four safeguarding referrals made in the six month before the inspection. Referrals were made on standard forms that were comprehensively completed. However, there was no record of the outcome of the referral. Safeguarding concerns were discussed in daily handover meetings and multidisciplinary team meetings.
- The trust had updated its lone working policy in May 2016. The policy included a list a procedures to enhance safe working. This included a requirement for up to date risk assessments, having an agreed code word or phrase that staff use when phoning the office to indicate they are encountering difficulties, and ensuring there was a clear record of the times and locations of meetings. Across the home treatment teams we saw compliance with this policy. Staff routinely visited patients in pairs.

Good

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Staff only visited patients alone if the patient was well known to the service and had been assessed as presenting a low risk. Staff had alarms fitted with global positioning systems (GPS) tracking and a call button that would immediately alert the police. Staff said they had never felt pressured in making a visit if they felt uncomfortable about the level of risk involved.

- All medication was collected from a local pharmacy. Once medicines were received from the pharmacy, they were signed out of the office by two members of staff before they were delivered to the patients' home. A log of this activity was kept in the office. Supervision whilst taking medication could be part of the patient's care plan. At Luton CRHT team, some medicines were stored in a locked cupboard in the staff office. Staff recorded the ambient temperature of this cupboard daily. Staff removed medicines from patients' homes to reduce the risk of duplication and ensure that patients took the correct medicines. If necessary, staff disposed of medicines that were no longer required. Staff gave controlled drugs that were no longer required to pharmacy for destruction. We checked 12 prescription charts. They all had the patient's name and allergy status completed. They also indicated if a medicine was to be obtained from the patients GP or whether it would be supplied by the trust.

Track record on safety

- During the previous year, there had been 21 incidents recorded at the Luton CRHT team. At the Bedford crisis team there had been seven patient deaths.

Reporting incidents and learning from when things go wrong

- Staff told us that they knew what to report and how to report it. Staff said that were able to discuss any concerns about incidents with colleagues and escalate matters to the team manager. All nurses could report incidents directly onto the electronic incident record.
- We reviewed the minutes of the March 2016 team meeting at the Luton CRHT team. These minutes showed that the team leader had presented a report of an investigation into a serious incident and this was discussed. The full report was circulated to the team, along with relevant national guidelines.
- Staff were able to give examples of when they had discussed incidents in team meetings. A support worker in the Bedford team told us that staff had met to discuss the findings of an investigation into a patient suicide and, as a result, there was more active communication with staff at the inpatient ward. Another incident involved medication being given to the wrong patient. This led to a new system in which patients confirmed their name, address and date of birth every time medication was given to them.
- De-briefing with staff involved in incidents took place with a manager straight after the incident. A more formal meeting was held within 48 hours. Staff said they had felt supported after serious incidents. A nurse said that a nursing director had met with the team after an incident to help with support and de-briefing.

London health based places of safety

Safe and clean environment

- We reviewed three health based places of safety at Homerton Hospital, Newham Hospital and the Royal London Hospital. The places of safety at each hospital were clean, well-maintain and functional.
- The places of safety at the Royal London and Newham Hospitals were fitted with closed circuit television (CCTV). The siting of toilet facilities did create blind spots but the risk this presented was mitigated by staff monitoring patients at all times. The wash basin at the Royal London Hospital did present a ligature risk, but again, this risk was mitigated by the level of staff observation.
- None of the places of safety were fitted with alarms but all staff carried personal alarms that could be used to call for assistance.
- At the Royal London, the place of safety was located close to the accident and emergency department, enabling rapid access to resuscitation equipment. The places of safety at Newham and Homerton hospital were adjacent to mental health wards which both had resuscitation equipment, emergency 'grab bags' with ligature cutters and clinic rooms with supplies of emergency drugs.

Safe staffing

- Senior nurses were available to be at the health based places of safety 24 hours each day. At the Homerton Hospital, each mental health ward had a designated rapid response nurse on each shift who attended the place of safety when required. A rota for these duties

was agreed in advance. These staff were taken from the established staff allocation on the ward. Similarly, at Newham Hospital the place of safety was staffed by designated response nurses from the mental health wards. Two nurses were allocated to these duties if the patient presented a higher level of risk. At the Royal London Hospital the place of safety was managed as part of the psychiatric liaison team. This team had two nurses per shift. During the day, medical cover was available from a consultant psychiatrist, specialist registrar and two junior doctors. At night the team was allocated a junior doctor who was supported by a duty on-call consultant psychiatrist. The duty senior nurses we interviewed said that staffing arrangements worked well and staffing levels were sufficient. The trust did not use bank or agency staff in places of safety.

Assessing and managing risks to patients and staff

- On arrival at the place of safety, patients were searched by the police in accordance with the Police and Criminal Evidence Act. An initial assessment of each patient was carried out by a duty doctor as soon as possible after the patient arrived at the place of safety. In Newham, the doctor usually arrived within 10 to 15 minutes. In the other hospitals, the initial assessment was carried out within the first hour. The initial assessment reviewed the patient's mental state and assessed any immediate risks. At the Royal London Hospital, the police stayed with the patient until the initial assessment had been completed.
- If patients required medical treatment, they were first taken to the nearest accident and emergency department. Whilst patients were in the place of safety, a nurse was with them at all times. If the patient's health deteriorated, the nurse had access to medical support and resuscitation equipment. Patients could also be transferred to an accident and emergency department if necessary.
- Medication was administered rarely at the health based places of safety. Staff said that if medication was given, the patient's consent would be sought. If it was thought that the patient did not have the capacity to make a decision about medication, an assessment would be carried out and recorded. Similarly, we were told that restraint and rapid tranquilisation took place very rarely. Staff said that if rapid tranquilisation was administered this was done in line with trust policies and patients would be physically checked by a doctor and observed to ensure their safety.
- All staff were trained in safeguarding as part of the trusts mandatory training programme. Staff explained that referrals to the safeguarding children team would be made if there was a child at the patient's home.

