Requires improvement

South West London and St George's Mental Health NHS Trust

Community-based mental health services for older people

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)
RQYXX	Trust Headquarters	Sutton Older People's Community Mental Health Team	SW3 9DL
RQYXX	Trust Headquarters	Merton Older People's Community Mental Health Team	SW17 7DJ
RQYXX	Trust Headquarters	Wandsworth Older People's Community Mental Health Team	SW17 7DJ
RQYXX	Trust Headquarters	Richmond Older People's Community Mental Health Team	SW14 8SU

Summary of findings

RQYXX	Trust Headquarters	Kingston Older People's Community Mental Health Team	KT6 7QU

This report describes our judgement of the quality of care provided within this core service by South West London and St George's 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 South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's 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?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for older people as **requires improvement** because:

Sutton, Merton and Richmond teams did not have adequate medicines management arrangements. Medication was not transported securely between the teams base and patient's homes, medication stock levels were not recorded at the team base. Patients' risk assessments were not recorded consistently and were not always updated in a timely manner. In Merton, Kingston and Wandsworth, patients were not always receiving regular physical health checks.

Staff in Merton team did not receive regular individual supervision.The administration support for the Kingston team was not operating well which led to patients' appointments being cancelled and staff being unable to locate patient records.

Senior managers in the trust had not visited the teams. Staff felt isolated from the trust and individual teams were working in silos. There was low staff morale in Kingston and Richmond teams. Staff told us this was because of the transformation process, poor engagement with the trust and the uncertainty about the future of Barnes Hospital. Staff gave feedback on services to the senior management team and felt they were not always taken seriously or treated with respect when they do.

However, staff were professional, caring and showed kindness and respect to patients and their carers. We observed at the Kingston Memory Clinic that patients understood their care, treatment and condition. There was evidence of appropriate involvement of, and provision of support to families and carers. For example teams had good working links with the Alzheimer's Society.

Arrangements for lone working were in place to ensure staff safety across the service. Arrangements for safeguarding were clear with good systems in place to monitor and follow up concerns.

Practice was evidence based and there was good access to a wide range of interventions. These included anti-psychotic medication for people with dementia and cognitive behavioural therapy for depression. The memory services provided effective post diagnostic interventions and support for both patient's and carers.

There was effective multi-disciplinary team working within teams. The teams worked well with GPs, the local authorities and other local services and groups. This enabled patients and their carers to experience a more joined up service. The staff teams displayed effective team working and mutual support.

Staff had manageable caseloads and managers ensured that workloads were evenly distributed across the teams. Referrals were prioritised and dealt with in a timely manner. There were good pathways to the service and patients were promptly allocated to an appropriate staff member. Wandsworth and Sutton took a proactive approach to re-engage with patients who missed appointments. Staff would make telephone calls and clinicians would follow up with home visits.

Patients at Merton attended clinic appointments at the Nelson Health Centre. We observed this was a dementia friendly environment and patients and carers fed back that it was accessible, bright and a pleasant atmosphere. Adjustments were made for patients requiring disabled access, brail on signs and hearing loops. There was easy access to interpreters.

The services had been innovative. At Kingston the psychiatrist had developed a tool for assessing patients with memory difficulties and this was implemented within the team. The admiral nurse developed a family assessment tool which is currently used by the team. The behaviour and communication service at the Wandsworth team had won three awards in service improvement, dementia care and mental health. The Wandsworth team produced their own staff bulletin which shared good practice and commended individual staff. There was leadership within this team.

Summary of findings

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

Are services safe?

Requires improvement

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

- Sutton, Merton and Richmond teams did not have adequate medicines management. Medication was not transported securely between the team's base and patients home, and medication stock levels were not being documented
- Patient's risk assessments were not recorded consistently.

However:

- Staff had manageable caseloads and managers ensured that workloads were evenly distributed across the teams.
- Arrangements for lone working were in place to ensure staff safety across the service.
- Arrangements for safeguarding were clear with good systems in place to monitor and follow up concerns.

Are services effective?

Good

We rated effective as **good** because:

- The memory services provided effective post diagnostic interventions and support for both patients and carers.
- There was good use of evidence based practice with a wide range of interventions available according to identified need.
- There was effective multi-disciplinary team working in teams.

