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

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Quality Report

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This report describes our judgement of the quality of care at this location. It 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.

Summary of findings

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Overall summary

This report gives the findings of our inspection of the community mental health services provided by South West London and St George's Mental Health NHS Trust. These services were registered with CQC under 'Trust Headquarters' and this was the first inspection of this location since it was registered.

We visited a number of teams across the five boroughs of Sutton, Merton, Richmond, Kingston and Wandsworth served by the trust. These teams provided care and support for people of all ages living in the community with mental health needs and included:

- Child and adolescent mental health services (CAMHS)
- Community mental health (CMHT) teams for adults
- Crisis and home treatment teams for adults
- Community mental health teams for older people (CMHTOP)
- Eating disorders out-patient and day services.

Our pharmacist inspectors also visited a Clozaril medication administration clinic and a home treatment team to assess the management of medicines.

We found areas of good practice and many positive interventions across the wide spread of teams we inspected. Some services for older people were seen to be delivering some outstanding specialist intervention work. Positive ongoing work was noted in the teams supporting people with learning disabilities and the services for eating disorders.

Overall, people told us they felt well supported and said that staff were hard working and committed to their work.

Areas for improvement included:

- Ensuring that comprehensive risk management plans were consistently put in place within the mental health services for adults and older people.
- Improving the quality of care planning for adults with mental health needs living in the community.
- Ensuring that, after referral, people using the service were able to contact a named member of staff about their care and support.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that staff understood their responsibilities under safeguarding procedures and were aware of how to raise concerns. Individuals we spoke to knew about the trust's whistleblowing process.

Staff learnt from incidents and there was time allocated to ensure that issues were discussed so that each service could learn and develop. Staff were aware of serious incidents in other parts of the trust and learning from these was being shared across teams.

Systems were in place across the community teams to identify and review risks; however, we found that risk management plans were not consistently put in place within the mental health services for adults and older people.

Staff across teams told us they felt the services were being stretched by increasing workloads which were not reflected in the staffing levels. Staff teams were concerned that they could not safely manage and provide the support that people of all ages required.

Are services effective?

People using the service, and their relatives or carers, had different experiences of how quickly they received services. Delays in allocating staff within adult mental health services sometimes meant that there was little or no continuity in who had contact with the person following their referral.

We found that services were using appropriate national guidance, standards and best practice to provide care across each service and to ensure these were then continually assessed and improved.

A multi-disciplinary approach was used to support adults, young people and children accessing the service, and their relatives or carers. We found, however, that the electronic reporting system did not always support staff to keep accurate and complete records. There was, therefore, an increased risk that information was not being effectively shared along the care pathway of a person using the service.

Staff received support from their line managers and their performance was appraised regularly. Team members received mandatory training; however many told us that they did always have access to specialist training courses.

Are services caring?

Staff across the community teams demonstrated their understanding of the needs of people using the service and were keen to look at issues from their perspective. Importantly, people using these services told us that staff treated them with dignity and respect.

We saw that people using the service and their relatives or carers were being involved in planning their care. However, shortfalls were identified in the recording of care plans within adult community mental health services, since information was remaining in daily progress notes.

People had access to physical health assessments and mental state examinations. Where these indicated the need for specialist input or treatment, this was planned and provided.

Are services responsive to people's needs?

We saw that teams were aware of what services were available locally and that care was planned around supporting people to access these. We found positive examples of services communicating with each other, with evidence of joint working to help ensure the continuity of people's care.

Summary of findings

However, staff and people using the service raised concerns about the continuity of input from community-based teams into people's care following admission to inpatient services. They also highlighted communication difficulties between the community mental health teams and the crisis and home treatment teams.

Sutton CAMHS had a challenge in ensuring young people with ASD accessed timely services due to restricted resources. At the time of our inspection there were 59 people on the waiting list for this service, and some people had been waiting up to nine months to access the service. The team were looking to use the CAPA approach for this group of young people to increase accessibility to services

Staff working in the learning disabilities teams raised concerns about the lack of appropriate inpatient provision for people with learning disabilities.

Are services well-led?

Staff told us their immediate line managers listened to them and were accessible and approachable. They felt less positive about communication with the trust leadership, with some people reporting that they did not always feel that they were consulted or involved with changes taking place in services.

Staff within some teams told us that they considered the trust's board and senior management did not fully understand the needs and complexity of their service. The Listening into Action initiative, though, was acknowledged by staff as a step forward.

Summary of findings

What we found about each of the main services at this location

Child and adolescent mental health services

We saw there were processes in place for staff to identify and manage risks children and young people presented to themselves and to others. Teams regularly reviewed these risks and risk management plans were in place where appropriate. The teams worked closely with the local authority regarding safeguarding concerns and they kept up to date on the outcomes of safeguarding investigations.

The teams followed national best practice guidelines and there were a range of treatment options available depending on individual need. Across the trust two pathways were used to establish an effective route for children and young people to access services appropriately and within a timely manner.