Track record on safety

- There had been no serious incidents reported in the 12 months before the inspection.

Reporting incidents and learning from when things go wrong

- Staff told us that incidents they would record included restraint, rapid tranquilisation, a patient absconding, a medical or physical health incident or a safeguarding concern. These matters would be recorded on an electronic incident recording system.
- Whilst there had been no specific incidents recently, the staff were able to tell us about the trust's policy on managing incidents which included a de-briefing session with staff immediately concerned, an investigation and the implementation of improvements that could be made to reduce the risk of such an incident happening again.

Luton and Bedfordshire health based places of safety

Safe and clean environment

- We reviewed two health based places of safety at the Weller Wing, Bedford Hospital, and Luton Mental Health Centre at Calnwood Road, Luton. The places of safety at each hospital were clean, well-maintained and functional.
- Neither place of safety was fitted with closed circuit television (CCTV). The siting of toilet facilities did create blind spots but the risks this presented was mitigated by staff monitoring patients at all times. Anti-ligature fittings had been used in the toilets.
- None of the places of safety were fitted with alarms but all staff carried personal alarms that could be used to call for assistance. In Luton, staff also had a radio they could use to contact the adjacent ward.

Good

Are services safe?

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- At Bedford Hospital, the place of safety was close to the accident and emergency department. Resuscitation equipment and emergency medicines were located close by. In Luton, the place of safety was located next to a psychiatric intensive care ward where there was resuscitation equipment, emergency 'grab bags' with ligature cutters and a clinic room with supplies of emergency drugs. Emergency drugs were all in date.

Safe staffing

- In both services, one senior nurse was allocated to the health based place of safety. They were supported by police officers who usually remained in attendance until the assessment was complete. In Luton, staff working on the nearby inpatient wards were allocated to the place of safety when required on the basis of a rota. These staff rotated on an hourly basis. Their role on the ward was not supernumerary, although additional staff could be allocated to the ward if required. In Bedford, the place of safety was staffed by the psychiatric liaison team, with support from the crisis and home treatment team between 9.00am and 9.00pm. The trust did not use bank or agency staff in places of safety.

Assessing and managing risks to patients and staff

- On arrival at the place of safety, patients were searched by the police in accordance with the Police and Criminal Evidence Act. A joint risk assessment was carried out by the duty senior nurse and police. Staff highlighted the importance of asking patients if they had drugs as an indicator of heightened risk. An initial assessment of each patient was carried out by a duty doctor as soon as possible after the patient arrived.
- If patients required medical treatment, they were first taken to the nearest accident and emergency department. Whilst patients were in the place of safety, a nurse was with them at all times. If the patient's health deteriorated, the nurse had access to medical support and resuscitation equipment. Patients could also be transferred to an accident and emergency department if necessary.
- All staff were required to be trained in safeguarding as part of the trust's mandatory training programme.
- Staff working at the place of safety in Bedford tended to be more isolated than colleagues in Luton. The Weller Wing at Bedford Hospital was a relatively small mental health unit with one acute admission ward for female patients and the administrative offices of the crisis and home treatment team. If a patient needed to be restrained there was an agreed local arrangement that staff would call the police for support.

Track record on safety

- There had been no serious incidents reported in the 12 months before the inspection.

Reporting incidents and learning from when things go wrong

- In Luton there had been seven incidents in the health based place of safety in the 15 months before the inspection. Three of these were staffing incidents, such as a duty doctor not responding to a request to attend. On one occasion, a patient became very aggressive and was placed in the adjacent seclusion room. There had been no incidents in the facility at Bedford. Staff told us that they would record aggression, violence, threats, restraint and rapid tranquilisation if these incidents occurred.
- Staff told us about the trust's policy on managing incidents which included a de-briefing session with staff immediately concerned, an investigation and the implementation of improvements that could be made to reduce the risk of such an incident happening again. In Luton, the police were included in the de-briefing.

Are services effective?

Good

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

Our findings

London home treatment teams

Assessment of needs and planning of care

- We attended three assessments by consultant psychiatrists that were all carried out on the day of the referral. During these assessments the psychiatrist gave patients time to talk about their concerns and explain matters that were affecting their mental state such as work, family and relationships. The purpose of medication and potential side effects were discussed, along with potential risks. We reviewed 23 patient records. These records showed that assessments had been completed at the first meeting with the patient.
- Each team had a different approach to recording care plans. Care plans in City & Hackney were completed with the patient on a standard form covering questions about what the patient was struggling with, their identified strengths and support networks and what the patient thought could help them. These questions led to care plans that were personalised, holistic and recovery orientated. Care planning in the other boroughs was less consistent. Plans for care were included in the progress notes, but there did not appear to be a distinct document that could be given to the patient.
- Information was securely stored on the electronic patient record. However, it was often difficult to find key documents. Teams had different approaches to recording and storing care plans. Some care plans were written in the progress notes whilst others were written on paper and uploaded to the electronic record.

Best practice in treatment and care

- Staff prescribed in accordance with best practice and national institute for health and care excellence guidelines The 55 medication charts we reviewed all showed prescribing within the British National Formulary guidelines.
- There were psychologists in both the Hackney and Newham teams. They provided assessments and initial treatment in mindfulness, cognitive behavioural therapy and distress tolerance. Psychologists also supported nursing staff with therapeutic approaches that under pinned their interactions with patients such as cognitive analytical therapy, anxiety management and brief solution therapy. In Tower Hamlets, patients had access to psychology by being referred to the Crisis Intervention Counselling and Psychology Service as well as psychological therapies service and work with the community mental health team to highlight referrals to the personality disorder service. On average, three or four referrals were made to this service each month.
- At the initial assessment, patients were given an information pack that included details of local services providing support with employment, housing and benefits.
- Whilst physical health checks were not routine, staff did have regard to patients' health care needs. If a patient was commencing a course of anti-psychotic medication an electo-cardiogram and blood tests would be carried out. If patients were diabetic, staff would give advice and assist patients with checking blood glucose levels. Patients were advised to see their GP if other concerns arose.
- In Hackney, the DIALOG scale was used at the initial assessment for each patient in which patients were asked to rate themselves on a scale of one to seven in response to questions about how satisfied they were with their mental health, relationships and other aspects of their life. This would be measured again on discharge to provide a measure of the patient's progress. In other teams, the Health of the Nation Outcome Scale was used to measure outcomes.
- There were records of audits being carried out on infection control, care records and medicines management. Audits were conducted by senior nurses and doctors. A recent medication audit in Newham highlighted gaps in signatures on medication charts and found that fridge temperatures were not recorded at weekends. We saw that these matters had been addressed.