However:

- In Merton, Kingston and Wandsworth, staff had not ensured patients were receiving regular physical health checks from their GP.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated patients' and carers with kindness and compassion
- Staff spent time talking to patients and their carers. They made sure they received information in a way that they understood.
- Relatives and carers were fully involved in the assessment and ongoing care where appropriate.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

- The changes to the administration support for the Kingston team had led to patient's appointments being cancelled and staff unable to locate patient records.

However:

- Referrals were prioritised and dealt with in a timely manner. Patients were promptly allocated to an appropriate staff member
- Wansworth and Sutton took a proactive approach to re-engage with patients who missed appointments. Staff would make telephone calls and clinicians would follow up with home visits.
- Patients at Merton attended clinic appointments at the Nelson Health Centre. We observed this was a dementia friendly environment and patients and carers fed back that it was accessible, bright and a pleasant atmosphere.
- Adjustments were made for people requiring disabled access, brail on signs and hearing loops. Interpreters could be easily accessed where needed.

Are services well-led?

Good

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

- There was effective team working and mutual support.
- Sutton and Merton service managers attended leadership programmes.
- The services were innovative, for example at Kingston the psychiatrist developed a tool for assessing patients with memory difficulties and this was implemented within the team. The admiral nurse developed a family assessment tool which was currently used by the team.
- The behaviour and communication service at the Wandsworth team had won three awards in service improvement, dementia care and mental health.
- The Wandsworth team produced their own staff bulletin which shared good practice and commended individual staff. There was very effective leadership within this team.

However:

- Some staff expressed that they felt isolated from the trust and senior managers and said that teams were working in silos.
- There was low staff morale in Kingston and Richmond teams, this was because of the trust's transformation process, poor engagement with the trust and the uncertainty about the future of Barnes Hospital.
- There was scope to improve staff engagement so staff feel valued and able to give feedback.

Summary of findings

Information about the service

We inspected five community mental health teams for older people providing specialist assessment, diagnosis, treatment and support. The services aim to provide care and treatment for older people experiencing a severe mental health difficulty in their own home. The teams were situated in Sutton, Merton, Wandsworth, Kingston and Richmond. Within some of the boroughs there were different commissioning arrangements so there were different sub-teams within services for older people.

Teams included psychiatrists, community psychiatric nurses, social workers, occupational therapists, psychologists, recovery support workers and administrative staff.

The service was offered to adults aged 65 and over with progressive memory problems, such as dementia and 75 and over with functional mental health problems, such as depression, anxiety and schizophrenia.

The majority of patients seen by the teams had dementia.

The older people's community teams were previously inspected during March 2014 and were found to be compliant in all outcomes.

Our inspection team

The team that inspected this core service consisted of an inspector, assistant inspector, two specialist advisors who were nurses and an expert by experience. Experts by experience are people who have direct experience of care services we regulate, or are caring for someone who has experience of using those services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited five community teams and their integrated memory services for older people with mental health problems
- spoke with 10 patients and 16 relatives and carers who were using the services
- spoke with five team managers and team leaders
- spoke with 30 staff members including doctors, qualified nurses, social workers, psychologists, occupational therapists, and administrators
- attended and observed two multi-disciplinary meetings

Summary of findings

- joined care professionals for 7 home visits and clinic appointments
- looked at 26 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service
- had a tour of the premises at each location
- reviewed the storage and management of medicines at each location

What people who use the provider's services say

We spoke with 10 patients and 16 carers. Patients we spoke with were happy with the care they received and felt they were involved with decisions about their treatment. They said staff were caring and respectful. They felt well supported and happy with their treatment.

Carers generally spoke very positively about the service they received. They said that they were given information about diagnosis and were signposted to extra support where appropriate. They valued the support of the carer support groups available to them. Carers said that staff were polite, responsive and treated them with dignity and respect.

Good practice

- There were systems for continuous improvement in the Kingston services. The psychiatrist had developed a tool for assessing patients with memory difficulties and this was implemented within the team. The admiral nurse, who is specially trained to work with carers, also developed a family assessment tool called the 'culturogram' which was being used by the team.
- The behaviour and communication service at the Wandsworth team had won three awards in service improvement, dementia care and mental health.
- The Wandsworth team produced their own staff bulletin which was circulated to the team via email. It shared good practice, commended individual staff and communicated updates within the team.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure good medicines management practice, ensuring the safe transportation of medication between the team bases and patients homes and keeping a record of medicine stock levels.
- The trust must ensure the Kingston team has effective administration support. This is to ensure that all letters are sent to patients and GPs in a timely manner, and information needed to deliver care is stored securely and available to staff when they need it

Action the provider SHOULD take to improve

- The trust should ensure the staff improve the consistency of the written individual patient risk assessments.
- The trust should ensure learning from incidents happens across all the teams and other parts of the trust.
- The trust shouldensure in Merton, Kingston and Wandsworth teams, that all patients are receiving regular physical health checks.
- The trust should continue to review staff engagement processes across the teams to ensure staff feel involved in decisions and valued.

