

Requires improvement 

West London Mental Health NHS Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL79	Hammersmith and Fulham mental health unit and community services	Hammersmith and Fulham Recovery Team	W6 8NF
RKL79	Hammersmith and Fulham mental health unit and community services	Hammersmith and Fulham Early Intervention Service	W6 8NF
RKL53	St Bernard's and Ealing community services	Ealing Recovery Team East	W3 8NJ
RKL53	St Bernard's and Ealing community services	Ealing Early Intervention Service	W7 3HL

Summary of findings

RKL53	St Bernard's and Ealing community services	Single Point of Access	UB1 3EU
RKL53	St Bernard's and Ealing community services	Ealing Recovery Team West	UB2 4AU
RKL14	Lakeside mental health unit and Hounslow community services	Hounslow Recovery Team West	TW13 5AL
RKL14	Lakeside mental health unit and Hounslow community services	Hounslow Recovery Team East	TW3 1SE

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Information about the service	9
Our inspection team	9
Why we carried out this inspection	9
How we carried out this inspection	10
What people who use the provider's services say	10
Areas for improvement	11

Detailed findings from this inspection

Locations inspected	12
Mental Health Act responsibilities	12
Mental Capacity Act and Deprivation of Liberty Safeguards	12
Findings by our five questions	14
Action we have told the provider to take	30

Summary of findings

Overall summary

We rated community based mental health services for adults of working age as requires improvement because:

- Staff did not monitor patients' physical health consistently. This put patients at risk of physical health conditions going undetected.
- In some teams, the majority of non-medical staff had not received an appraisal in the last year. One recovery team reported no appraisals for non-medical staff in the last 12 months. Staff in one recovery team did not receive individual managerial supervision.
- At the inspection of June 2015, we found long waiting lists for psychological therapies. At this inspection, no improvement had been made. Waiting lists for psychology had become longer. The longest waiting time was 24 months in Ealing and the shortest 15 months in Hammersmith and Fulham.
- Mental health support workers in the single point of access team had received no formal training to carry out their duties, especially responding to crisis calls at night time, before taking up their posts. Staff vacancies in the single point of access team were high at 70%. The service said it was difficult to recruit to the role due to the lack of face to face contact with patients.
- The number of patients not attending appointments was quite high. The rates had largely stayed the same over the last 6 months, with no plans to reduce this or engage patients in other ways.
- Team managers could not always access key performance monitoring indicators in order to understand the performance of their team and make improvements.
- At the inspection of June 2015, we found that staff did not all have lone working devices or bring them when they went on home visits. Whilst we did find that this had improved and all staff received their own personal alarm from the trust, some staff did not use them whilst out in the community.

However:

- At the inspection of June 2015, we found that patients' crisis plans could not easily be found and were not always kept up to date. At this inspection, there had been improvements. We saw crisis plans had been updated and were easy to find. The teams had good systems in place for assessing and managing risk. Patient risk assessments were updated regularly.
- At the inspection of June 2015, we found that some of the premises presented a risk due to the layout or the alarm systems in place to keep staff and patients safe. At the current inspection, we found this had improved. All rooms where staff saw patients had alarms fitted to the walls or staff kept personal alarms on them. One team had moved from unsuitable premises to safer accommodation.
- At the inspection of June 2015, we found that community recovery teams had large numbers of patients supported by duty workers and caseloads for junior doctors were very high. At the current inspection, we found this had improved. Care co-ordinators and doctors had smaller caseloads. Patients had a named care co-ordinator and relatively small numbers of patients were waiting for a care co-ordinator to be allocated.
- At the inspection of June 2015, we found that staff supported patients over the age of 65 without any training about how to meet their specific needs. Since the last inspection, most staff had received training in supporting older people and were better equipped to meet their needs.
- Patients said staff treated them with dignity and respect.
- Staff morale was good despite staff feeling busy and dealing with complex caseloads.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

- At the inspection in June 2015, we found that patients' crisis plans could not easily be found and were not always up to date. At the current inspection, we found this had improved. We saw that patients had crisis plans and these were updated and easy to find.
- At the inspection in June 2015, we found that some of the premises presented a risk due to the layout or the alarm systems in place to keep staff and patients safe. At the current inspection, we found this had improved. All rooms where staff saw patients had alarms fitted to the walls or staff kept personal alarms on them.
- At the inspection in June 2015, we found that community recovery teams had large numbers of patients who had not been allocated a care co-ordinator and were being supported by duty workers. The caseloads of junior doctors were very high. At the current inspection, we found this had improved. The community teams had created transition teams to support new referrals coming into the teams. Most patients had a named care co-ordinator and relatively few were being held by duty workers while they awaited allocation. The case loads of care co-ordinators and most junior doctors were smaller.
- All staff had access to a lone working safety device and knew about the lone working protocol.
- Teams had good systems in place to manage risk. Most teams discussed patient risks on a daily basis and updated individual risk assessments and management plans promptly.
- Each service had a dedicated safeguarding lead and staff could recognise the signs of abuse for children and vulnerable adults. There were good systems in place to track the progress of safeguarding investigations.
- Staff knew how to report incidents and felt supported to do so.

However:

- Some staff did not use the lone working devices that had been provided.
- Staff vacancies in the single point of access team were high at 70%. The service said it was difficult to recruit to the role due to the lack of face to face contact with patients.

Good



Summary of findings

Are services effective?

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

- Staff did not monitor and record patients' physical health consistently. Lack of physical health checks increased the risk of patients' physical ill-health going undetected and therefore untreated.
- Not all staff had received an appraisal in the last year. One recovery team reported no appraisals for non-medical staff in the last 12 months.
- In Ealing recovery team west, staff received only group supervision and did not receive one to one managerial supervision.
- Mental health support workers in the single point of access team had received no formal training for carrying out their duties, especially responding to crisis calls at night time, prior to commencing in their roles. There was a risk they were ill equipped to deal with very difficult situations.

However:

- At the last inspection in June 2015, we found that staff supported patients over the age of 65 but had not received training to meet their specific needs. At the current inspection, we found that most staff had received training in supporting older people and had found it helpful when delivering care and treatment.
- Staff had access to training to further develop their skills.
- Staff had a good understanding of the Mental Capacity Act and Mental Health Act.

Requires improvement



Are services caring?

We rated caring as **good** because:

- Patients and carers told us that staff treated them with dignity and respect.
- The majority of patients felt involved in decisions about their care and treatment. They felt able to discuss their choices with staff.
- Patients had access to independent advocacy services when needed. The services were advertised across the teams.
- Patients sat on recruitment panels for new staff.

Good



Summary of findings

- Patients could give feedback about the service and how to improve the teams via questionnaires and the trust's 'patient opinion' website.

Are services responsive to people's needs?

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

- At the inspection of June 2015, we found long waiting lists for psychological therapies. At this inspection, no improvement had been made. Waiting lists for psychology had become longer. The longest wait was 24 months in Ealing.
- The percentage of patients not attending appointments was quite high. The rates had largely stayed the same over the last 6 months, with no clear plans to reduce this or engage patients in other ways.