Children and young people felt involved in their care and felt their concerns were listened to by staff. The teams adapted the service delivered, according to the needs of the child or young person, and the support they required.

The teams worked closely with other agencies and professionals to support children and young people during transitions to other services. A piece of work was being carried out to establish whether the teams were meeting the needs of the local population and there was equitable access to services across the boroughs.

Staff felt well supported by their managers and colleagues. There was strong team leadership and multi-disciplinary working. However, the services were going through a transformation process and staff felt disengaged and not listened to regarding their concerns about the proposed model of service delivery.

Services for older people

People were offered good care from the community mental health teams for older people. Staff were knowledgeable and people told us they were provided with care in a compassionate and thoughtful way.

Staff were aware of their roles and responsibilities and they had access to internal training to ensure their knowledge was up to date. They had a good awareness of best practice in clinical settings. People told us they were involved in their care planning and interventions which were provided by the community mental health teams. There were some specialist teams based within community services for older people which provided support which met people's needs and ensured that good quality care was based in the community and that hospital admissions were avoided where possible. There were specialist home treatment teams for older people which covered Kingston, Sutton and Merton. These teams ensured that people with cognitive impairments had access to specialist support out of work hours in their own homes and community. In Wandsworth older people had access to the adult home treatment teams.

There was a "Challenging Behaviour Team" which covered Sutton and Merton and a Behaviour and Communication Support Team in Wandsworth which provided support to people, families and staff in residential and nursing homes. These teams supported people who displayed behaviours which challenged the environment they were living in.

The teams had memory clinics and services which were configured in different ways depending on the commissioning arrangements by local Clinical Commissioning Groups (CCGs). We found that the services liaised well with local authorities and inpatient services.

Staff told us they felt the services were being stretched by increased referral rates which was not reflected in the staffing levels. We were told that staff often worked early, finished late and sometimes worked at weekends to cover the work that needed to be done.

Staff told us they felt supported by their immediate managers. Most staff told us they were aware of the trust leadership. Some staff told us they felt that older people's services were not prioritised by the trust. A staff consultation had started during the visit but at this time the trust had not provided a response to the staff feedback.

Summary of findings

Services for people with learning disabilities or autism

Staff told us that they were confident tin raising concerns about practice of other staff and were confident that actions would be taken by the managers of the community teams. This meant that processes were in place to safeguard people who used the service from harm and abuse. Staff demonstrated a good understanding of what they required to do to make improvements to the treatment and care provided to people who used the service.

Staff told us that they were able to access training specific to people with learning disabilities, ensuring they met people's needs. There were vacancies in MSCMHLDT for a clinical psychologist and one community learning disabilities nurse and at WCMHLDT two trainee psychologists and one community learning disabilities nurse. The team managers told us that this had been difficult, but "everybody pulls together and we manage."

The trust uses a computerised system with all care plans, risk assessments and notes for people who used the service kept electronically. We viewed six randomly selected care plans which were found to be comprehensive and demonstrated how staff supported people who used the service and showed that people who used the service or their carers were involved in the formulating of care plans and the review processes. Regular health checks were carried out where required ensuring people's wellbeing and physical health was monitored. Overall the records we viewed were of a good standard, regularly updated, comprehensive and well maintained.

Staff told us that they worked together as a team with other professionals, which ensured people's mental health and physical health needs were met holistically. People who used the service told us that they were always involved in their care and were able to discuss any issues with members of the teams. Staff told us us that they were able to access other professionals available from community teams managed by local authorities, however they told us that at times this was very challenging.

MSCMHLDT and WCMHLDT was fully accessible for people who have mobility problems and information was available in a format accessible to people who were not able to read.

We did not monitor responsibilities under the Mental Health Act 1983 at MSCMHLDT and WCMHLDT; however we examined the providers responsibilities under the Mental Health Act 1983 at other locations and we have reported this within the overall provider report.

Adult community-based services

We found evidence that the teams worked with people to keep them safe. Risk assessments were completed at the first visit along with care plans. We saw people were supported with comprehensive risk management plans.

Staffing levels varied significantly in the teams. Merton team was fully staffed and included social workers (AMHPs). All staff we spoke with on this team said they felt the team was well staffed, whilst Kingston and Wandsworth had vacancies and the staff teams did not have social workers attached. Staff we spoke with felt that these teams were understaffed even when they had their full complement of workers.

People's records we viewed clearly demonstrated collaborative working with MDT’s such as district nurses, CMHT’s and hospital wards.

We saw that paper care plans were completed during the initial assessment visits with people who used the service. They were then scanned into the trust data base system. Most care plans we checked were signed by people and/or their relatives.

The manager told us staff had access to specialist training. Some staff told us they completed CBT training and a recovery worker said they had applied to be seconded to train as a nurse.

We saw that information about the trust complaints system was contained in the welcome packs that people were given.

Summary of findings

Community-based crisis services

We found evidence that the teams worked with people to keep them safe. Risk assessments were completed at the first visit along with care plans. We saw people were supported with comprehensive risk management plans.