South West London and St George's Mental Health NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Sutton Older People's Community Mental Health Team	Trust Headquarters
Merton Older People's Community Mental Health Team	Trust Headquarters
Wandsworth Older People's Community Mental Health Team	Trust Headquarters
Kingston Older People's Community Mental Health Team	Trust Headquarters
Richmond Older People's Community Mental Health Team	Trust Headquarters

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.
- Mental Health Act was covered in the induction training and as part of the trusts mandatory training on consent.
- All consultants and some junior doctors had completed the training to be an approved clinician and carry out the functions under section 12 of the Mental Health Act as having special experience in the diagnosis or treatment of patients with mental health issues.

Detailed findings

- Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act was part of the trusts mandatory consent to treatment training. The compliance rate for the community based mental health services for older people was 91.3% (trust target 95%).
- Teams had leads on the Mental Capacity Act.
- Staff demonstrated a good understanding of the principles of the Act.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Interview rooms in Sutton, Merton, Wandsworth and Richmond services were fitted with alarms so that staff could call for help if needed. In Sutton, some staff were unable to identify where the alarms were located in clinic rooms. In Kingston, alarms were fitted in the corridor immediately outside clinic rooms. Staff in some services told us that if they had concerns about their safety when working in the community, they would call their duty leader to alert them using a safety word. Staff working in the Sutton home treatment team also had hand held alarms.
- We saw that where patients and carers visited the teams, patient areas were clean and well-maintained. A poster in the clinic rooms reminded staff of the safest way to wash their hands and minimise the risk of cross infection.

Safe staffing

- Sutton older people's community mental health team had four nurses and two part time occupational therapists who were care co-ordinators. In addition, the team had a recovery support worker and input from a locum clinical psychologist two days a week. The service manager had a small caseload of noncomplex patients. The home treatment team had two full time and one part time nurse, and three recovery support workers. The service had two consultant psychiatrists covering the community team and home treatment team. The challenging behaviour team was led by a clinical psychologist (who set the service up), two nurses and one support worker. The newly commissioned memory service had three nurses. One of the nurses was a specialist dementia service practioner. The occupational therapist was covered from the community mental health team on a short term arrangement while recruitment was ongoing.
- Merton older people's community mental health team had five nurses and one occupational therapist. The team had one clinical psychologist and one recovery support worker. In addition there were two qualified social workers and one social worker assistant. There was a vacancy for a social worker. The home treatment team had three nurses and four recovery support workers. The service had two consultant psychiatrists covering the community and home treatment team.
- Wandsworth older people's community team had four nurses and two assistant practitioners. In addition they had an occupational therapist and a clinical psychologist. The memory assessment service had similar staff numbers with two consultant psychiatrists covering the community and memory assessment service. The behaviour and communication support team had one psychologist, two nurses, one occupational therapist and an assistant psychologist.
- Kingston older people's community team had four nurses and one occupational therapist. In addition, the team had three social workers, three recovery support workers and a locum clinical psychologist. The team had two consultant psychiatrists. The team told us they had difficulty recruiting social workers and nurses into vacant posts.
- Richmond older people's community team had seven nurses, four nursing assistants and two occupational therapists. In addition, the team had two part time psychologists and two consultant psychiatrists and one junior doctor.
- In Sutton, the average caseload per care co-ordinator was 24. In Merton, the average caseload per care co-ordinator was 39 at the time of inspection. In Wandsworth nurses had an average caseload of 36 at the time of inspection. In Kingston, the average caseload per care co-ordinator was 24. In Richmond the average caseload per care co-ordinator was 22. Staff had manageable caseloads and managers ensured that workloads were evenly distributed across the teams. In some teams occupational therapists had a higher caseload due to extra referrals and assessments on top of their care co-ordinator duties. Team managers reviewed the caseloads of staff during supervisions and team meetings to ensure they were fair and manageable.