Skilled staff to deliver care

- Each team included a team leader, nurses, support workers, consultant psychiatrists and junior doctors. The teams in Hackney and Newham both had psychologists and occupational therapists. Due to different commissioning arrangements with the local authorities, Hackney was the only team with social workers. In Tower Hamlets, two support worker posts were designated as bilingual posts for people speaking English and Bengali.

Are services effective?

Good

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

- All teams were well established with a number of staff having worked within these teams for many years. Staff all felt their team had a lot of experience. Most staff had been in post for more than five years.
- When new staff joined the teams, they were supernumerary for the first two weeks, enabling them to spend time shadowing experienced colleagues. New staff were also required to work through an induction checklist to confirm they were familiar with the environment and they had read the trust's policies.
- Records showed that individual supervision sessions were carried out with more than 85% of the staff team each month and that all staff had an annual appraisal. We reviewed nine supervision records, most recorded on a standard form covering sickness, annual leave, review of cases, mandatory training, safeguarding and policy updates. The quality and detail of these records varied. Most of the records included positive comments about the employee's performance. The staff we spoke with confirmed that they attended supervision each month and spoke positively about the support they received. Team meetings were held once a month. Records showed these meetings were well attended.
- Across all three teams there were examples of staff achieving professional development through formal training. A number of nurses were trained as approved mental health professionals and some senior nurses had qualified as non-medical prescribers. In Hackney, seven nurses had completed psycho-pharmacological training. In Newham, a senior nurse had completed a certificate in management studies and a health care assistant had become a registered mental health nurse. Informal training and development took place within team meetings. Staff told us about training sessions on the Mental Capacity Act and managing diabetes.
- We reviewed the supervision record of one employee who was subject to the capability procedure. The record showed that problems were identified, targets were set and there was clear evidence of improvement.

Multi-disciplinary and inter-agency team work

- Multidisciplinary meetings took place in each team at least once a week to review patients care and treatment. We attended a meeting in Hackney where there was a full range of professionals, including a social worker and psychologist. Patients were discussed in depth and discharge plans were developed for every patient.
- Handover meetings were attended by all the staff. Each patient was reviewed and, where appropriate, changes were made to their red, amber or green status. New referrals were discussed in more depth. At the end of the meeting, the patient visits for that day were planned and co-ordinated to minimise travel time. In Newham and Tower Hamlets staff tended to work long days so the services operated on a single shift. In Hackney, the there was an early shift and a late shift. The afternoon handover between these shifts was limited to a discussion between shift co-ordinators. In all teams, discussions in handover meetings were recorded on individual patient records.
- Staff from the home treatment teams attended the hospital wards most days to assess patients' suitability for early discharge. When patients were discharged to the community mental health team there was a joint visit to the patient with the new care co-ordinator.
- Communication between the home treatment teams was limited. Whilst there had been one trust wide meeting of home treatment teams in May 2016 to prepare for the CQC inspection, there was little evidence of support, shared learning, or joint initiatives across these teams.
- These teams had strong working relationships with primary care services, psychiatric liaison teams, and safeguarding team within the local authority. Staff told us about local third sector organisations that provided a range of support to people using mental health services.

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

- Staff did not receive any specific training on the Mental Health Act. Any matters relating to the Mental Health Act were discussed with approved mental health professionals within the team.
- At the time of our visits there were six patients subject to the Mental Health Act. All six were liable to be detained under section three of the Act with leave granted under section 17. The inpatient consultant retained the role as responsible medical officer. We were told that it was rare for patients to be subject to community treatment orders.
- Patient records showed that assessments of patients' capacity to consent to treatment were routinely assessed. None of the patient were receiving treatment were subject to section 58 of the Act and, therefore, certificates authorising treatment were not required.

Are services effective?

Good

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

- Patient records showed that information was given to patient about how the Mental Health Act applied to their situation when they were first detained. However, this was not repeated when they were placed on leave under the care of the home treatment team.
- Team leaders all knew staff who worked in the Mental Health Act office and said they would contact these colleagues if they had any queries.
- We reviewed the statutory documents for all six patients who were liable to be detained. These documents were filled out correctly, up to date and stored appropriately.
- Staff were aware of patient advocacy services although it was not clear whether any detained patients were using these services.

Good practice in applying the Mental Capacity Act

- All staff had received training on the Mental Capacity Act within their team. Information about the Act, including the principles, was displayed on notice boards throughout the teams' offices. All staff had a credit card sized guidance booklet entitled 'Ten Point Guide to the Mental Capacity Act.' This included the principles of the Act, the components of decision making and advice on supporting people to make decisions.
- Staff told us that the Mental Capacity Act may be used in their professional practice if a patient's mental health deteriorated and they were no longer able to make decisions about taking medication, where they were staying or interaction with mental health services. Staff told us that they would usually contact a doctor to assist with an assessment of mental capacity and that action could be taken through using either the Mental Health Act or Mental Capacity Act, as appropriate.

Luton and Bedfordshire home treatment teams

Assessment of needs and planning of care

- Comprehensive assessments were carried out for each patient at the initial appointment. These assessments included discussions of patient's mental health, their physical health, family circumstances, social circumstances, risks and other issues that could be affecting the patient's mental state.
- All patients had a care plan that was reviewed and updated during the regular visits. Care plans were written with patients. They included details of the patient's recovery goals, their desired outcomes and a list of actions. The plans were focussed on the wishes and self-defined needs of the patient.
- Information was secured stored on the electronic patient record. Key written documents were uploaded to the system.