Staffing levels varied significantly in the teams. Merton team was fully staffed All staff we spoke with told us they felt the team was well staffed. The Kingston and Wandsworth had identified vacancies and staff in these teams we spoke with, felt that these teams were understaffed even when they had their full complement of workers.

People records we viewed clearly demonstrated collaborative working with MDT's such as district nurses, CMHT's and hospital wards.

We saw that paper care plans were completed during the initial assessment visits with people who used the service. They were then scanned into the trust database system. Most care plans we checked were signed by people and/or their relatives.

The manager told us staff had access to specialist training. Some staff told us they completed CBT training and a recovery worker said they had applied to be seconded to train as a nurse.

We saw that information about the trust complaints system was contained in the welcome packs that people were given.

Specialist eating disorders services

Care and treatment was provided to people in a way that was safe. Individual risks were assessed and plans were in place to manage identified risks. Staff understood the trust's safeguarding policy and procedures and made appropriate referrals to local authority safeguarding teams. There were sufficient staff in the out-patient team and day service to ensure people were cared for appropriately and safely.

People`s care and treatment reflected relevant research and guidance. Use of evidence-based practice was evident in terms of the assessment and management of people's needs. There were clear pathways of care between services which ensured people's needs were met in a seamless manner. Recent evaluations of both services showed that people who use the services benefitted significantly in terms of improvement in health and quality of life. Staff were appropriately trained and supported to provide high quality care and treatment. They were described as flexible, open and non-judgemental.

People told us they felt respected by staff and involved in making decisions about their care. People's needs were assessed and care and treatment was tailored to their individual needs. Care plans were reviewed regularly to ensure they remained appropriate to people's needs. Staff respected the privacy and dignity of people using the service.

The services were flexible and responded to people's needs. People's religious, cultural and other individual needs were addressed. The eating disorders services worked well with other teams and providers at times of transition, such as a person's transfer or discharge from the service. This helped ensure appropriate support was in place before a person was discharged. There was an effective complaints process in place.

The services were well-led, the culture open and staff were encouraged to reflect upon their practice. People were regularly asked for their opinions about the service and action was taken to improve services in response to feedback. Staff knew about developments in the trust as a whole but often felt disconnected from the trust board and senior management. Many staff told us they doubted the trust board fully understood the needs and complexity of the eating disorders service and did not think their views were represented at board level.

Summary of findings

What people who use the location say

We left comment cards at various locations around the trust, but none of these were completed during our time on site. The comments from people using the service have been included throughout the report.

Some people served by the adult community teams raised concerns about the responsiveness of the service saying they sometimes found it difficult to contact staff and would not always receive a callback when they requested one.

Some feedback about the effectiveness of the support provided by the out of hours crisis service was not very positive. Individuals told us they would have to attend their local A&E department for support.

Concerns were raised about the limited availability of talking therapies, with individuals reporting extended waiting times following referral.

People were consistently positive about the services provided by the learning disability teams. People said that the service they received was safe and effective, staff were caring and communicated well with them.

Children, young people and their relatives or carers said they were involved in their care and felt their concerns were listened to by staff.

Areas for improvement

Action the provider MUST take to improve

- Comprehensive risk management plans should be put in place for all individuals where a risk to themselves or others has been identified.

Action the provider SHOULD take to improve

- Ensure that all people referred to services are provided with the contact details for a named staff member they can talk to regarding their care and support.
- Ensure the electronic record systems support accurate and complete record-keeping by staff across all teams.

Good practice

Our inspection team highlighted the following areas of good practice:

- The Behaviour and Communication Support Service in Wandsworth and the Challenging Behaviour service in Sutton and Merton and the Community Mental Health Team in Kingston were providing specialised outreach services to older people in residential and nursing homes. These interventions were already proving effective in reducing the use of anti-psychotic medication.
- The Intensive Home Treatment Team and Sutton and Merton provided a specialist service to older people into the evenings and through the weekends, therefore helping to avoid hospital admissions.
- Positive work was noted in ensuring that children and adolescents could access services through the use of CAPA (Choice and Partnership Approach), with a single point of referral scheme and single point of access scheme.

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

Detailed Findings

Services we looked at:
Adult community-based services; Adult community-based crisis services; Child and Adolescent Mental Health community services; Community- based services for older people; Community-based services for people with learning disabilities or autism; Specialist eating disorder outpatient services

Our inspection team

Our inspection team was led by:

Chair: Mr Steven Michael, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust

Team Leader: Nicholas Smith, Care Quality Commission

Our inspection teams for the community services were lead by CQC inspectors and included other CQC inspectors, psychiatrists, senior specialists with NHS experience, nurses and Experts by Experience.

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

The trust provides a range of community services for people living in Kingston, Merton, Richmond, Sutton and Wandsworth.

People receive services through a network of around 50 community teams offering a range of different services. These include teams supporting people who may be acutely unwell as well as those who need more long term care. There are also community teams meeting the needs of older people as well as for those individuals with more specialist needs such as people who have a learning disability or an eating disorder.