However:

- The community teams worked actively with local community groups to support patients from diverse backgrounds.
- Patients knew how to complain and staff displayed information in every team on how to do this.

Requires improvement



Are services well-led?

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

- Team managers could not always access key performance monitoring information easily in order to understand the performance of their team, benchmark performance against other teams and services across the trust and make improvements in the service. Improvements were being made to the data collection and analysis, but this had not been embedded across the teams.

However:

- Staff knew and understood the trust's visions and values.
- Morale among staff was good even though they were often very busy and managed complex caseloads. Staff felt supported by their teams and managers.
- Local senior management visited the teams and staff knew of them.
- Teams had a service risk register or other ways of identifying and managing risks to the service.

Requires improvement



Summary of findings

Information about the service

West London Mental Health Trust provides a range of community-based mental health services for people of working age and older people with mental health problems.

Early intervention services (EIS) work with people who are experiencing a first episode of psychosis. They provide specific support and treatment over a three year period.

Community recovery teams support patients who have complex mental health and social care needs. They provide patients with longer term support. The recovery teams are “ageless” services, which means they are not restricted to supporting patients of working age. However, the trust has separate cognitive impairment teams within the community who support and treat older adults with dementia and associated cognitive conditions.

We inspected the following services:

Ealing recovery team east;

Ealing recovery team west;

Ealing early intervention service;

Hammersmith and Fulham recovery team;

Hammersmith and Fulham early intervention service;

Hounslow recovery team east;

Hounslow recovery team west.

Single point of access

The services were last inspected in June 2015. When the CQC inspected the trust in June 2015, we found that the trust had breached regulations. We issued the trust with three requirement notices for community based mental health services for adults of working age. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

The team was comprised of a CQC inspection manager, a CQC inspector, four specialist advisors, two of whom were nurses, one an occupational therapist, one a social worker, two people observing and an expert by

experience making telephone calls to patients and carers offsite. An expert by experience is a person who has personal experience of using, or supporting someone using, community mental health services.

Why we carried out this inspection

When we inspected the trust in June 2015, we rated the community based mental health services as **requires improvement** overall.

We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.

Following the June 2015 inspection, we told the trust it must make the following actions to improve community based mental health services:

- The trust must ensure there are sufficient suitably qualified staff so that patients have a care co-ordinator rather than being held by duty staff and junior doctors are not holding large caseloads of patients, which creates a risk to the safety and welfare of patients. Recovery team patients must have a named clinician responsible for their care and treatment.

Summary of findings

- The trust must ensure that patients have personalised crisis plans that reflect their individual circumstances and must ensure these are up to date. These must be stored in patient records where they can be found quickly by all staff.
- The trust must ensure that the premises used by staff and patients are safe. The provider must ensure that staff safety alarms work and can be heard in an emergency
- The trust must ensure that accurate and complete patient care records are maintained.
- The trust must ensure that staff are trained to meet the specific needs of older patients.

These related to the following regulations under the Health and Social Care Act (Regulated

Activities) Regulations 2014:

Regulation 9 Person Centred Care

Regulation 15 Premises and equipment

Regulation 17 Good governance

Regulation 18 Staffing

We have followed up these areas for improvement at this inspection.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited five treatment and recovery teams, the single point of access and two early intervention teams
- spoke with 18 patients who were using the service over the telephone
- spoke with 13 patients who were using the service face to face

- collected 40 comment cards that we placed at each team premises
- spoke with the managers of each team
- spoke with four team leaders
- spoke with 49 other staff members; including psychiatrists, nurses, an administrator, an employment advisor, a peer support worker, psychologists, mental health support workers and social workers
- attended and observed six multi-disciplinary and zoning meetings

- looked at 34 care and treatment records of patients
- observed four out-patient appointments with patients
- accompanied staff on five home visits
- listened to two recordings of telephone triage assessments
- 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

We collected feedback from 18 patients who used the services over the telephone and 13 in person. We also received feedback from patients on 40 comment cards,

which were collected from boxes that we placed in the community team bases. Before the inspection visit, we attended a carers' forum in Ealing where we received feedback from carers of patients using the services.

Summary of findings

Patients gave generally positive feedback about the care and treatment they received. Patients described staff as respectful, kind, polite, non-judgemental and friendly. One patient told us that some staff went the extra mile and were respectful over the telephone. The patients we spoke with who had an allocated care co-ordinator described them as consistent and helpful. However, a small number of patients described via the comment cards and over the telephone that some staff members were rude and not very person centred.

Patients did not generally wait long for their appointments and found that staff saw them promptly for an arranged appointment. Some patients told us that sometimes staff had cancelled appointments but this did not happen regularly. Some patients described feeling anxious about the changes in staffing within some of the teams. Some boroughs were being restructured and therefore not all teams would continue to have social workers working within them.

Patients felt involved in decisions about their care and treatment. For example, patients felt involved in decisions about their medication and staff responded to feedback about the effects of medication. A carer told us that staff gave them a CD to better understand their relative's mental health condition and how best to support them. However, some carers told us they did not get a copy of their relatives' care plans or know much about them.

Some patients told us that they felt happy about getting less support. Patients felt positive about being less reliant on the community mental health teams when they were discharged. They felt reassured that if they needed to come back and get extra support they could.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that staff monitor and record patients' physical health consistently and on an on-going basis so that their physical health needs can be met.
- The trust must ensure that patients in the recovery teams are able to access psychological therapies in a timely manner.
- The trust must ensure all staff receive a performance appraisal annually.
- The trust must ensure that all staff at Ealing recovery team west receive one to one managerial supervision on a regular basis.

- The trust must ensure clear performance data is available and accessible to service and team managers so that they can clearly identify how to make improvements in services.

Action the provider **SHOULD** take to improve

- The trust should ensure initial and on-going training takes place for mental health support workers on the support and information telephone line in the single point of access team.
- The trust should take steps to reduce the number of patients who do not attend their appointments across all teams
- The trust should continue to encourage all staff to use their lone worker devices when conducting home visits or appointments outside of the office.

West London Mental Health NHS Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hammersmith and Fulham Recovery Team	Hammersmith and Fulham mental health unit and community services
Hammersmith and Fulham Early Intervention Team	Hammersmith and Fulham mental health unit and community services
Ealing Recovery Team East	St Bernard's and Ealing community service
Ealing Early Intervention Team	St Bernard's and Ealing community service
Single Point of Access	St Bernard's and Ealing community service
Ealing Recovery Team West	St Bernard's and Ealing community service
Hounslow Recovery Team West	Hounslow community service
Hounslow Recovery Team East	Hounslow community service

Detailed findings

Mental Health Act responsibilities

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

- We reviewed three community treatment orders in different teams; we found them to be clear, up to date, and completed appropriately.
- Staff had completed Mental Health Act training and knew their responsibilities under the Act.
- Staff received support from the trust's Mental Health Act administrator and approved mental health professionals they worked with.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training completion rates for staff in respect of the Mental Capacity Act (MCA) were low. However, staff said they received training from the local authorities on this topic as they considered it better quality.
- The majority of the staff we spoke with understood the principles of the MCA and how to assess a patient's capacity to consent.