Best practice in treatment and care

- Staff prescribed in accordance with best practice and national institute for health and care excellence guidelines. The medication records all included the patient's name and allergy status. They also indicated whether a medicine was to be obtained from the patient's GP or whether it would be supplied by the trust.
- Both teams had a psychologist and psychology assistants. Psychologists provided a psychological perspective on risk assessments, as well as supporting the team to understand that patient's immediate needs. Individual clinical work focused on the most complex patients, often people with personality disorders.
- At the initial assessment, patients were given an information pack that included details of local services providing support with employment, housing and benefits.
- Patient's physical healthcare needs were reviewed at the initial assessment and discussed at subsequent visits. Staff were able to carry out basic physical assessments covering the patient's weight, height, blood pressure, temperature and oxygen saturation. Treatment of physical health needs was arranged through the patient's GP.
- Neither of the services used outcome measures, although plans were being made to introduce this. The psychologists used some outcome measures, such as the Becks depression inventory, to assess patients and measure their progress.
- Audits took place of care records, capacity assessments, risk assessments and medication management. Audits were conducted by doctors or senior nurses.

Skilled staff to deliver care

Are services effective?

Good

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

- Each team included a team leader, nurses, support workers, a psychologist, assistant psychologists, consultant psychiatrist and junior doctors. Luton CRHT also included a social worker.
- Both teams were well established with a number of staff having worked within these teams for many years. Staff all felt their team had a lot of experience. Most staff had been in post for more than five years.
- When new staff joined the teams, they were supernumerary for the first two weeks, enabling them to spend time shadowing experienced colleagues. New staff were also required to work through an induction checklist to confirm they were familiar with the environment and they had read the trust's policies.
- Staff usually had supervision each month. Supervision records tended to be brief, but showed evidence of discussions about casework, a review of recent complaints and general discussions about the employees' progress. All records contained an up to date appraisals which included a review of work during the previous year, objectives for the following year and reflections of the appraiser and the person being appraised. We noted there were a number of very positive comments about the progress employees had achieved.
- Staff had access to specialist training. Two staff had qualified as approved mental health professionals. There were plans to offer more nurses training in psycho-social interventions.

Multidisciplinary and inter agency working

- In each team there was a multidisciplinary meeting twice a week to discuss patients' progress and review plans for discharge. We attended one of these meetings. We noted there was attendance by all disciplines within the team and everyone contributed to the discussion.
- Handover meetings attended by all staff took place at the start of each shift. All patients were reviewed and a plan of visits was agreed for that shift.
- Staff frequently visited the acute admission wards and attended ward rounds there to discuss patients who could be discharged to their care. Assessments were carried out on the wards. Staff also said there were good links with the community mental health teams. When patients were discharged from the crisis teams, a joint visit took place with the new care co-ordinator from the community team. There were also good links between the crisis teams in Luton and Bedford. The team leaders of these services met every two weeks.
- Both teams told us about good links with other local services, including third sector providers.

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

- All staff in the Luton and some staff in the Bedford team had completed training in the Mental Health Act, although this was not part of the mandatory training.
- During our inspection, no patients were detained under the Mental Health Act. Team leaders said that patients were occasionally on leave from the ward under section 17 of the Act or subject to community treatment orders, but this was rare.
- If staff needed advice on the Mental Health Act they would firstly discuss this with an approved mental health professional within the team. If they needed further advice they would contact the Mental Health Act office.
- Leaflets about the local advocacy service were available for patients.

Good practice in applying the Mental Capacity Act

- All staff had received training on the Mental Capacity Act within their team. Information about the Act, including the principles of the Act, was displayed on notice boards throughout the teams' offices. All staff had credit card sized guidance entitled 'Ten Point Guide to the Mental Capacity Act.' This included the principles of the Act, the components of decision making and advice on supporting people to make decisions.
- Staff told us that the Mental Capacity Act may be used in their professional practice if a patient's mental health deteriorated and they were no longer able to make decisions about taking medication, where they were staying or interaction with mental health services. Staff told us that they would usually contact a doctor to assist with an assessment of mental capacity and that action could be taken through using either the Mental Health Act or Mental Capacity Act, as appropriate.

London health based places of safety

Assessment of needs and planning of care

Are services effective?

Good

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

- Significant gaps in recording the times at which patients were assessed made it difficult to form a clear judgement on whether assessments were completed in a timely manner. However, the duty senior nurses said that approved mental health professionals (AMHP) attended the place of safety promptly. At the Homerton Hospital, AMHPs were based on site during the day. At Newham, the response times were between 20 minutes and one hour. Staff explained that it could take longer for AMHP to respond at night.
- Details of the assessments were recorded on the electronic patient record.

Skilled staff to deliver care

- The health based places of safety were staffed by senior nurses (Band 6 or above). Staff received training each year in the policies and processes surrounding section 136 of the Mental Health Act 1983 which concerns mentally disordered persons found in a public place. Staff also received training on risk assessments, restraint and resuscitation.

Multidisciplinary and inter-agency team work

- There was no single distinct team of staff working in places of safety and so no formal team meetings took place. Staff were assigned to the place of safety from their substantive role on acute mental health wards or within the psychiatric liaison team.
- There were different arrangements for joint working with agencies across the three boroughs. For example in Tower Hamlets there was a crisis care concordat signed by the clinical commissioning group, the local authority, the police, the ambulance service, East London Foundation Trust and Barts Health NHS Trust. Meetings were attended by representatives of all the partner organisations. In Hackney and Tower Hamlets, staff told us that a liaison meeting with the police took place every two months. In Newham a police liaison officer had recently been appointed.
- At the Homerton hospital, the lead nurse told us about a joint initiative with British Transport Police to review the number of deaths of people jumping from bridges across the Thames in the City of London.