Why we carried out this inspection

We inspected this provider as part of our in-depth mental health inspection programme. One reason for choosing this provider is because they are a trust that has applied to Monitor to have foundation trust status. Our assessment of the quality and safety of their services will inform this process.

Detailed Findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the services.

We carried out an announced inspection of the community mental health teams including the crisis and specialist teams on 17, 18, 19 and 20 March 2014.

During our visit we held focus groups with a range of staff, including those working in the local teams. We spoke with a wide range of staff such as nurses, doctors and therapists. We observed some care and met with people who use services, family members and carers who shared their views and experiences of the service.

To get to the heart of people who use the services and have experience of care, 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?

The inspection team inspected the following services at this inspection:

- Community-based mental health services for Kingston North and South (CMHT).
- Community-based home treatment and crisis services at Kingston, Wandsworth and Merton.
- Child and adolescent mental health services (CAMHS) in Kingston, Wandsworth and Sutton . We also spoke to some staff based at the Richmond service.
- Community-based services for people with learning disabilities or autism in Wandsworth, Sutton and Merton. We also visited the Wandsworth Child and Adolescent Mental Health (CAMHS) Learning Disabilities Service.
- The specialist eating disorder outpatient service and adult day unit based at Springfield University Hospital.

Child and adolescent mental health services

Information about the service

Our inspection looked at the care and treatment provided by the Kingston, Wandsworth and Sutton Child and Adolescent Mental Health services (CAMHS) teams. We also spoke to some staff based in the Richmond team.

CAMHS would typically be structured on a four-tiered model, depending on the complexity and severity of the person's needs. During this inspection, we focussed on tier 3 services supporting children and young people in the community undertaking a range of home based, school based or clinical based appointments.

Summary of findings

We saw there were processes in place for staff to identify and manage risks children and young people presented to themselves and to others. Teams regularly reviewed these risks and risk management plans were in place where appropriate. The teams worked closely with the local authority regarding safeguarding concerns and they kept up to date on the outcomes of safeguarding investigations.

The teams followed national best practice guidelines and there were a range of treatment options available depending on individual need. Across the trust two pathways were used to establish an effective route for children and young people to access services appropriately and within a timely manner.

Children and young people felt involved in their care and felt their concerns were listened to by staff. The teams adapted the service delivered, according to the needs of the child or young person, and the support they required.

The teams worked closely with other agencies and professionals to support children and young people during transitions to other services. A piece of work was being carried out to establish whether the teams were meeting the needs of the local population and there was equitable access to services across the boroughs.

Sutton CAMHS had a challenge in ensuring young people with ASD accessed timely services due to restricted resources. At the time of our inspection there were 59 people on the waiting list for this service, and some people had been waiting up to nine months to access the service. The team were looking to use the CAPA approach for this group of young people to increase accessibility to services

Staff felt well supported by their managers and colleagues. There was strong team leadership and multi-disciplinary working. However, the services were going through a transformation process and staff felt disengaged and not listened to regarding their concerns about the proposed model of service delivery.

Child and adolescent mental health services

Are child and adolescent mental health services safe?

Safe environment

The clinics provided a safe environment for children, young people and their families. People were required to be let into the building by the reception staff to ensure unwanted visitors could not walk in.

Learning from incidents

All incidents were recorded centrally and reviewed by the service's team leader. Multi-agency discussions took place when required depending on the nature of the incident to ensure appropriate action was taken and appropriate risk management strategies were put in place.

Serious untoward incidents were discussed at the service's governance meetings and a root cause analysis was undertaken to establish why the incident occurred and what could prevent the incident from happening in the future.

The teams used the information on incidents during team meetings to review the risks young people prevented to themselves and others.

Staff were invited to trust presentations to explore the findings from serious case reviews. Staff were aware of serious untoward incidents that had occurred within CAMHS and learning from this was shared across the teams.

Safe staffing levels

Staff reported that caseloads were increasing and staffing had not increased in line with this. Therefore there were concerns within the staff teams that they could not safely and appropriately manage and provide the support that young people required.

The Sutton CAMHS team had two vacancies and were using agency staff to backfill. The team had not yet been able to recruit a substantive team leader and a learning disabilities nurse to support the Autistic Spectrum Disorder (ASD) programme.

Safeguarding

All staff were aware of who the safeguarding lead was for the trust and consulted them when further advice was required. Safeguarding concerns were discussed amongst the staff teams.

The services were proactive in referring cases to the local authorities' safeguarding teams if there was a risk that a child or young person was subjected to abuse. The teams liaised closely with the local authority regarding a child or young person where there were safeguarding concerns, and ensured the staff teams were aware if a safeguarding investigation was ongoing and the outcome of the investigation. The teams were made aware from the local authority or the police if there were any particular family members or individuals that should not be attending clinic appointments with the young person.

Whistleblowing

Staff were aware of the whistleblowing policy and processes.