Requires improvement

Are services safe?

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

- Locum staff were used in services to cover vacancies while recruitment for permanent staff took place. Cover arrangements for sickness and leave ensured patient safety.
- All the teams had rapid access to a psychiatrist when required and staff often had the mobile phone numbers of the psychiatrists who were attached to their teams.
- Mandatory training rates had improved across the five teams and was above 88% for most subjects. The main topics where improvements were needed were for the training in adult basic life support, conflict resolution and breakaway and medicines management. We were told that additional training sessions had now been arranged and staff were addressing training needs during management supervisions.

Assessing and managing risk to patients and staff

- All five older people's community mental health teams had staff on 'duty' that received and prioritised referrals to ensure urgent referrals were followed up quickly. Named duty managers were available to support staff when needed.
- The teams used an electronic patient record system. These covered risks in terms of the patient's physical and mental health. The risk assessments were completed using a standard format in the patient electronic system. We reviewed 26 care records and the quality of the risk assessments were variable. Some were very comprehensive and about a third were brief. The areas of risk were not always reflected in the care plans. Some risk assessments were not being updated in response to ongoing issues in a timely manner.
- We saw the Sutton team used a 'zoning' system which meant that patients were assigned a risk level of red, amber or green according to the levels of risks which were present and this informed the way work was allocated and considered for each patient.
- Staff had received training in safeguarding in adults and children. They knew how to recognise possible abuse and alert this as needed. Qualified staff knew about the specific safeguarding arrangements in each borough. Four staff members in the Kingston team were safeguarding adult managers and had been trained to investigate safeguarding concerns. In the Sutton and Merton, there were specific safeguarding leads with teams. Teams monitored the progress of safeguarding investigations. All the teams worked closely with the local authorities when there were safeguarding concerns raised.
- We looked at medicines management practice, including the transport, storage and dispensing of medicines. Wandsworth and Kingston used adapted briefcases to transport medicines and syringes. Within Sutton, Merton and Richmond teams, staff transported medicine in their own personal handbags and the trust had not supplied adapted briefcases or medicine bags.
- Medicine fridge temperatures were regularly checked and remained within acceptable parameters. Medicine could only be accessed by qualified staff from coded key boxes. At Wandsworth and Kingston teams, staff recorded medicine stock levels, Merton and Richmond did not have systems in place to record medicine stock levels. CPNs ensured correct medicine and doses were administered and took medicine cards with them.

Track record on safety

- There were no serious incidents reported over the last 12 months for all the older people's mental health community teams.

Reporting incidents and learning from when things go wrong

- Teams of staff knew how to report incidents.
- Most managers were confident that staff knew how to report incidents and reported appropriately. However, in the Wandsworth team we were told that not all incidents that should be reported were reported. This was highlighted on their internal risk register and was being addressed with staff in team meetings. We were told that incident reporting had improved.
- Staff described incidents that had occurred in the teams recently. The incidents were investigated and lessons identified. Improvements were made to the services to reduce the risk of the same type of incident happening again. Lessons learned were shared with staff in team meetings. An example of this was the Sutton team who were working to improve fire safety had implemented a self-neglect and hoarding protocol when assessing patients in their homes.

Requires improvement

Are services safe?

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

- However, there was a relative lack of systems for sharing learning across boroughs. Most staff were unaware of learning from incidents across older people's services in different boroughs.
- Staff were given support after incidents and there were staff debriefing sessions with multidisciplinary input if needed. Staff said they felt well supported after serious incidents

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

Assessment of needs and planning of care

- We reviewed 26 care plans on the electronic records system. Care plans were completed for each patient and up to date. Care plans reflected patient views and were holistic.