Are services safe?

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

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

Our findings

Safe and clean environment

- At the inspection of June 2015, we had concerns about the premises used by the Ealing early intervention service, which were unsafe. Since the inspection, the service had moved to different premises. Access to the service was controlled via a set of double doors, which made it safer for staff and patients using the service. However, in the premises used by Ealing recovery team east staff reported that people sometimes followed staff and patients into the building without being challenged. Once inside the reception area there was easy access to the rest of the building.
- At the inspection of June 2015, we had raised concerns about the audibility and fitting of alarms in consultation rooms used by staff and patients. During the current inspection, we found that improvements had been made. Staff saw patients and carers in interview rooms that were fitted with alarms so that staff could call for help if they needed it. In the building used by the Hammersmith and Fulham recovery team and early intervention service, the alarms could not be heard on the second floor where the early intervention service had all of their offices. Staff used a two way radio to alert staff on the second floor if any alarms sounded in the consultation rooms. Alarms had been fitted in consultation rooms at Ealing recovery team east during a recent refurbishment of the premises. During the inspection, we heard an alarm going off in Hounslow recovery team east and saw that staff came to assist. In Ealing recovery team west, staff used personal alarms kept on their person when seeing patients on the premises rather than alarms fitted in the rooms.
- Most teams had well-equipped clinics. Medical equipment was serviced and calibrated. Emergency equipment and automated external defibrillators were kept where staff could easily locate them and they were checked regularly to ensure they were fit for purpose. Clinic rooms contained completed and up to date fridge temperature monitoring and cleaning logs.

- Consultation rooms and communal areas were visibly clean and well maintained. The rooms and premises were cleaned regularly. Hand-cleaning gel was available in reception areas. At Hounslow recovery team west, staff members cleaned their hands in the clinic room before attending to a patient. Staff disposed of clinical waste safely and appropriately. In the clinic rooms plastic bins used for the disposal of sharp objects including syringes and needles were not over-filled. At Ealing recovery team west, staff applied stickers to equipment that had been cleaned. However, in other teams although equipment was visibly clean staff did not always apply stickers to show the date it had last been cleaned.

Safe staffing

- All teams had staff vacancies. Ealing recovery team east had a staff vacancy rate of 24%. There were three vacancies for social workers, two for occupational therapists and six vacancies for nurses. The Hammersmith and Fulham team had a vacancy rate of 31%. The team's vacancies included five nursing and three social work posts. The Ealing recovery team west had a vacancy rate of 34%. The manager informed us that they had been struggling to recruit a good calibre of band 6 nurses. Instead, the service recruited four assistant practitioners at a band 4 level. Hounslow recovery team east had a vacancy rate of 27% while Hounslow recovery team west's vacancy rate was 12%. The majority of vacancies in the teams were covered by long-term locum staff. This helped provide continuity of care to patients.
- The single point of access had opened in April 2016 and had a very high staff vacancy rate of 70%. Six of the nine band 6 nurses in the team were locum staff employed on a long-term basis. There were four vacancies for band 4 mental health advisors. Some staff had transferred into the team temporarily from in-patient wards. Managers had attempted to recruit new staff at regular intervals but with limited success. The manager told us that the nature of the role of staff in the single point of access, solely undertaking telephone triage assessments, and the lack of face-to-face contact with patients made it unattractive to many.

Are services safe?

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- At the June 2015 inspection, we had raised concerns that almost all staff in the Ealing early intervention service were locum staff. At the current inspection, we found that there had been some improvement and there were more permanent staff in the service. The proportion of permanent staff had been higher but there had been a few recent resignations from the service. The service continued to try to recruit permanent staff. The manager used regular long-term locum staff to cover vacancies in the meantime. There were three vacancies in the team at the time of the inspection, all covered by long-term locum staff.
- At the June 2015 inspection, staff in the recovery teams had high caseloads. Large numbers of patients waited to be allocated to a care co-ordinator and were held by duty staff until this happened. Not all recovery team patients had a named clinician responsible for their care.
- At this inspection, we found that the caseloads were lower than in June 2015. The average caseloads for care co-ordinators in Ealing recovery team east ranged from 11-21 patients with a maximum of 21 patients who were more complex and classified as care programme approach (CPA). Caseloads in the Hammersmith and Fulham recovery team were slightly higher and ranged from 11-27. There were five clinicians in the Ealing recovery team east holding caseloads of more than 150 patients but these were not patients on CPA. These patients attended for periodic out-patient appointments. No clinicians in the Hammersmith and Fulham teams had caseloads of over 150 patients. At Hounslow recovery team east, caseloads ranged from eight to 20 and in Hounslow recovery team west, the average caseload was between 14 and 21. In Ealing recovery team west, the average caseload ranged from 12 to 25. Staff told us that caseloads were more manageable than they had been in 2015. Care co-ordinators in the two early intervention teams had caseloads of less than 20 patients each.
- The majority of patients on CPA had an allocated care co-ordinator. In the Ealing recovery team east, 23 patients were awaiting allocation to a care co-ordinator. The manager said they had delayed allocating some patients in order to maintain staff caseloads at 25 or lower. Several patients waiting for allocation were in-patients. The manager prioritised allocation for patients whose discharge from hospital had been delayed, where safeguarding was involved or there were children at risk in the household. In the Hammersmith and Fulham team, ten patients awaited allocation to a care co-ordinator. Allocations of new patients usually took place weekly. The Hounslow recovery teams each had one patient awaiting allocation to a care coordinator.
- Since the last inspection, the trust had introduced a case weighting tool. This supported managers to maintain balanced caseloads across their teams. Managers discussed caseloads with staff in one to one supervision.
- Staff, and therefore patients, in all of the services had good access to a psychiatrist. In the recovery teams, staff were able to refer patients to see a doctor quickly; free appointments were kept aside each day for this. In the Ealing recovery team east, a doctor was available three whole days a week for short notice appointments. There were a smaller number of appointments slots available at short notice on the other two days.
- Staff had completed most trust mandatory training. Where training was incomplete, managers booked staff onto training courses unless staff were on long-term sickness absence or maternity leave.

Assessing and managing risk to patients and staff

- The teams assessed and managed risk well in all of the teams we visited. The teams had a clear risk management system in place that used a traffic light system of red, amber and green to categorise risk to patients. The recovery teams held zoning meetings every day. Ealing early intervention team and Ealing recovery team west held a detailed zoning meeting every week and Hammersmith and Fulham early intervention team held zoning meetings three times a week. Zoning meetings included discussion of high risk patients, those categorised as red and amber, and the plans and actions needed to keep them safe. At zoning meetings, the multidisciplinary teams discussed and reviewed the risks affecting individual patients. Staff updated individual risk assessment and management plans during the meeting. Most patient risk assessments we reviewed across all teams were detailed and updated regularly.
- At the inspection of June 2015, we identified that many patients did not have personalised crisis plans in place

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that were up to date and stored in a place where staff could find them quickly. At the current inspection, we found there had been an improvement. We were able to find crisis plans easily for all 34 patients, whose records we reviewed. Crisis plans explained what patients should do and who they should contact in an emergency. The majority were up to date. Patient records had a new section for crisis plans called 'my crisis plan'. This section was filled in with the patient. At Hounslow recovery team west some of these personalised crisis plans were being used whilst some staff continued to use the older version. Where staff filled these in with the patients, they were personalised and specific to the individual. They stated how the patient felt they needed to be cared for in a crisis and what made them well.