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

- Staff had received training in the Mental Health Act, but this was not part of their mandatory training.
- Patient records were not always completed in full which made it difficult to reach a judgement about the timing of visits by AMHPs, method of conveying the patient, whether relatives were contacted, whether patients were told about rights and arrangements after the initial assessment had taken place.
- Most of the forms did not confirm that the patient had been found in a public place. One form failed to give any details of where the patient been taken from or why they had been taken. On four records it was clear that the person had been unlawfully taken from inside their own property, not from a public place. There appeared to have been no recognition of this from police, the local authority or the trust. We found no evidence of paperwork relating to patients being subject to section 136 of the Mental Health Act was audited or checked to ensure legal compliance.
- We did not see any evidence to show that patients were given information about their rights and how the relevant section of the Mental Health Act applied to them.
- If staff required legal advice about the Mental Health Act they would speak to their manager or an AMHP. Advice was also available from the Mental Health Act Office.

Good practice in applying the Mental Capacity Act

- Staff were aware of the principles of the Mental Capacity Act.

Luton and Bedfordshire health based places of safety

Assessment of needs and planning of care

- Only about half the patient records which were checked in Bedfordshire showed the time at which the patient was conveyed to the place of safety and the time of assessment. On the records that did show the times, three patients were assessed in four hours or less, three were assessed after four to six hours and one patient was assessed after seven hours having been initially taken to the accident and emergency department for a physical examination. At Luton only about a third of the patient records included details of the time of

Are services effective?

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assessment and discharge. Of these the longest period of detention was nine hours. Six detentions were completed in five hours or less and four lasted between seven and eight hours.

Skilled staff to deliver care

- The health based places of safety were staffed by senior nurses (Band 6 or above). Staff received training each year in the policies and processes surrounding section 136 of the Mental Health Act 1983 which concerns mentally disordered persons found in a public place. Staff also received training on risk assessments, restraint and resuscitation.

Multidisciplinary and inter-agency team work

- There was a team meeting and development day for all staff on the duty senior nurse rota four times each year.
- Staff spoke positively about the support they received from the police. When the police bought someone to the place of safety they phoned ahead to ensure that a nurse was available there when they arrived. We were told that there were regular meetings between the trust, the police and the local ambulance service. A street triage service had been introduced in both areas as a joint initiative between mental health services and the police.

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

- Staff had received training in the Mental Health Act, but this was not part of their mandatory training.
- The patients records were not always completed in full which made it difficult to reach judgements about the timing of visits by approved mental health professionals (AMHP), method of conveying the patient, whether relatives were contacted, whether patients were told about rights and arrangements after the initial assessment had taken place.
- Most of the forms did not confirm that the patient had been found in a public place. Most forms failed to give any details of where the patient been taken from or why they had been taken. On two records it was clear that the person had been unlawfully taken from inside their own property, not from a public place. There appeared to have been no recognition of this from police, the local authority or the trust. We found no evidence of paperwork relating to patients at the place of safety being audited to check legal compliance.
- One patient was 15 years old and had not been assessed by a doctor or approved mental health professional with knowledge and experience in caring for this age group, nor was there any evidence that consultation had taken place with a suitably skilled or experienced professional.
- We did not see any evidence to show that patients were given information about their rights and how the relevant section of the Mental Health Act applied to them.
- If staff required legal advice about the Mental Health Act they would speak to their manager or an AMHP. Advice was also available from the Mental Health Act office.

Good practice in applying the Mental Capacity Act

- Staff were aware of the principles of the Mental Capacity Act.

Good

Are services caring?

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

Our findings

London home treatment teams

Kindness, dignity, respect and support

- Across the three teams, we saw that staff had a very caring and supportive attitude towards patients. Nurses listened to patients carefully and responded to questions thoughtfully. We saw staff put patients at ease with a kind and friendly approach. Staff showed a lot of sensitivity when talking about matters that the patients were finding difficult to discuss. When one patient raised concern that their medication had not worked, the nurse discussed this with the doctor as soon as they returned to the office and the medication was changed.
- Patients told us that staff were caring a compassionate. A number of patients said that staff were professional, respectful and polite. None of the patients we spoke with raised any concerns about the staff they had worked with.
- During home visits and handover meetings, we saw that staff were very knowledgeable about their patients and understood their personal circumstances very well. Patients said that whilst they did not always see the same person, they found staff to all be very caring, supportive and consistent in their approach.
- At the initial interview, patients were asked for details of people that the service could contact in an emergency and patients were asked to sign a form to confirm any consent that was given to disclose information. Patients in Hackney were given a leaflet about their records and the trust's policy on sharing information.

The involvement of people in the care they receive

- We observed that patients were very actively involved in discussions and decisions about their care and treatment during all the visits we attended. Patients told us that they had copies of their care plans and said they had a good understanding of the purpose of their treatment and their overall objectives.
- The information pack for patients in Hackney included a letter offering support to families and carers. When patients were living with family or friends, the involvement of these people became an integral part of patient care.
- Advocacy services were provided by local voluntary sector organisations. Patients said they knew about advocacy services that were available but had not had any need to use them.
- The trust had a centralised system to ensure that people using services were part of interview panels for staff at senior nursing grades and above. Each team leader confirmed that this had taken place in recent recruitment panels.
- Each team asked patients to complete a questionnaire when they were discharged. In Tower Hamlets there had been 14 responses in the six weeks before the inspection. Responses were mainly positive although only 40% said they had been given enough information. Seventy percent said they been treated with kindness, dignity and respect. Responses in Hackney were very similar, with 80% saying they were treated well, and only 44% saying they had sufficient information to cope with their mental health.
- In Newham there was a weekly community meeting for patients at the day hospital.