Best practice in treatment and care

- Staff told us that the national institute for health and care excellence (NICE) guidance was available at the team bases and they were supported to follow best practice. A number of clinical audits were undertaken by clinical staff including rolling audits on lithium monitoring and use of anti-psychotic medication in dementia.
- The teams offered psychological therapies recommended by NICE guidance which included cognitive behavioural therapy. In Merton, at the time of inspection we were told there was a waiting list of 6 people for psychological therapies.
- The trust had developed two teams, the Sutton and Merton challenging behaviour service and the behaviour and communication support service in Wandsworth. These teams provided a model of care and treatment for people in residential and nursing homes based on the 'Newcastle Model' which looked at behaviours which were challenging to services in the context of a number of factors, including neurological impairment, life story, social environment and physical health. Formulation plans were developed with staff and managers in care homes as well as with patients and their family members. The teams had based their models of care on the national dementia strategy, NICE and the Royal College of Psychiatry guidelines around best practice.
- Occupational therapists and social workers within teams offered support and advice to patients in relation to housing and benefits.
- Teams followed NICE guidance in relation to falls in older people.
- Staff used a variety of recognised rating scales and assessment tools when assessing patients for potential cognitive impairment. These included the Addenbrooke's cognitive examination, the mini mental state examination and the geriatric depression scale.
- The Merton team provided a cognitive stimulation therapy group, which provided post-diagnostic therapeutic interventions to patients with dementia.
- Younger patients with suspected cognitive impairment were referred to other specialist services for further investigation.
- Staff considered patient's physical health needs as part of the assessment. These included checks for smoking, alcohol and a detailed last GP check. We found that not all patients had received an annual physical health check from their GP. This was identified on the team's dashboard. The teams carried out limited physical health checks which included blood pressure monitoring, urine analysis and weight checks. If teams were concerned about a patient's physical health they would liaise with patient's GP.
- Staff monitored patients who were prescribed lithium and anti-psychotic medication; this included regular monitoring of blood pressure and pulse.
- Staff used health of the nation outcome scales to measure outcomes for patients. The Merton team used the quality and outcome framework for physical health activity. The behaviour and communication team in Wandsworth and the challenging behaviour team in Sutton and Merton used a recognised 'challenging behaviour' scale to ascertain the progress made by patients and the effectiveness of their treatment.

Skilled staff to deliver care

- Teams were made up of a range of disciplines including doctors, nurses, occupational therapists, psychologists, recovery support workers and pharmacist input. Two of the teams, Merton and Kingston had social workers located with the team due to local arrangements made between the relevant local authorities and the trust. However, in Sutton, Wandsworth and Richmond did not have social workers as part of their team. Staff in the Kingston team told us they were worried that they may lose their social work input due to the Section 75 agreement being withdrawn. They told us this would impact collaborative working between the team and patients not having direct access to Approved Mental Health Professionals (AMHPs) or best interest assessors.
- In the Kingston team, at the time of the inspection one social worker was an AMHP and trained as a

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.

safeguarding assessment manager. The team manager and two social workers had completed the best interest assessor course and were waiting for confirmation from the university.

- A neuropsychologist provided input to the Sutton team two days a week.
- Staff in all teams had completed an annual appraisal in the last 12 months. Teams had arrangements in place for supervision and staff knew the name of their supervisor. All teams had completed regular one to one supervisions, apart from Merton team. Only 37.5% of the nurses in the Merton team had achieved the trust target of having a one to one supervision every 6 weeks.
- Staff had access to additional specialist training. For example, several staff had been trained to investigate safeguarding concerns and others had undertaken specialist courses in dementia care. Staff identified further training needs in their annual appraisal and supervisions.

Multi-disciplinary and inter-agency team work

- The older people's community mental health teams each had weekly multi-disciplinary meetings. The meetings enabled staff to work together to review existing patients, new referrals and risk ratings.
- Staff in the teams told us they worked with trust inpatient services. Staff in the Sutton and Merton team visited patients on Crocus ward to ensure that inpatient stays, when necessary, were as brief as possible and helped to facilitate home visits from the ward. Staff attended ward rounds in the inpatient wards to ensure that discharges could be made in a timely manner.
- There was good joint working with the third sector. Teams worked closely with the Alzheimer's Society. Teams each had an Alzheimer's Society dementia advisor on site who offered post diagnostic support for dementia to patients and carers during clinic hours. The Alzheimer's Society dementia advisor also offered a variety of carers support groups. Every three months the Alzheimer's Society partner gave feedback on new developments, this included updates on support groups and dementia cafes. We were told that a volunteer from the Merton carers support group attended weekly ward rounds to offer support to carers.
- The older people's community mental health teams worked closely with social care services. For example, the Sutton team told us they had a monthly adult social care pathway meeting where they discuss complex cases. This included a service manager from social services and an admiral nurse.
- Teams worked closely with GPs, mainly to keep them updated with patient progress. They were invited to patient discharge planning teams. They were not usually able to attend but sent written information to help inform the meeting. Staff also liaised with GPs to seek advice, for example in the Merton team, we were told the doctor liaised with Merton GPs to discuss memory service assessments. In Kingston, the team worked closely with the lead GP in the borough to contribute to the recent development of the Kingston dementia support service. This service provided after care for patients diagnosed with dementia.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act was covered in the induction training and as part of the trusts mandatory training on consent.
- All consultants and some junior doctors had completed the training to be an approved clinician and carry out the functions under section 12 of the Mental Health Act as having special experience in the diagnosis or treatment of patients with mental health issues.
- Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.
- Teams had access to advice from the MHA administrators from the trust.