- Staff received training in safeguarding vulnerable adults and children and 'prevent' training. Up until 31 October 2016 88% of staff had received training in safeguarding vulnerable adults. This was slightly lower than the trust target of 90%. 100% of staff had completed safeguarding children training. Staff identified safeguarding concerns and knew the procedures to follow to escalate concerns. Several staff had been trained as safeguarding adult's managers and inquiry officers. Staff considered and made safeguarding referrals in multidisciplinary team discussions we attended. Some staff attended local multi-agency risk assessment conferences where women at high risk of domestic violence and abuse were discussed. Staff had good understanding of their responsibilities in respect of protecting children. Teams tracked the progress of safeguarding referrals effectively.
- The Hammersmith and Fulham early intervention team had made the highest number of child safeguarding referrals with 19 since January 2016. Ealing recovery team west reported 31 adult safeguarding referrals since January 2016 and 10 safeguarding children referrals since April 2016. The Hammersmith and Fulham recovery team had the highest number of adult safeguarding referrals with 52.
- The trust had a lone working policy in place to support staff working alone in the community and help ensure their safety. At the inspection in June 2015, not all staff had access to a safety device that they could use in the community. At the current inspection, we found that staff working in the community had access to a lone

working device. When this device was activated it raised an alarm in a monitoring centre. Staff recorded when they were entering and leaving an appointment and where they were. However, managers and staff told us that they did not always use the device when they went on visits in the community. During a home visit with staff, we noted that they left their lone working device in their car and did not take it with them into the patient's home. Managers said they were constantly reminding staff about the need to use the device and were looking at different ways to address the problem of non-use. At Ealing recovery team west, the service posted notices on the walls of the office to remind staff to take their lone working devices with them when they went on a home visit. Discussions with staff teams about the use of the device were recorded in clinical improvement group minutes. This issue was on the risk register for all teams. Staff recorded their movements during the day on a board or in a book.

- Staff regularly checked the temperature of fridges used to store medicines. Staff transported medicines in lockable bags. Each team stored depot medication either in the fridge or cupboard depending on what type of medication it was. A depot is an injection, which releases the medication over a long period. The teams held regular depot clinics at the majority of premises for the patients to attend. The trust pharmacist undertook regular audits of each team's medication. The audits checked the safe storage, out of date medication and the cleanliness of equipment within the clinic rooms.

Track record on safety

- In relation to patient deaths there had been two serious incidents of actual or suspected self-inflicted harm in Ealing recovery team east in the 12 months from November 2015 to October 2016. A further 10 incidents were being reviewed at the time of the inspection. In the Hammersmith and Fulham recovery team there had been one serious incident and five incidents were pending review. In the last 12 months, the trust reported three serious incidents in the early intervention services we visited. These were one suspected or actual homicide and one suspected or actual self-inflicted harm in Ealing early intervention service and one suspected or actual self-inflicted harm in the Hammersmith and Fulham service. In the last 12

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months Hounslow recovery team east reported three serious incidents of actual or suspected self-inflicted harm and two serious incidents in Hounslow recovery team west.

Reporting incidents and learning from when things go wrong

- Staff knew what type of incidents they should report and how to report them. Managers described an open reporting culture. Staff said they were encouraged to report incidents
- Staff knew of incidents that had occurred in the teams and the circumstances surrounding these. Staff discussed incidents in team and business meetings and in clinical improvement groups. Staff made improvements to the service in response to learning from incidents in order to reduce the risk of the same type of incident happening again. Senior staff in Ealing recovery team east described how the team had learned from recent deaths of patients due to physical health conditions, particularly diabetes. The team were to receive additional training so that they could support people with diabetes more effectively. A doctor was now coming in to the service one day a week to carry out physical health checks on patients who were receiving depot medication in clinics at the services. Most staff we spoke with were aware of the incidents and lessons learned. In Ealing early intervention team, the criteria for

red zone patients had been expanded to include any patients on community treatment orders following a recent serious incident. Staff told us about an incident in Ealing recovery team west that occurred during a community visit to a patient. Following the incident staff updated the risk management plan and additional safety measures were put in place.

- Staff could access information on incidents reported over the past year and trends across the trust on the trust intranet.
- Staff felt supported after serious incidents. This support included a de-brief and support within the team. Staff discussed incidents at team meetings and in clinical improvement group meetings. Staff were able to access counselling when this was needed.

Duty of candour

- Staff knew and understood their responsibilities under the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Managers described incidents where patients and carers had been informed when things went wrong and given an apology.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed these had been completed. The single point of access team carried out assessments over the telephone. Assessments usually took 30 to 40 minutes to complete. We listened to two recordings of assessments completed by staff the day before our visit to the service. The recordings showed that staff took a full social and health history of the patient, explored past and current risks and established an understanding of the presenting problems. Staff explored potential safeguarding issues.
- In the early intervention services staff carried out assessments of patients over eight weeks. Assessments included meeting with the patient's family and carers when the patient consented.
- At the inspection in June 2015, we found that patient care records were not always accurate and/or complete. During the current inspection, we reviewed the care records of 33 patients across the five recovery teams and two early intervention services and found that improvements had been made. All 33 patients had care plans in place although these varied in quality. Care plans of all four patients in the Hammersmith and Fulham early intervention service were very detailed, personalised, holistic and recovery oriented. The voice of the patient was evident in all of the plans. The standard of care plans in the Ealing early intervention team was similar with three of five patient care plans personalised and holistic. Four out of the five care plans we reviewed at Hounslow recovery team west were detailed and had been updated regularly. These care plans were personalised and recovery oriented. Two out of the four care plans we looked at in Hounslow recovery team east were updated regularly, detailed and personalised. At Ealing recovery team east, all of the three care plans we looked at were detailed and recovery oriented. Care plans of patients in the Ealing recovery team east and Hammersmith and Fulham recovery team were less individualised and few were

clearly recovery oriented. Patients' views were recorded in seven of the 11 recovery team patient care plans. Overall, patient care records were accurate and complete.

- Ninety nine per cent of patients on the care programme approach (CPA) had received a CPA review of their care in the last 12 months. The trust was encouraging teams to review CPA patients every six months. Team managers were aware of their performance against this new target and followed up with care co-ordinators if CPA meetings had not taken place.
- All care records were stored securely and were accessible to staff in the electronic patient records system. GPs were able to make referrals to the single point of access using an electronic referral form that was held within their own electronic records system. This was then sent by secure email to the single point of access. This helped ensure that referrals arrived at the service quickly.