Risk management and managing risk to the person

The teams used 'zoning' to identify and review the risks people who used the service presented to themselves and others. People identified as in the red zone were considered high risk and their needs were reviewed weekly during a 'zoning' meeting with the multi-disciplinary team (MDT). The 'zoning' meeting was used to discuss young people that were at risk of harm and where there were safeguarding concerns. The team also used the 'zoning' meeting to identify any young people who had stopped engaging with the service or stopped complying with their medication.

The 'zoning' meetings gave the teams time to discuss high risk cases as a MDT and provide case reflection on how the team supported the needs of individuals. The teams also used the 'zoning' meetings to devise crisis plans for particular young people.

During these meetings the teams identified the risks young people presented to the staff teams, and agreed on measures to put in place to manage the safety of the staff and other young people whilst they were at the clinic. One staff member told us, "Risk management is always at the fore."

Are child and adolescent mental health services effective?

(for example, treatment is effective)

Use of clinical guidance and standards

National best practice guidance was used to establish the models of care used across the specialist CAMH services. A

multi-disciplinary approach was used to support children and young people accessing the service, and their families. The team followed recommended treatment for the range of diagnoses experienced, for example the services used a combination of Cognitive Behavioural Therapy (CBT), Family Therapy, art therapy, drama therapy and additional treatment options. One young person told us, "I get CBT. It actually has helped a lot." The teams were also implementing the Choice and Partnership Approach (CAPA). Not all teams had fully implemented the programme but had integrated the main principles of the approach into their service delivery and appointment structure. Teams in Richmond and Wandsworth had also introduced Improving Access to Psychological Therapies (IAPT).

A high proportion of the young people accessing Sutton CAMHS had undertaken deliberate self-harm and emerging personality disorders. A mentilisation based treatment (MBT) service was developed to meet the needs of this population. Using this treatment model the team had seen a reduction in deliberate self-harm with these young people.

The team in Sutton had started to use video interaction guidance, as recommended by the National Institute for Clinical Excellence (NICE), for children under five years old with a serious attachment disorder. The team were also using the 'Babies in mind' programme to identify high risk families. This meant they could work with expectant mothers during pregnancy and mothers and their new born babies to improve attachments.

Monitoring quality of care

The teams were using the Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) and goal based outcomes to monitor the quality of service provision and measure the progress children and young people made. One parent told us, "Within six weeks we've seen a difference." However, the teams had not started to analyse this data to look at trends in young people's functioning and whether this improved after engaging the services.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

Wandsworth CAMHS used a single point of access to ensure timely access and accurate referral to the tier 3 team. This included all referrals being assessed as to their appropriateness for tier 3 input. All referrals made to tier 3 services were expected to be seen by a professional within two weeks. Those not seen within two weeks were case tracked and the team explored the reasons why this target was not met. The tier 3 team were working with their tier 2 colleagues to ensure appropriate signposting to services to ensure children and young people got the help and support they required.

Sutton CAMHS were using a single point of referral for children and young people to access the service. Performance figures during October and December 2013 showed the service received 280 referrals during this timeframe. 100% of these referrals were screened within one working day, 100% were signposted to appropriate services within 48 hours, and 86% had contact with the relevant service within one working day.

There were processes in place across all teams to identify urgent cases and prioritise access to services. A duty clinician was allocated each day and protected appointments were made available for people requiring urgent support. The team also undertook a liaison role with families and schools to provide advice and guidance on how to support the child or young person whilst waiting for an appointment.

People received different experiences regarding access to the service. One parent told us, "I'm pleasantly surprised to be seen so quickly." Whereas, another parent told us, "It took a long time to get this started. We were panicking with growing agitation and confrontations."

Sutton CAMHS had a challenge in ensuring young people with ASD accessed timely services due to restricted resources. At the time of our inspection there were 59 people on the waiting list for this service, and some people had been waiting up to nine months to access the service. The team were looking to use the CAPA (Choice and Partnership Approach) approach for this group of young people to increase accessibility to services. There were some borough differences in supporting this group of children and young people. The team in Kingston told us they had "fantastic" support from local agencies in meeting the needs of children and young people with ASD or Attention Deficit Hyperactivity Disorder (ADHD). However, they found that children with mild learning disabilities, who were finding school difficult, were not always getting the service they required due to gaps within tier 2 services.

The behavioural support team (BST) was based within each local authority and liaised with local schools to provide

additional support and coping skills to young people who had difficulties within the classroom. The BST also provided teaching staff with guidance and advice on how to support young people with these needs. One parent told us, "My daughter is going to get art therapy based at school. I think it's weekly, and they're already in communication with the school."

Are staff suitably qualified and competent

Members of the team were able to offer a range of medical and psychological treatments to meet people's needs. Some staff had been trained in integrated psychological therapies, autism diagnostic schedule, and staff were currently receiving training in Video Interaction Guidance (VIG). However, staff in Sutton mentioned that accessing training, outside of mandatory training, had become more difficult as funding had become restricted. One person had started their Eye Movement Desensitisation and Reprocessing (EDMR) training before they joined the trust. Now they had to pay for the rest of the training themselves.