Luton and Bedfordshire home treatment teams

Kindness, dignity, respect and support

- We consistently observed positive and supportive interactions between staff and patients. Staff listened carefully to patients and responded sensitively.
- Patients we spoke to were generally positive about the service they had received. They said staff were caring and supportive. However, we received two comment cards from patients who gave mixed views of their experiences with the Bedford team. They said that whilst some staff had been caring, they were concerned about the competency and attitude of others. There were specific concerns about poor communication, a focus on rapid discharge and care plans being 'cut and pasted' from other patients care plans.
- Throughout our interviews with staff it appeared that staff knew patients very well. This was demonstrated in the depth of discussion about patients at team meetings and handovers. During visits to patients, we saw that staff had a good understanding of the patient's relationship, employment situation and other social factors that could affect their recovery. One patient said they felt staff had a very good understanding of their situation.

Good

Are services caring?

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

- At the initial interview, patients were asked for details of people that the service could contact in an emergency and patients were asked to sign a form to confirm any consent that was given to disclose information.

The involvement of people in the care they receive

- Care plans focused on the self-defined needs of patients and their own aims and aspirations. Patients told us they had copies of their care plans. We saw that care plans were discussed and updated when staff met with patients, and that staff took a collaborative approach to working with patients.
- Both services had set up a carers' support group. These groups were an opportunity for mutual support amongst carers. Senior staff also attended these groups to give advice and support.
- Advocacy services were provided by local voluntary sector organisations. Patients were given information about advocacy services.
- The trust had a centralised system to ensure that people using services were part of interview panels for staff at senior nursing grades and above. Each team leader confirmed that this had taken place in recent recruitment panels.
- Each team asked patients to complete a questionnaire when they were discharged from the service. Patients were asked if they been treated with kindness, dignity and respect, if they had been listened to, if they had been given enough information and if they knew who to contact in a crisis. Since April 2016, there had been 10 responses in Bedford and 11 responses in Luton. Overall, responses were very positive. In the Luton team, one or two patients gave negative feedback about being listened to, being treated with dignity and knowing who to contact in a crisis.
- In Luton, a 'You said – We did' board was displayed in the waiting area. It stated that more psychology assistants had been appointed and a carers' group set up in response to concerns that had been raised.

London health based places of safety

Kindness, dignity, respect and support

- During this part of the inspection we did not observe any interactions between staff and patients. However, staff spoke about patients in a caring manner.
- We were told that ambulances were used to convey patients to the place of safety. Staff said it was very rare for police vehicles to be used.

Involvement of people in the care they receive

- Staff told us that patient's views were sought and considered throughout the assessment process. In Hackney, a project was being carried out to understand the experiences of people who had used the place of safety.

Luton and Bedfordshire health based places of safety

Kindness, dignity, respect and support

- During this part of the inspection we did not observe any interactions between staff and patients. However, staff spoke about patients in a caring manner.
- Staff told us that the police were responsive and had a very positive attitude towards patients. We were told that ambulances were used to convey patients to the place of safety. Staff said it was very rare for police vehicles to be used.

Involvement of people in the care they receive

- Staff told us that patients' views were sought and considered throughout the assessment.

Are services responsive to people's needs?

Outstanding ☆

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

Our findings

London home treatment teams

Access and discharge

- All teams had a target to see 80% of new referrals within 24 hours and urgent referrals in four hours. Data showed that all teams consistently achieved the 24 hour target in more than 85% of referrals. Staff said that referrals requiring four hour response times were very rare. In Newham, patients were usually seen on the same day if a referral was made before midday.
- In May 2016, the service in Newham had been closed to new referrals for two days when the caseload had reached 40 patients. The service had tried to access bank staff to maintain the level of service but none were available.
- A telephone 'crisis' line operated throughout the night. This service provided telephone support. Emergency services and assessment by the emergency duty team could be arranged through this service. There was a dedicated telephone line that patients using the home treatment teams could phone during the day. This was answered by a senior nurse who could arrange additional visits if necessary.
- The criteria for using the home treatment teams was set out in the operational policy. This stated that patients were aged between 16 and 65 and in a state of mental health crisis so severe that they would otherwise be admitted to an acute inpatient ward. The policy states that there needs to be evidence of patients presenting an actual or potential danger to themselves or other such as there being a recent suicide attempt, threats of harm to others, recent history of significant self-harm, command hallucinations or significant disordered thoughts that interfere with daily living. The exclusion criteria stated that the service would not usually be appropriate for people with a primary diagnosis of substance misuse, people with learning disabilities without a dual diagnosis of mental health, crisis solely relating to relationship issues and people whose mental health problems are the result of an organic disease such as dementia.
- Efforts were made to actively engage people who were reluctant to attend. Staff were flexible in offering appointments at the patient's home or in a public place. The service also focused on patients strengths and self-defined difficulties. Staff gave examples of how they offer help with practical things at patient's homes as a way building a trusting and supportive relationship. If patients did not attend appointments, or if they weren't at home when staff called, a further visit would take place two or three hours later. Staff would leave a note saying that they had called. In some cases, patients gave permission for a friend or neighbour to be contacted if the patient was not at home. Further action depended on the level of risk the patient presented. If the patient was considered at high risk the police would be asked to conduct a welfare visit.
- Appointments were made at times that were convenient for the patient. Patients told us they valued being seen every day and appreciated the staff making appointments at times that fitted in around their work and other commitments.
- Appointments were very rarely cancelled and patients were informed if staff were running late.

The facilities promote recovery, comfort, dignity and confidentiality

- Interview rooms had adequate sound proofing.
- Notice boards displayed accessible information about treatments, local services, patients' rights and details of how to complain about the service. Patients were also given packs containing this information at their first appointment.

Meeting the needs of all people who use the service

- Appointments were offered at places that were convenient to patients, thus ensuring that the service was fully accessible to people requiring disabled access.
- Information leaflets could be translated into languages spoken by people who use the service.
- Staff frequently used interpreters to assist their work with patients whose first language was not English. They were booked by the team administrator using the service provided by the local authority. In City & Hackney, records showed that an interpreter had been used on 16 occasions during the month prior to the inspection. Interpreters were most frequently required to speak French, Turkish and Urdu. In Newham, interpreters had been used on seven occasions in the previous month. In Tower Hamlets, two support workers posts were designated as bi-lingual role for support workers who speak English and Bengali.