Best practice in treatment and care

- Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. From 1 April 2016, the early intervention services had a target of more than 50% of people experiencing first episode psychosis to commence a NICE recommended package of care within two weeks of being referred to the service. The performance of the teams in respect of the target had improved over the last six months. In September and October 2016, the teams in Hammersmith and Fulham and Ealing achieved the target for between 75% and 100% of patients. Staff offered a range of evidence based therapeutic interventions including cognitive behavioural therapy for psychosis and family interventions. Staff provided therapeutic groups including mindfulness and dialectical behavioural therapy skills groups.
- Patients in all three boroughs had access to psychological therapies. Psychologists and psychotherapists were integrated into the teams. Although patients had access to psychological therapies, there was a long waiting time for this.
- Psychologists used a number of tools to measure outcomes for patients including generalised anxiety disorder 7-item scale and the patient health

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questionnaire-9. These helped measure the effectiveness of the treatments offered. Staff in the recovery teams and early intervention services completed health of the nation outcome scales for patients.

- Services offered support for patients' social needs such as housing, benefits, and employment. For example, employment advisors supported patients to remain in work and to find paid employment or voluntary work, as well as training courses. They helped patients prepare for interviews including through role-play.
- Clinics that were not medically led had been introduced at Ealing recovery teams east and west. These included a social care clinic which offered carers' assessments, nurse-led clinics where medication could be discussed and psycho-social interventions provided, housing advice clinics and a form-filling clinic, which was peer led. A qualified benefits advisor held sessions for patients every month. Staff described care as being more centred on patients' needs rather than automatically referring them for a medical appointment. The early intervention services provided a number of groups for patients including a cooking group, football group and a social activities group. Peer support workers facilitated hearing voices groups and supported patients individually.
- Staff considered the physical health care needs of patients but this was often poorly recorded and difficult to monitor and track over time. For example, we reviewed the care records of 11 patients in two recovery teams, Ealing recovery team east and Hammersmith and Fulham. Three of the 11 patient records showed clear evidence of on-going physical health monitoring, seven did not. This was similar in the early intervention services. We reviewed the care records of nine patients in the two early intervention services. Three of the nine patient records showed evidence of on-going physical health monitoring and six did not. Staff in the recovery teams told us that they did not carry out physical health checks but referred patients to their GP or signposted patients on to other specialist services. Staff hoped that a wellbeing clinic might be set up at the service in the future for patients to be supported with physical health checks. At Hounslow recovery team west, staff described a similar situation. A physical health clinic ran at the service but had stopped due to a staff member leaving. Staff did not know whether this would resume. There was a risk that staff would not identify changes in the physical health of patients and consequently not be able to take prompt action to meet patient's individual physical health needs.
- No staff in the Ealing recovery teams east and west had been trained in smoking cessation. This was not seen as a priority except when discussing possible admission to hospital with a patient because the hospitals were smoke free environments. A doctor had recently started holding weekly clinics at Ealing recovery team east in order to review the physical health of patients receiving depot medication. This had been introduced in recognition of the need to improve the physical health care of patients supported by the team. Administration staff requested encounter records from patients' GPs once a year or more frequently when needed. Staff told us that patients on high doses of anti-psychotic medicine had a care plan in place indicating the physical health checks that should be carried out. Staff at both Ealing recovery teams acknowledged the need to improve work to promote physical health and carry out physical health checks in-house. Staff did not routinely record physical health measures such as blood sugar levels, blood pressure and weight.
- Physical health care in the early intervention services was much better although not always recorded clearly in patient records. The Hammersmith and Fulham early intervention service had a physical health care policy, which highlighted NICE guidelines on physical care monitoring and the use of anti-psychotic medicines. The team provided a health and well-being group for patients, which included physical activity and a focus on healthy eating, lifestyle, drugs and alcohol, sexual health and relationships. Patients were involved in running the group. The service provided a nurse-led health care clinic and encouraged patients to attend at three, six, nine and twelve months. The clinic ran three times a month. Patients filled in a physical health questionnaire, which covered side effects from medicines, dental care and treatment, and eating and exercise habits. One staff member had been trained in smoking cessation level two and could prescribe nicotine replacement therapy. Managers reminded staff in clinical improvement group meetings to discuss smoking cessation with patients and promote the availability of in-house smoking

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cessation advisors. In the Ealing early intervention team, staff had a portable physical health kit that they could take with them to patients' homes and carry out physical health checks.

- Staff actively participated in clinical audit. Psychiatrists described a number of clinical audits they had completed in the last year. For example, one psychiatrist had conducted an audit of the use of clozapine in early intervention services and another psychiatrist in a recovery team had conducted an audit on the use of paliperidone. In Ealing recovery team west, regular audits on the quality of care plans had been carried out. The trust conducted an audit of physical health checks on patients in the community teams as part of the commissioning for quality and innovation audit in June 2016. The audit identified a need to support patients with self-care, the need for staff training in physical health checks, nurse led clinics and to introduce a proforma for physical health checks.

Skilled staff to deliver care

- Teams included staff from a range of professional backgrounds including nurses, psychiatrists, occupational therapists, psychologists and social workers. Psychologists were integrated in all of the teams. The trust employed peer support workers in the community teams. Employment/vocational advisors from a voluntary sector organisation were embedded in the teams and available for patients needing support with employment or training.
- All new staff including locum staff received an induction from the trust and to their area of work and responsibilities.
- Non-medical staff we spoke with in most teams said they had completed an annual appraisal in the last 12 months. However, information provided to us by the trust showed that, in the last 12 months, 83% of eligible staff in the Hammersmith and Fulham recovery team had completed an appraisal and 42% of staff in Ealing recovery team east. In the early intervention services, the percentage of non- medical staff that had completed an annual appraisal was 83% in Hammersmith and Fulham and 50% in Ealing. Ealing recovery team west had the lowest appraisal completion rate of 0%. This meant that no staff in this

team had completed an appraisal. Therefore, staff development could not be assessed and managers and staff could not see how they were progressing within their performance.