Staff in the Kingston and Wandsworth services informed us there was support for clinicians and if their manager identified gaps in their skill set they were able to access training to enhance the work that individuals were able to provide. For example, clinicians were being sent on IAPT training.

There were concerns that the on call system had changed and was now shared between CAMHS and the learning disabilities services. There were concerns that this meant that at times the specialist trainee on call was not CAMHS trained.

The teams had reflective practice meetings and case discussions to reflect on how best to support a child or young person. The team also received managerial and clinical supervision as required, although staff reported they were finding it increasing difficult to find the time to undertake these duties.

Are child and adolescent mental health services caring?

Choice in decisions and participation in reviews

Young people were involved in their care decisions and participated in choices about how their treatment was delivered. Staff told us they empowered young people and their families to be involved in their treatment, and were mindful to look at problems and treatment from the perspective of the child. Children, young people and families were involved in developing their care plans and received copies of them. One young person told us, "We do talk about what I feel, why, the possible reasons and what I can do and how I could do something different." A parent told us, "[my daughter] feels respected and involved."

Children and young people were able to request to change clinician if they preferred to get support from another member of the team. The team also worked with families to provide appointments that were convenient. One parent told us, "They [staff] work around us as we make appointments to our convenience."

Effective communication with staff

One young person told us, "90% of the time I feel listened to." However, they also said, "They tend to ask exactly the same questions." A parent told us, "I'm listened to from the very first appointment."

Children and young people were encouraged to ask questions if there were aspects of their treatment that they were unsure about. If they had questions about their medication the consultant psychiatrist spent time explaining it to them and why it was recommended that they take certain medicines. Children and young people were allocated a care coordinator (a staff member allocated to support them) who they were able to contact if they had any concerns or questions regarding the care and treatment they received. However, one parent felt they did not have enough time to ask questions at the end of their session. The consultant rang them at home later on but they would have preferred to ask the questions at the time rather than going home with unanswered questions.

Do people get the support they need?

The services were mindful to provide children and young people with the support they needed. The staff were supporting the children and young people through their care pathway and were working with other agencies and professionals to ensure young people were not 'bounced around' between services. For example, senior therapists were able to provide short intensive support and treatment to support a young person through their crisis to stop them from requiring an inpatient admission. This meant there was less disruption to the young person and they were able to be supported in the community and continue with their education.

Child and adolescent mental health services

Staff were mindful to continue to offer support throughout the discharge process if a young person was experiencing difficult life decisions or experiences. For example, one young person was discharged from the service but there was a safeguarding investigation ongoing. The staff gave the young person the option to continue to access the service and have the occasional appointment to support them through this time.

Staff reported they often worked over their contracted hours to ensure children and young people received the support they required. The team commented that all members were committed to providing a high quality service to ensure children and young people received their required treatment.

Privacy and dignity

A young person told us the team respected their decision to not have their family involved in their care and treatment. They told us, "They offered family support, but I want to do it alone."

Are child and adolescent mental health services responsive to people's needs? (for example, to feedback?)

Service meeting the needs of the local community

The Sutton CAMHS have started to capture data on which areas within the borough they received referrals from. The team had also started to map levels of deprivation within the borough. Early data suggests that referrals were not coming from areas of highest deprivation within the borough and therefore staff felt the service was not currently meeting the needs of that population. The team had plans to engage further with GP practices in the areas with the highest deprivation to increase awareness and referrals for children and young people who require the service before they reached crisis.

There was a lack of tier 2 services across the boroughs we visited. This meant more referrals were being made to the tier 3 services as there was no service available to provide the level of support this client group required.

Providers working together during periods of change

The teams established close working relationships with multi-agency partners, local acute hospitals, adult community mental health teams (CMHTs), the adolescent assertive outcome team and tier 4 inpatient CAMHS which aided joint working and ensured young people's needs were met during transition between services. One parent told us, "[my daughter] was in hospital and CAMHS staff came out to see her there." The team informed us that liaison and transition to the adult IAPT service worked well in Kingston and the teams worked together on how to support young people nearing 18 years old. The team in Wandsworth met with their adult CMHT colleagues every three months to discuss the needs of young people requiring transition to an adult service. However, due to pressures in the adult CMHT the young people were not always seen in a timely manner which meant the Wandsworth CAMHS team continued to support young people after their 18th birthday.

We spoke to a professional from a neighbouring borough attending the Kingston service for a MDT review meeting. They informed us they had good support from the team and there was good communication between the two services.

The medics within the team liaised with tier 4 services regarding young people that required support from inpatient services. The person's care coordinator remained involved during a young person's admission on an inpatient unit to remain updated on the progress the person was making and prepared arrangements for the young people to be discharged back to the community when suitable.