Good practice in applying the MCA

- The Mental Capacity Act was part of the trusts mandatory consent to treatment training. The compliance rate for the community based mental health services for older people was 91.3% (trust target 95%).
- Staff said that the social workers and doctors in the teams led on the Mental Capacity Act and that they would only be involved if they knew the patient. The staff that we spoke to demonstrated a good understanding of the principles of the Act.
- Staff were aware of the MCA policy and how they could access it.

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.

- The mental capacity assessments, where needed were not consistently documented in patient records. Staff in Sutton told us they were recording capacity to consent within progress notes, sometimes under 'patient agreement' rather than 'capacity to consent, this made it difficult to assess evidence of appropriate use of the MCA. In Richmond we found that the use of the MCA was recorded to a high quality.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Carers gave positive feedback for all five teams. They described staff as friendly, caring and respectful. A carer reported that the Sutton North Cheam resource centre had been supportive and staff were polite and caring. A patient from the Merton home treatment team said staff were very good at listening and were responsive to their needs.
- We observed good interactions between staff and patients that were respectful, kind and compassionate. For example, we attended four appointments at the Kingston memory assessment clinic and saw staff interacting and engaging well with patients. They were professional, caring and were responsive to patient's needs.
- We observed a neuropsychological assessment at the dementia hub in Merton. The psychiatrist was caring, holistic and ensured involvement of both patient and carer. The psychiatrist signposted the carer with verbal and written information for extra support.
- At Wandsworth, we observed a behavioural and communication formulation meeting. Staff showed an understanding of patient's journey and made sure the care they delivered was patient centred.

The involvement of people in the care they receive

- Patients and their carers were involved in assessments and were fully involved in multi-disciplinary meetings and care plan review meetings where their individual plans were discussed. Carers said they felt involved in decisions about care.
- Staff involved carers in discharge planning. Staff invited carers to patient discharge planning meetings and signposted them to other sources of help when this was appropriate, including for an assessment of their needs as a carer. Copies of the discharge care plan were sent to carers as well as patients.
- Patients had access to support from an independent advocates when needed.
- People were able to give feedback on the care they received. In Kingston we saw 'patient first' leaflets in waiting rooms which encouraged patients to share their experience of the trust online. We also saw a 'patient first' newsletter from February 2016, which shared positive experiences of the Kingston and Richmond older people's services.
- The teams responded to feedback by highlighting what people had said in surveys and what staff had done to address the concerns raised. 'you said, we did' boards were displayed in patient waiting areas reporting on the actions taken.
- We saw leaflets in waiting rooms which informed people how to complete a real time feedback survey online. While teams had terminals to allow patients and carers to give 'real time feedback' the staff said that the use of this technology was very limited. Feedback came more through compliments and complaints received by the individual teams.