- Ninety six per cent of doctors in the two recovery teams had completed an appraisal. Staff told us they received individual supervision from a manager or senior practitioner every month. Staff felt very positive about the quality of supervision they received. Supervision records showed that more than 80% of staff in the early intervention services received monthly supervision. However, the trust figures for Ealing recovery team east was 38% and for the single point of access 30%. The trust explained that staff did not record supervision as they were expected to but it was taking place. In Ealing recovery team west, staff reported that they had been receiving group supervision but did not receive individual managerial supervision. This meant that staff could not speak in confidence to their line manager about any training and development needs or personal issues that may be affecting their performance.
- Occupational therapists received professional supervision from an occupational therapist. Specialist registrars had access to supervision from a psychologist for their psychological work. Psychologists received supervision weekly. Staff in the early intervention services held reflective practice meetings every week and those trained in the delivery of systemic family therapy received bi-monthly supervision.
- At the inspection in June 2015, we found that although the recovery teams accepted patients of any age staff had not received specific training in working with older people. During the current inspection, the trust provided information to show that four training modules for staff in working with older people had been provided. The modules covered understanding the concept of 'old age'; understandings of the concepts of mental health and mental illness; understanding losses associated with older adulthood; and understanding neurocognitive functioning in older adulthood. Between 73 and 83 staff in all five recovery teams had attended each module. Staff reported that the training had been very helpful to their work.
- Staff could undertake further training to equip them for their role and develop their knowledge and skills. For example, one staff member was taking a course in

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mental health law. Several staff had completed five day training in dialectical behavioural therapy, a specific type of cognitive-behavioural to help treat borderline personality disorder. Staff in the early intervention services had completed, or were undertaking courses in delivering family interventions and cognitive behaviour therapy for psychosis. Staff reported there were good professional development opportunities in the trust.

- However, mental health support workers in the single point of access had received no formal training before taking up their duties, which included answering the telephone, providing information and advice, and responding to patients in crisis at night. At night there were two mental health support workers responding calls on the mental health advice line. They had access to managers for support at night by telephone if they needed it but sometimes had to respond to very distressed callers who were considering harming themselves. These calls could be very stressful particularly for new and less experienced mental health support workers.

Multi-disciplinary and inter-agency team work

- The teams made up a range of disciplines including nurses, occupational therapists, doctors, social workers, psychologists and mental health support workers. They met together regularly and provided a multi-disciplinary approach to patient care and treatment.
- Staff from different professional backgrounds told us that the multi-disciplinary teams worked well together. Each team had a clinical improvement group meeting on a monthly basis. The whole team and a patient or carer representative attended this meeting. The meetings covered recruitment, governance and training issues.
- There were effective working relationships between teams. The recovery teams worked closely with the crisis and assessment teams to prevent patients being admitted to hospital. The Hammersmith and Fulham recovery team and early intervention service managers met together to discuss patient transfers from one team to the other.
- The Hammersmith and Fulham early intervention team did not have a regular interface with the local child and

adolescent community health team to help young people who needed to transition into the early intervention service. However, medical staff had prepared a protocol to enable this to happen.

- Staff from the single point of access met with other agencies including the police. The manager had attended clinical commissioning group network meetings and a GP away day to explain the service and encourage appropriate referrals. They held weekly interface meetings with the increasing access to psychological therapies (IAPT) teams to facilitate referrals. The manager met monthly with the recovery teams, crisis and assessment teams and primary care mental health teams.
- The recovery teams worked closely with primary care mental health teams. Staff liaised regularly with GPs to discuss possible discharges and transfers of care. Under the 'safer discharge' protocol staff had to directly discuss discharges with the GP before they discharged patients into their care. Staff attended the multi-agency public protection arrangement meetings where offenders in the community were discussed.

Adherence to the MHA and the MHA Code of Practice

- Training in the Mental Health Act was mandatory in the trust. Most staff had completed this training. In the single point of access, Hounslow recovery team east and Hammersmith and Fulham early intervention service 100% of staff had received training. In Ealing recovery team east 79% of staff had completed the training, 80% in Hammersmith and Fulham recovery team and 88% in the Ealing recovery team west. In Hounslow recovery team west 58% of staff had received training in the Act.
- Most staff said they had a good understanding of their responsibilities under the Mental Health Act. Staff knew where to obtain advice about the Mental Health Act, including contacting the trust Mental Health Act administration office and from approved mental health professionals in their team.
- We reviewed three community treatment orders (CTO) and found that staff had completed them appropriately. One of the CTO records we looked at staff had advised the patient of their right to appeal.

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- Patients had access to an independent Mental Health Act advocate to support them with their community treatment order and at tribunals.

Good practice in applying the MCA

- Low numbers of staff in the teams had completed trust on-line training in the Mental Capacity Act 2005 (MCA), which was mandatory training. Managers told us that many staff had completed MCA training provided by the local authority instead, which was more in-depth. Staff we spoke with understood the legislation and how it applied to their work. Staff presumed that patients had capacity unless they had concerns that this was not the case. Staff carried out capacity assessments when they had concerns about a patient's capacity to give informed consent. Staff clearly documented assessments where appropriate
- Staff understood the importance of gaining the informed consent of patients and this was recorded in most patients' care records we looked at across the teams.
- Patients had access to an independent mental capacity advocate when needed.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff in interactions with patients and carers during home visits and outpatient appointments. They spoke respectfully to patients, were kind, compassionate and genuinely patient-centred. Staff listened actively to patients' wishes and concerns. Staff gave good explanations of the purpose of visits to patients. Recordings of telephone triage assessments in the single point of access showed that staff explained care and treatment options to patients well and were supportive.
- We spoke to patients over the telephone and face-to-face. The majority of patients were positive about the care and treatment they received from the teams and staff. Patients described staff as respectful, kind, polite, trustworthy and helpful. Most patients said they had been allocated a care co-ordinator where applicable. Staff gave patients information leaflets on local services and patients said they could access this easily. Patients described being referred to specialist services and staff explained clearly, what treatment they were receiving. However, two patients reported that they felt some staff to be unfriendly and not always helpful.
- We collected comment cards from patients at the various team premises. The majority of comments were positive. Patients said that the clinical staff supported them and responded in a timely way. We received other comments that the staff were kind and treated patients with dignity and respect. We received a small amount of negative comments about the services. These were that at one recovery team appointments were routinely cancelled and reports of some staff being rude.
- Staff in the single point of access did not leave a message for patients unless there was a personalised voice message on their telephone, in order to protect their privacy. Staff would break confidentiality in an emergency and when it was in the patient's best interests. Some patients spoke about reception staff within the teams promoting their confidentiality and making them feel welcome.
- Most patients and carers felt involved in their care and treatment. Patients stated they were given choices in the treatment they received. A patient we spoke with felt involved in and well informed about their plan of care and treatment, options and rights. Patients referred to the Hammersmith and Fulham early intervention team for providing clear written information about the purpose of the service and the assessment. The majority of patients spoke about being involved in decisions about their medication. A few patients told us they had experienced side effects of their medication so the doctor changed the dosage to suit the patient.
- We received feedback from carers about the teams. They felt able to ask questions about their relative's treatment. One carer told us that staff had given them a CD with information about how to support their relative with their mental health issues. The carer found this approach helped. The recovery teams had dedicated carers support workers. They carried out carers assessments and referred carers to local support groups. The Hammersmith and Fulham early intervention service provided a family and friends group every month. The group offered mutual support, education, reassurance and peer support. The group ran in the evening to enable people to attend after work or college.
- Local advocacy information was displayed in all the patient waiting areas. Some patients had a named advocate to attend appointments and reviews with them.
- Staff had placed suggestions boxes in reception areas where patients and carers could post suggestions for improvements to the services and other feedback. Patient waiting areas in some teams, had a 'you said, we did' board. In Ealing recovery team west they had a TV which displayed information about the trust. The service provided feedback forms such as 'tell us what you think' and 'would you recommend us to family and friends' on the board. The waiting room also had a freepost envelope to 'patient opinion' so that patients could share their experiences on the trust's website.
- Patients sat on recruitment panels for new staff. A patient or carer was part of the clinical improvement group meetings. However, the teams had struggled to recruit someone who could attend the meetings regularly.