Discharge plans were developed with the young person and their families. The young person was able to re-engage with the service up to three months after discharge without requiring re-referral. However, one parent told us, "[the doctor] did an assessment and said she thought the CAMH tier 3 service wasn't the right place so [her daughter] was discharged with no discharge plan and no further help discussed."

Learning from complaints

The trust's complaints process was on display and accessible to children and young people at each of the services we visited. The trust's complaints process had recently changed and now all complaints (formal and informal) were reported to the trust's complaints department. Staff were aware to listen to people's complaints and apologise where mistakes had been made. The teams informed us they tried to resolve complaints in a timely manner and to the satisfaction of the complainant.

Child and adolescent mental health services

All complaints were discussed during team meetings. Learning from complaints was discussed amongst staff to improve the quality of service delivery and engagement with young people and their families, but also to ensure consistency in complaint handling.

Are child and adolescent mental health services well-led?

Governance arrangements

The service's governance structure was used to review the service's performance against the trust's priorities, quality accounts and Commissioning for Quality and Innovation (CQUIN) targets. The service's governance group also looked at the service's performance dashboard to ensure young people were receiving an appropriate service, for example, they all had a care coordinator and they received the required CPA meetings. The team's performance was discussed on a regular basis through team meetings. Audits were undertaken to look at the team's performance supporting specific client groups including people who undertook deliberate self-harm and young people requiring neurodevelopmental assessments.

Through the governance structure the Wandsworth team held specific workshops looking at risk assessments, and capacity and consent.

Engagement with patients

Children, young people and families were asked to feedback about their experiences of the service. The majority of findings viewed identified positive feedback on their experiences and the support they received from staff. People felt they were listened to, their concerns were taken seriously and they received the help and treatment they required. However, some people identified that appointment times were not always at a time convenient to them. Comments from people who used the service included, "It was great to know there was someone I could talk to who actually listened to me," "[staff] focused on my goals and how to help me."

Young people were invited to be involved in the naming of the single point of access service within Wandsworth and designed the service's logo and leaflet. The team in Wandsworth involved young people in the recruitment and selection process for new staff, initiated a young carers group and have made a business case for the development of young people advocates.

Engagement with staff

A service transformation programme was in its initial stages at the time of our inspection. The majority of staff spoken with felt they had not been included or were able to meaningfully engage in the process. They felt their comments and concerns were not being listened to. Staff felt there was a lack of information provided about how they were affected and what job opportunities were available within the new model. Staff felt that their specialist knowledge and skills were not being considered when developing the new model of service delivery. However, an updated consultation document had not been produced since the staff returned their responses to the consultation and therefore staff were unclear whether any changes to the model of service delivery had been made in response to concerns raised by staff.The trust have confirmed that a consultation response paper has been shared with staff, and a number of the issues raised by staff have been incorporated into the new model.

Staff were positive about the appointment of the new chief executive officer (CEO). They felt the CEO was approachable, open and honest about their plans for the trust. Staff also felt the CEO was keen to engage with staff and listen to their ideas, for example, through the 'Listening into action' initiative.

Effective leadership

At service level staff reported that professionals worked well together and supported each other. They informed us that senior clinicians were available and accessible if they required additional support or advice. Staff felt the strong professional leadership within the teams provided a supportive and cohesive team during a stressful and uncertain period of change.

The service director for the London boroughs of Sutton and Merton undertook regular 'drop-in' clinics at the service for staff to ask questions and discuss any concerns they had. Staff said the managers and the clinical leads were visible within the team and were accessible if they needed any further support or advice.

Services for older people

Information about the service

The Community Mental Health Teams for Older People operate across Sutton, Merton, Richmond, Kingston and Wandsworth. Within some of the boroughs there are different commissioning arrangements so there were different sub-teams within services for older people. The services aim to provide care and treatment for older people experiencing a severe mental health difficulty in their own home.

As a part of this inspection, we visited the teams covering Sutton, Merton, Wandsworth and Kingston.

Summary of findings

People were offered good care from the community mental health teams for older people. Staff were knowledgeable and people told us they were provided with care in a compassionate and thoughtful way.

Staff were aware of their roles and responsibilities and they had access to internal training to ensure their knowledge was up to date. They had a good awareness of best practice in clinical settings. People told us they were involved in their care planning and interventions which were provided by the community mental health teams. There were some specialist teams based within community services for older people which provided support which met people's needs and ensured that good quality care was based in the community and that hospital admissions were avoided where possible. There were s community mental health teams for older people which covered Kingston, Sutton and Merton. These teams ensured that people with cognitive impairments had access to specialist support out of work hours in their own homes and community. In Wandsworth older people had access to the adult home treatment teams.

There was a "Challenging Behaviour Team" which covered Sutton and Merton and a Behaviour and Communication Support Team in Wandsworth which provided support to people, families and staff in residential and nursing homes. These teams supported people who displayed behaviours which challenged the environment they were living in.

The teams had memory clinics and services which were configured in different ways depending on the commissioning arrangements by local Clinical Commissioning Groups (CCGs). We found that the services liaised well with local authorities and inpatient services.