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

- The services were accessible and responded promptly to referrals. Referrals to the older people's community mental health teams came mainly from GPs.
- When referrals came to the community teams they were reviewed by a staff member. In the Merton all new referrals were triaged daily by the consultant and reviewed by the dedicated duty person who arranged urgent assessments and obtained more information about routine referrals. Urgent referrals were prioritised and where possible they were seen and assessed within 24 hours. The local commissioner target for assessing urgent older people's community mental health teams referrals was 7 days which the teams mostly met. In Sutton, Merton and Wandsorth, urgent referrals out of hours were responded to by the crisis team.
- Non-urgent referrals were discussed in clinical meetings within a week and, where appropriate, allocated to staff for assessment. The target time from the point of referral to the assessment of patients was 28 days. Almost all patients were seen and assessed within this period. Delays were sometimes caused by patients going on holiday or appointment cancellation, but delays beyond 28 days were minimal. In Sutton, during February 2016 100% of patients referred to the team were assessed within 28 days. In Richmond, some staff were not clear on local commissioner targets for non-urgent community mental health waiting times for referral to assessment.
- Some new referrals were signposted to other services such as neurological services or the improving access to therapies team if this would better meet their needs.
- The older people's community mental health teams offered services to people aged 75 years or over who had a functional illness. Referrals with a functional illness aged under 75 were referred to the adult services. There were no age restrictions for accepting referrals for people with memory impairment. Before a patient was taken on by teams, they were required to have had a physical health check by their GP to exclude ailments such as infections and vitamin B12 deficiencies.
- Teams took active steps to engage with patients with memory impairments. Staff told us of an example in the Sutton team, where the psychiatrist left a meeting to see a patient who had attended clinic on the wrong day.
- Teams took a proactive approach to re-engage with people who did not attend appointments. In Wandsworth, staff called patients or carers prior to appointments to remind them. If patient did not attend an appointment twice, the doctor or nurse would arrange to see the patient at home.
- Patients were encouraged to move on from the community teams as they recovered. However, staff were flexible and responsive to patient's needs. They recognised that some patients needed to be supported for extended periods to prevent relapse and admission to hospital.
- Sometimes there were delays in discharging patients from the service. Delays were usually caused by difficulties in finding appropriate accommodation or placements for patients and delays in obtaining funding for identified placements.
- Teams had recently implemented the shared care protocol which involved sharing patient care with GPs. In Kingston, this had resulted in over 200 patients being discharged back to primary care.
- The Kingston team had experienced changes in their administration support and were using a recently centralised team. We found that information had been lost between the Kingston base site and the administration hub, this resulted in appointments being cancelled and letters being sent out late. When we visited the Kingston site, the doctor could not find patient care plans on the system ahead of an appointment at the memory clinic. The administration hub had failed to prepare them. The doctor had to spend time contacting the administration hub to send them. The trust acknowledged the period of transition that was taking place and the impact on staff. They were monitoring how long it was taking for discharge letters to be sent out by the administrative hub. In April 2016, 100% of discharge letters were sent within 7 days with the longest delay being 5 days. The trust had also introduced 'BigHand' digital transcription software to support the dictation and typing of letters. The trust 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.

also monitoring the number of cancelled appointments and there were 13 in March 2016 for Kingston older peoples team. This demonstrated that the administrative support was improving.

The facilities promote recovery, comfort, dignity and confidentiality

- Teams had a full range of rooms and equipment to support treatment and care.
- Information leaflets on a range of relevant topics for patients and carers were displayed in patient waiting areas. These supported people to make decisions about their care and treatment. Patients and carers informed us they felt they had been given enough information about their treatment.
- Waiting areas were welcoming. They were bright and well-lit and the Kingston service had particularly good signage, including pictorial representaions and brail, which was helpful to people with cognitive and visual impairment. Clinic environments were dementia friendly, we saw positive feedback from Merton patient and carer surveys which described the dementia hub in Merton as clean and bright with a very pleasant atmosphere.

Meeting the needs of all people who use the service

- Adjustments were made in clinic environments for people requiring disabled access. Clinic sites were both accessible and had bathroom facilities appropriate for patients who used a wheelchair.
- Clinic sites were also adapted for patients who were at risk of falls, for example handrails were available. We also observed staff assisting patients who were at risk of falls around Sutton clinic site.
- Clinic sites were adapted for patients who had dementia. Sites had clear signage and made use of different colours to help patients orientate themselves around the clinic environments The Merton dementia hub had a calm and well-lit environment specifically designed around people with dementia.
- A range of information leaflets were displayed in patient areas of all the services. These including leaflets on dementia, support for carers and medication. In Kingston there was a poster detailing how to access information in nine different languages.
- Staff said that where needed interpreters could be booked to support patients. This would be assessed and arranged upon referral. In Sutton, staff had booked British sign language interpreters for patients who were deaf. There were also hearing loop facilities on site.

Listening to and learning from concerns and complaints

- Between December 2014 and November 2015, older people's community mental health service received 11 formal complaints. Kingston older people's community mental health team received six complaints, Richmond older people's community mental health team received three and Wandsworth older people's community mental health team received two. Six complaints were upheld and no complaints had been referred to the ombudsman.
- Between December 2014 and November 2015, older people's community mental health service received 85 compliments. Sutton older people's community mental health team received the most compliments with 28.