The involvement of people in the care they receive

Are services caring?

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- The trust had an internet page called patient opinion. Patients could go there, share their experiences with

services, and give their feedback. The community mental health teams had patient 'stories' on the website detailing how staff treated them and how long they had waited to access services.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

- New routine referrals into the recovery teams were reviewed by a transitions team embedded within each recovery team. The Ealing recovery team east transitions meeting received and reviewed 15-20 routine referrals a week and decided which professional should see the patient. We observed good multidisciplinary input into the transitions meeting we observed. Routine referrals were seen within two weeks of referral. A manager told us that the speed at which patients were seen had improved. There was no longer a need for all patients to see a doctor if this was not appropriate to their needs. Patients could be referred directly to nurse and social care led clinics and their needs addressed more promptly. In Hammersmith and Fulham recovery team, the transitions team assessed all new referrals before presenting them at the referrals and allocations meetings. Transitions team staff carried out up to two assessments every day. In Hounslow recovery team west, the transition worker would also attend ward rounds. The recovery teams rarely received urgent referrals.
 - The Hammersmith and Fulham early intervention service aimed to maintain a team caseload of 111 patients. The actual number fluctuated between 105 and 125. Most referrals into the team came from the in-patient wards, the crisis and assessment teams and child and adolescent community mental health teams. Very few referrals had come directly from the single point of access. The service aimed to keep patients for up to three years. The majority of patients were then discharged to primary care and about 10% transferred to the recovery team. The recovery teams received referrals mainly from the single point of access and the early intervention teams. The early intervention team had 10 patients on a list waiting to transfer to the Hammersmith and Fulham recovery team. The early intervention manager met with the recovery team manager regularly to try to facilitate smooth transfers. In Ealing, staff were able to transfer patients from the early intervention team to the recovery teams more easily and there was no waiting list.
 - Recovery teams prioritised cases based on risk. High-risk patients were discussed in the zoning meetings.
- Patients considered high risk could access a doctor rapidly. In some teams, those patients with a lower risk who did not need care co-ordination waited for a medical review from the doctor. The manager for both Hounslow recovery teams said there was usually up to a three-month wait to see the doctor. The duty worker provided support to patients if they needed it whilst waiting for their appointment.
- Recovery team patients had long waits to be seen by a psychologist and assessed. The number of patients waiting for psychological assessment was 99 in Ealing recovery team east, 92 in Ealing recovery team west, 47 in Hammersmith and Fulham and 156 patients in the two Hounslow recovery teams. Overall, patients in Ealing were waiting 24 months to be seen. In Hounslow, the waiting time was 19 months and in Hammersmith and Fulham 15 months. The trust had plans to improve the availability and accessibility of psychological therapy for those who needed it most. Proposed strategies included offering more group interventions and the introduction of a process to approve the provision of therapies delivered for longer than average NICE recommendations. However, in the meantime nearly 200 patients had to wait for approximately two years.
 - Upper age limits in the early intervention service had recently been removed in response to national guidance. However, the early intervention teams continued to see only patients aged 35 and under. Staff referred older patients experiencing a first episode psychosis to virtual first episode psychosis teams, which sat within the recovery teams.
 - The teams were flexible when they offered appointments to patients and would visit patients at home when this was appropriate.
 - The number of patients who did not attend (DNA) appointments was quite high in all of the teams. In the six months from April to September 2016 in Ealing recovery team east, 15.5% of appointments had not been attended by patients. In Hammersmith and Fulham recovery team, the number of DNAs was higher at 18.9%. The average DNA rate in the Hammersmith and Fulham early intervention team was 16% and 17.7% in the Ealing early intervention service. In Ealing, recovery team west 15.3% patients did not attend appointments. Hounslow recovery team east it was

Are services responsive to people's needs?

Requires improvement 

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

12.4% and in Hounslow recovery team west it was 14.4%. Staff sent reminder letters to patients and telephoned the day before their appointment to remind and encourage them to attend. Staff in the early intervention teams made home visits to patients who did not attend. The DNA rates had remained the same over the last six months in all of the teams. The teams did not have specific plans in place to address the relatively high rate of DNAs and improve patient attendance at appointments.

- Duty workers in each team were able to respond quickly to calls from patients and were available every day. Duty managers were available to support the duty staff. Out of hours, patients could contact the emergency duty team at the local authority or the information and advice telephone line based in the single point of access.
- The recovery teams aimed to work with patients for up to two years, depending on patients' needs. The recovery teams had identified discharge co-ordinators who supported the team to discharge patients, although they had only recently come into post. The discharge co-ordinator worked with the primary care mental health teams to facilitate the transfer of patients back to the care of their GP. In the recovery teams, a virtual clinic was set up to discuss discharges. The discharge co-ordinator and the consultant psychiatrist attended this. Staff discussed patients who had not been seen in the last 6 months and felt they no longer needed support. Staff discharged some patients to primary care mental health services where they had a psychiatric nurse working within the team to support patients from the recovery teams to move between primary and secondary care. Each borough had a primary care mental health team and found it a more integrated way of working as patients could be supported by their GP.
- The recovery teams operated a 'safer discharge' protocol. This was an agreement with the GP services that when a patient was ready for discharge the teams would notify the patient's GP. The GP had to agree the discharge before the teams could go any further in the discharge process. This often made the discharge process slower.
- The single point of access (SPA) had received over 6200 referrals since the beginning of April when it opened.

Senior nurses screened all emergency referrals to confirm the level of urgency. Fifty per cent of referrals assessed by the SPA team were referred on to the crisis and assessment teams or recovery teams. The team knew that a higher volume of calls was received between 12 and 2pm, so more staff were available to answer the calls at this time. The team aimed to contact urgent referrals immediately or referred the person to the crisis and assessment team straightway if they could not make contact. If patients were not transferred to another team immediately, they were contacted by telephone for a triage assessment. The team aimed to contact emergency referrals within one hour, urgent referrals within three hours, routine plus in 24 hours and routine referrals in 72 hours. If high-risk referrals could not be contacted, they were transferred to the crisis and assessment team for an urgent home visit. Across the three boroughs approximately 77% of referrals required triage. A one-week audit of referrals in September 2016 showed that 26% of referrals were emergency or urgent, 38% were routine plus and 35% routine.

- SPA staff made two or three attempts to contact people referred by telephone. If the person could not be contacted clinicians discussed the level of risk and sent an 'opt in' text or 'opt in' letter encouraging them to make contact if they needed help.