Are services responsive to people's needs?

Outstanding ☆

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

Listening to and learning from complaints

- There had been no complaints in the Newham service in the previous year. In Tower Hamlets there had been one complaint in the last six months. In Hackney there had been three complaints in the previous six months.
- Information about how to make a complaint was displayed on notice boards and leaflets were given to patients at their first appointment.
- The team leader in Hackney gave an example of a complaint that was upheld. This was discussed in the team meetings and a training session was arranged for the full team on understanding the specific diagnosis that the complainant had.

Luton and Bedfordshire home treatment teams

Access and discharge

- Both teams saw new referrals within 24 hours and urgent referrals in four hours. The team in Bedford committed to see patients in the accident and emergency department within two hours and made initial telephone contact following GP referrals within four hours. Urgent referrals could be seen more quickly.
- A telephone 'crisis' line operated throughout the night. This service provided telephone support. Emergency services and assessment by the emergency duty team could be arranged through this service. There was a dedicated telephone line that patient using the crisis teams could phone during the day. This was answered by a senior nurse who could arrange additional visits if necessary.
- The criteria for using crisis teams was set out in the operational policy. This stated that patients were aged between 16 and 65 who were in a state of mental health crisis so severe that they would otherwise be admitted to an acute inpatient ward. The policy stated that there needed to be evidence of patients presenting an actual or potential danger to themselves or other such as there being a recent suicide attempt, threats of harm to others, recent history of significant self-harm, command hallucinations or significant disordered thoughts that interfered with daily living. The exclusion criteria stated that the service would not usually be appropriate for people with a primary diagnosis of substance misuse, people with learning disabilities without a dual diagnosis of mental health, crisis solely relating to relationship issues and people whose mental health problems are the result of an organic disease such as dementia.
- Staff told us that they try to engage people by making the service relevant to them, talking about their self-defined needs and presenting ways in which the service can help. We saw an example of a visit to a patient who was reluctant to engage with the service. In this situation, the nurse took time to build a rapport and skilfully helped the patient to talk more about their feelings by talking about general subjects, not just the patient's mental health. By the end of the visit the patient felt able to ask questions and was reassured that they could call the service at any time.
- The services had a specific policy for patients who failed to attend appointments with the crisis teams. The policy set out a four stage process for re-establishing contact involving telephone calls, visits to the property, contacting the GP and asking the police to conduct welfare visits.
- Appointments were made at times that were convenient for the patient. Patients told us they valued being seen every day and appreciated the staff making appointments at times that fitted in around their work and other commitments.
- Appointments were very rarely cancelled and patients were informed if staff were running late.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients were not seen at the offices of the Bedford crisis team. The Luton team had offices in a modern building. The waiting area was clean and well maintained.
- Interview rooms had adequate sound proofing.
- Information was displayed in the waiting areas about making complaints, advocacy services, the patient advice and liaison service and safeguarding.

Meeting the needs of all people who use the service

- Appointments were offered at places that were convenient to patients, thus ensuring the service was fully accessible to people requiring disabled access.
- Information leaflets could be translated into languages spoken by people who use the service.

Are services responsive to people's needs?

Outstanding ☆

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

- Using interpreters was an integral part of the service. In Luton, interpreters had been used on 14 occasions in the month before the inspection. The languages that the interpreters were most frequently requested for were Urdu, Bengali and Polish. In Bedford, there were no records of interpreters being booked but we were told this happened a few times each month.

Listening to and learning from concerns and complaints

- Information about how to make a complaint was displayed on notice boards and leaflets were given to patients at their first appointment.
- There had been no complaints about the team in Luton. We reviewed the record of one complaint in Bedford which was investigated thoroughly.
- Staff told us that the outcomes of complaints investigations were discussed in team meetings. We saw evidence of complaints being discussed in supervision sessions.

London health based places of safety

Access and discharge

- Each facility was open 24 hours a day, 7 days a week and had not been closed in the previous 12 month. Patients were not excluded from using the facilities if they were intoxicated due to drugs or alcohol, unless they required medical assistance and an admission to the accident and emergency department was more appropriate.
- The frequency of use of places of safety varied between each borough. The service in Hackney provided comprehensive data about the use of the place of safety in May 2016, showing that 27 patients had been admitted. Of these, 11 had been discharged, eight had been admitted to hospital and eight had been transferred to another NHS trust. Eleven of the 27 patients had been discharged within four hours. Patients who were detained for more than eight hours had all been admitted to hospital or transferred to another trust. In Newham and Tower Hamlets, staff told us that patients were assessed as quickly as possible.
- None of the staff reported difficulties in beds being available for patients who were admitted to hospital after being in the place of safety.

The facilities promote recovery, comfort, dignity and confidentiality

- Only the facility at Newham Hospital had a dedicated entrance where ambulances or police vehicles could park directly next to the entrance. At the Royal London patients were required to pass through the accident and emergency department to get to the place of safety. At Homerton Hospital the place of safety was situated on the first floor meaning that patients had to pass through public areas of the hospital and travel to the first floor in a lift.
- The soft furnishings, designed to minimise the risk of injury to staff and patients, were in good condition and all areas were well lit. There was a toilet and wash basin in each area, and a clock that was visible to the patient. Blankets and food were available from the adjacent wards.

Meeting the needs of all the people who use the service

- Each place of safety was accessible to people in wheelchairs.
- Children were not admitted to the places of safety. The crisis concordat included arrangements for children to be seen in the accident and emergency departments.
- A telephone interpreting service was available for patients whose first language was not English.

Listening to and learning from complaints

- There had been no complaints in the 12 months before the inspection.
- Leaflets about how patients could complain about the service were available.

Luton and Bedfordshire health based places of safety

Access and discharge

- Most assessments were completed within five hours, although times were not recorded in the documents.
- Each facility was open 24 hours a day, 7 days a week. Patients were not excluded from using the facilities if they were intoxicated due to drugs or alcohol, unless they required medical assistance and an admission to the accident and emergency department was more appropriate.
- Use of the places of safety varied. In Luton there had been 78 uses of the place of safety in the three months before the inspection. In Bedford, the usage was much lower with around seven to nine people being assessed

Are services responsive to people's needs?