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- Information leaflets explaining how to make a complaint were available in patient waiting areas and information was also available on the trusts website. Staff knew how to manage a complaint and if the matter could not be addressed immediately they could signpost the complainant to use the formal complaints process.
- Staff told us that complaints, comments and other feedback from patients was discussed in team meetings to ensure that learning, where possible could be facilated. Team managers provided examples of learning and service changes they had made in response to individual complaints.

Are services well-led?

Good

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

Our findings

Vision and values

- Some teams felt senior managers in the trust were not accessible and were not aware of visits to their teams. Some staff said they felt isolated from the trust and that individual teams were working in silos.
- Some staff felt confused about the direction of the trust. In Richmond, staff felt the trust's priorities changed frequently due to focus on achieving foundation status. Some staff said they were uncertain of the trust visions.
- Staff gave feedback on services to the senior management team and felt they were not always taken seriously or treated with respect when they do.

Good governance

- Managers had information on the performance of their service. This included information that was lifted from the electronic patient record system, training data, information on incidents, complaints, patient feedback and data provided by the manager on supervision and appraisals. This was brought together with key performance indicators to form a dashboard that provided an immediate overview of areas for improvement.
- The managers we met felt they had sufficient authority and information to make decisions at their service level. Each team had their own administrator, apart from Kingston. In Kingston, staff spent increased amounts of time on administration tasks that had not been dealt with adequately at the centralised administration hub. Staff told us this has caused some stress and were concerned about the impact this was having on patient care and treatment. We were told the administration had started to improve since January 2016 after implementation of electronic auto transcription.
- Managers had systems in place to submit items to the trust risk register.

Leadership, morale and staff engagement

- Staff felt well supported. They were able to raise concerns with their line manager and were listened to.
- There were no reported cases of bullying or harassment in any of the teams. Staff were aware of how to use the whistleblowing process.
- Morale differed across older people's community mental health teams. Sutton, Merton and Wandsworth teams described morale as good. Staff said they enjoyed their jobs and they worked well as a team were able to contribute ideas about how teams could improve. However, in Kingston and Richmond we saw there was low staff morale. In Richmond, staff were uncertain about the future of Barnes Hospital site and did not feel the trust consulted them about this. In Kingston, staff were concerned about the trust's transformation process in relation to Section 75 agreement being withdrawn. Staff were uncertain about their jobs. They felt there was poor engagement with the trust.
- Some staff told us they felt that older adults services were not given a voice within the trust. They were not valued by the trust as there was a focus on services for working age adults.
- Staff described effective team working and mutual support. There had been a recent merger of teams in Richmond. Staff said management teams were very transparent during the process and the teams work well together. Since the merger, staff have been offered weekly supervisions for extra support.
- Team managers told us there were opportunities for leadership development in the trust.Sutton and Merton Service Managers had attended leadership programmes.
- Managers told us they used the duty of candour and explained to people when things went wrong. They supported staff to report incidents and mistakes.

Commitment to quality improvement and innovation

- At Kingston the psychiatrist developed a tool for assessing patients with memory difficulties and this was implemented within the team. The admiral nurse developed a family assessment tool which is currently used by the team.
- The behaviour and communication service at the Wandsworth team had won three awards in service improvement, dementia care and mental health.

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- The Wandsworth team produced their own staff bulletin which shared good practice and commended individual staff. There was leadership within this team.
- In Sutton, feedback from patients and carers said there was a lack of coffee and teas in waiting rooms. In response, the Sutton team partnered with local college South Thames and had recently interviewed ten young people to become volunteers to make tea and coffee in the waiting room. This in turn will enable young people to practice life skills. This arrangement was planned to start in April 2016.
- In Richmond, the occupational therapist was involved in a research project on the topic of living with dementia.
- We were told that Sutton and Wandsworth were working towards accreditation for the Royal College of Psychiatrists, memory service national accreditation programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment should be provided in a safe way for patients. There must be the proper and safe management of medicines. Medication at Sutton, Merton and Richmond was not stored, administered and transported in a safe manner at all times. This was a breach of regulation 12(2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance. In the Kingston team administration support was not working well and letters were not reaching patients and GPs in a timely manner, and information needed to deliver care was not always available to staff when they needed it. This was a breach of regulation 17(1)