The facilities promote recovery, comfort, dignity and confidentiality

- At the inspection in June 2015, we found that the premises used by the Ealing early intervention service were not a comfortable temperature for staff and patients using them. At the time of the current inspection, the Ealing early intervention service had moved their offices so this was no longer a matter of concern.
- The recovery teams and early intervention teams all had appropriate accommodation and access to a range of consultation rooms, meeting rooms and the medical equipment that staff needed to carry out their role. Waiting areas were welcoming. They were bright and well lit. Interview rooms and waiting rooms were adequately furnished.
- Interview rooms had adequate soundproofing and conversations could not be overheard.

Are services responsive to people's needs?

Requires improvement 

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

- The services provided a range of information to patients and carers about local services, independent advocacy, housing and welfare support services, community centres and faith groups. Staff displayed information in waiting areas advising patients how they could make a complaint. Information on the trust's recovery college was available at all the recovery team premises.
- The occupational therapists within the recovery teams facilitated a community group programme for patients. This consisted of activities such as cooking, gardening; sports group and meet up group. Patients who used these groups enjoyed them and found them helpful in their recovery.

Meeting the needs of all people who use the service

- Patients with limited mobility, including wheelchair users, could access consultation rooms, which were located on the ground floor in all the services.
- Staff recognised community groups who could offer support to patients from diverse backgrounds, including from the Afghan and Somali communities, and would refer patients and carers where appropriate. In Ealing recovery team west, staff did work to raise awareness of female genital mutilation and the needs of the local population more generally. The service also provided training to staff about these specific needs. Staff advertised eastern European advice centres in waiting rooms and English speaking classes for patients whose first language was not English.
- Information leaflets were available in different languages. Staff could get an interpreter when they needed one. Staff in the single point of access used a telephone interpreter when referral forms indicated this was needed.

- Staff in the early intervention services in particular knew the importance of culture and background in the understanding and interpretation of mental health and ill health. They had identified the ethnic backgrounds of patients using the service with a view to determining whether the services were reaching all local communities.

Listening to and learning from concerns and complaints

- The services provided information to patients and carers about how they could make a complaint. Patients told us that they knew how to complain and felt able to complain informally to staff.
- Between 1 July 2015 and 30 June 2016, Hammersmith and Fulham recovery team received 12 complaints of which four were upheld. In the same period Ealing recovery team east, received eight complaints of which three were upheld. Ealing early intervention service received one complaint and Hammersmith and Fulham early intervention services received two complaints. None of these three complaints was upheld. Managers told us that patients sometimes complained about changes in doctors, not being aware that their doctor would change and not receiving appointment letters. In the same period, Ealing recovery team west received eight complaints of which four were upheld. Hounslow recovery team east received 10, with eight being upheld and Hounslow recovery team west received 16, with 10 being upheld. The majority of complaints were about the patient's clinical treatment and staff attitudes.

Are services well-led?

Requires improvement 

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

Our findings

Vision and values

- Staff understood the vision and values of the trust.
- Staff knew of the new chief executive of the trust. Some staff said she had visited their service. The clinical director made regular visits and was well regarded.

Good governance

- The governance systems in place supported the teams to learn from incidents and complaints and make improvements in care and treatment.
- Each team held a clinical improvement group every month. The group involved all staff. The meeting discussed incidents, learning from incidents, learning from safeguarding and how the work of the team progressed. Managers attended a tri-borough clinical improvement group where they shared learning, performance information, finance and operational issues across the different teams. Managers communicated key information about changes in the trust and significant events in this meeting. This meeting helped facilitate communication from teams to the trust board and vice versa. Monthly senior management team meetings for primary and planned care staff discussed governance issues such as investigations, clinical audits and risk registers.
- Data was collated for each service and distributed by the data quality improvement manager. The data detailed overdue care plan approaches, complaints, caseloads and waiting lists for allocation. The managers also had access to 'scorecards' to show them how their team performed. These scorecards brought up the data for mandatory training completion rates and supervision provided on a monthly basis.
- Team managers, especially from the recovery teams had difficulty accessing detailed performance data such as referral to assessment and treatment times at a team level and could not always benchmark their performance against other similar services and teams in the trust. This made it hard to know accurately how many patients were receiving clinical treatment within the target timescales. There was also a risk of teams not meeting their performance targets and this not being identified early so that improvements could be made.

- All teams, except the Hammersmith and Fulham recovery team had a risk register, which highlighted the particular risks affecting the team. Although the Hammersmith and Fulham recovery team did not have a risk register, the manager had identified the main risks affecting the team. Most team registers included actions to be taken to address or mitigate the identified risk, date for the action and whether or not it had been completed. The Ealing recovery team east risk register showed that several actions had been taken to address risks within a specified time. However, the Hounslow risk register had an action assigned to a manager who had left the team six months before and had not been completed and two other risks where no mitigating action had been identified.

Leadership, morale and staff engagement

- In the Ealing early intervention service, the staff sickness rate was 4% and in Ealing recovery team east it was 3%. The sickness rate was 1% in the single point of access, Hammersmith and Fulham recovery team and early intervention service. However, the sickness rates over the last 12 months in Hounslow recovery team west was 11.6%. Some staff we spoke with had worked at the trust for years and enjoyed the support they received from their managers and colleagues.
- Staff felt positive about their teams and their professional roles. They felt that leadership in the teams had been strengthened since the inspection in June 2015. Staff acknowledged that while they had high caseloads and were often busy, they felt very supported in their teams and able to go to their managers for support. At Hounslow recovery team east, staff informed us about the upcoming changes to their team with social workers leaving and no longer being integrated into the team. Staff were anxious about this. The team manager was doing what they could to boost morale and recruit more nurses.
- Staff and managers said they received good support from the clinical director and from their line managers. They felt able to raise concerns and said they would be listened to. Black and minority ethnic staff felt they could progress in the organisation. Peer support workers said they received good support from colleagues.

Are services well-led?

Requires improvement 

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.

- Some staff said they did not feel that senior trust managers entirely understood the importance of their work as the focus of the trust was the forensic services, which formed the major part of the trust's service provision. Most staff we spoke with were optimistic

about their work. Staff felt aware of planned changes in the community teams in respect of the development of patient pathways and spoke positively about this. Staff were aware of whistleblowing processes in the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Staff did not consistently assess, monitor and record the physical health of service users. This meant that physical health risks may not have been identified and therefore appropriately mitigated.

This was a breach of regulation 12(2)(a)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Service users in the recovery teams did not always receive care and treatment that met their needs in a timely way.

Waiting lists for psychological therapy were very long. Patients were waiting up to 24 months to be seen in some teams.

This was a breach of regulation 9(1)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staff must receive appropriate supervision and appraisal to enable them to carry out their duties.

This section is primarily information for the provider

Requirement notices

Many staff had not received an appraisal in the last year. In one team, no staff appraisals had been completed.

Staff in Ealing recovery team west did not receive one to one managerial supervision.

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

The trust must ensure clear performance data is available and accessible to service and team managers so that they can clearly identify how to make improvements in services.

This was a breach of regulation 17(1)(2)(a)