Outstanding ☆

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at the place of safety each month. None of the staff reported difficulties in beds being available for patients who were admitted to hospital after being in the place of safety.

The facilities promote recovery, comfort, dignity and confidentiality

- The health based place of safety at Bedford had a dedicated entrance where ambulances or police vehicles could park directly next to the entrance. At Luton, the entrance was shared with the psychiatric intensive care ward.
- The soft furnishings, designed to minimise the risk of injury to staff and patients, were in good condition and all areas were well lit, although the lighting was not adjustable. There was a toilet and wash basin in each area, and a clock that was visible to the patient. Blankets and food were available from the adjacent wards.
- Patients could use a telephone provided by the staff.

Meeting the needs of all the people who use the service

- Each place of safety was accessible to people in wheelchairs.
- In Luton, staff told us that patients under the age of 18 were admitted to the place of safety and were assessed immediately by the child and adolescent mental health service and could be transferred to the trust's inpatient child and adolescent service at the Coborn Centre in East London.
- An interpreting service was available for patients whose first language was not English.

Listening to and learning from complaints

- There had been no complaints in the 12 months before the inspection.
- Leaflets about how patients could complain about the service were available.

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

London home treatment teams

Visions and values

- All staff knew and agreed with the organisations values and these values were reflected in the teams' objectives.
- Staff knew who the senior managers were and told us that senior managers, such as the borough director, frequently visited the service. The director of nursing had also visited.

Good governance

- Overall, the governance of these services appeared sound. Levels of mandatory training were high and staff received supervision each month. Appointments were co-ordinated at the daily handover meeting and focussed on maximising the amount of time dedicated to direct care. Clinical audits took place. Staff were familiar with procedures associated with the Mental Health Act, Mental Capacity Act and safeguarding.
- The key performance indicators for each service were the response times to referrals and the number of patients that had been assessed by the home treatment teams prior to admission to the inpatient service, described as the gatekeeping target. Responses to referrals within 24 hours exceeded 85% and over 90% of patients were assessed as part of the gatekeeping target.
- Team managers had access to a range of data, showing trends over time to support them in the management of the services. These enabled timely improvements to take place as needed.
- All the team leaders felt they had sufficient authority and administrative support. The team leader could contribute items to the trust risk register through their line managers.

Leadership, morale and staff engagement

- The sickness rate across the crisis services was 2.21% and the vacancy level was 4.81%. Six staff out of a total of 85 had left the services in the previous year.
- None of the people we spoke to complained of bullying or harassment.
- Staff said they knew how to use the whistle blowing process and felt able to raise concerns without any fear of victimisation. Information about whistle blowing was displayed on staff notice boards.
- All staff we spoke with were very positive about their work. Levels of morale, job satisfaction and empowerment all appeared very high.
- There appeared to be a culture of leadership development. All the team leaders had been promoted from within the services. Nurses had also been promoted within the team.
- Discussions at handover meetings and team meetings indicated a good level of team work and mutual support. Everyone contributed to these meetings and there was no evidence of hierarchies.
- There were examples of transparency and staff talking to patients about mistakes that had been made.
- Monthly team meetings provided an opportunity for all staff to give feedback on services and contribute to service development.

Commitment to quality improvement and innovation

- The services in City & Hackney and Tower Hamlets had both been accredited by the Royal College of Psychiatrists Home Treatment Accreditation Scheme since 2012.
- A consultant at the Tower Hamlets home treatment team had produced a quality improvement paper on carrying out clozapine titration at a crisis house instead of requiring an inpatient admission.

Luton and Bedfordshire home treatment teams

Vision and Values

- All staff knew and agreed with the organisations values and these values were reflected in the teams' objectives. The priorities in the Bedford crisis team annual plan included improving outcomes, engaging carers and facilitating partnership working.
- Staff knew who the senior managers were and told us that senior managers, such as the director, frequently visited the service. The deputy director of nursing had also visited the services. The medical director visited once a quarter.

Good governance

Are services well-led?

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- There were examples of transparency and staff talking to patients about mistakes that had been made.
- Monthly team meetings provided an opportunity for all staff to give feedback on services and contribute to service development.

Commitment to quality improvement and innovation

- Neither service had been accredited by the Royal College of Psychiatrist Home Treatment Accreditation Scheme.
- The service in Bedford introduced a street triage service in partnership with Bedfordshire Police on 1 June 2016. The service in Luton was developing in expertise supporting women with post-natal depression.

London health based places of safety

Vision and values

- Staff were aware of the values of the trust.

Good governance

- Overall, there appeared to be good governance of these services. Staff were available to attend the place of safety when required and patients were assessed promptly. There had been no incidents or complaints in the 12 months before the inspection.
- We found it difficult to assess the performance of the service in relation to key data because the forms to record the detention in the place of safety were often incomplete.

Leadership, morale and staff engagement

- Staff all appeared to be motivated. We were not made aware of any problems with sickness and turnover. There were no concerns about bullying and harassment, staff said they could raise concerns about the service with their managers.
- Staff morale appeared good and staff spoke very positively about the work they were doing.

Commitment to quality innovation and improvement

- In City & Hackney, there was a project being run to better understand the experiences of people who had used the place of safety. The trust was also working with the City of London police to reduce deaths by jumping from bridges.

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.

Luton and Bedfordshire health based places of safety

Vision and values

- Staff were aware of the values of the trust.

Good governance

- Overall, there appeared to be good governance of these services. Staff were available to attend the place of safety when required and patients were assessed promptly. There had been no serious incidents or complaints in the 12 month before the inspection.
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- Staff morale appeared good and staff spoke very positively about the work they were doing.

Commitment to quality innovation and improvement

- A street triage service had been set up in both areas in collaboration with police and ambulance services.