Staff told us they felt the services were being stretched by increased referral rates which was not reflected in the staffing levels. We were told that staff often worked early, finished late and sometimes worked at weekends to cover the work that needed to be done.

Services for older people

Staff told us they felt supported by their immediate managers. Most staff told us they were aware of the trust leadership. Some staff told us they felt that older people's services were not prioritised by the trust.

Are services for older people safe?

Safe environment

We saw that areas where people visited the teams for clinics were clean, safe and accessible. In Kingston CMHTOP (Community Mental Health Team for Older People) one of the occupational therapists in the team was the disability and equality champion and as a part of their role, they assessed the accessibility of clinical areas including the seating available, the doors and general issues around access. This meant that people were seen in areas which met their needs.

Learning from incidents

Staff were able to learn from incidents and there was time allotted in team meetings to ensure that issues which related, not only to their own teams, but to similar services, were discussed so services could grow and develop.

The trust had meetings at Springfield University Hospital every three months which were based around learning from specific serious incidents. These meetings allowed staff to learn and reflect on the incidents which were presented. Staff were encouraged to attend these meetings.

In Kingston CMHTOP the manager explained to us how their practice had changed following a serious untoward incident (SUI) which had occurred in the team and they had made changes to the way that information was communicated. In Sutton CMHTOP the manager told us about an incident which had occurred and had led to a Serious Case Review (SCR). Recommendations from the SCR were leading to changes in practice and increased joint working with other agencies. This would be embedded in a new policy which was being written in response to the SCR.

All the teams had a good awareness of recent serious incidents.

Safe staffing levels

People who used the service told us they did not feel that staff rushed them and staff were courteous and patient. The teams had different requirements in terms of staffing levels. There were some vacant posts in the teams we visited and some of the teams had been affected by long term sickness. We were told that when there was a need for additional staff, senior management authorised the use of

agency staff. In Kingston and Sutton, staff told us they often worked beyond their contracted hours. All the teams told us that referral rates to their services had increased and this had not been reflected in increased staffing.

Staff told us they often felt stretched but were able to provide a safe and effective service. One person told us, regarding working additional hours, "The trust has to understand that if the staff withdrew their goodwill, the services would collapse".

Safeguarding

Staff we spoke with demonstrated a good understanding of safeguarding and were aware of the actions to take if they had any concerns which needed to be raised. We checked the training records of staff and saw that they had completed safeguarding training as a part of their mandatory training. We were told that in Kingston CMHTOP, staff had attended further training at a higher level as this had been provided by the local authority.

All the teams worked closely with local authorities when there were safeguarding concerns raised.

Managing risk

We observed part of a team meeting in Sutton CMHTOP and saw that risk was discussed extensively. We saw that the trust used a 'zoning' system which meant that people 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 person. We checked documentation in all the teams we visited and saw that risk assessments were completed and were up to date. We saw, however, that some risks which had been identified did not have corresponding risk management plans in place.

In Kingston, Sutton and Merton, there were community mental health teams which worked specifically with older people and people with cognitive impairments. These teams operated outside office hours and at weekends. This meant that there was greater scope for positive risk taking as people were provided with additional support from specialist teams.

We were told that the trust had a 'virtual risk team' which was based at the Springfield University Hospital and worked across the trust. The team in Wandsworth told us they provided advice and support about positively managing risk.

Whistleblowing

Staff told us they felt supported by their managers and felt that they were able to raise concerns with them. Most people told us they were aware of whistleblowing processes if they did have concerns about patient safety.

Are services for older people effective?
(for example, treatment is effective)

Use of clinical guidance and standards

The teams we visited ensured that nationally established clinical guidance such as the National Institute for Clinical Excellence (NICE) guidance relating to the use of anti-psychotic medication for people with dementia, was embedded in their practice. Staff told us they were updated about clinical guidance and best practice through their team and business meetings and through communications with the trust.

The trust had developed two teams, the Sutton and Merton Challenging Behaviour Service and the Behaviour and Communication Support Service in Wandsworth. These services 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 [BJ1] of a number of factors, including life story, pre-morbid personality, physical health, mental health, medication, environment and cognitive status. Formulation plans were developed with staff and managers in care homes as well as with people who used the service and their family members. The team in Wandsworth had adapted the model which they were using to better meet the needs of people using the service. We saw that these teams had based their models of care on the National Dementia Strategy, NICE and the Royal College of Psychiatry guidelines around best practice.

Monitoring quality of care

All the teams we visited used the trust's systems to monitor and measure the quality of care delivered. For example, we saw that managers had access to information about the timeliness of visits and responsiveness to referrals. The teams used the trust dashboard to access current information about the teams' training needs, sickness and other absences. We saw that, in addition, teams carried out some local audits which were relevant to their own services. The Behaviour and Community Support team in Wandsworth and the Challenging Behaviour Team in

Services for older people

Sutton and Merton used a recognised 'challenging behaviour' scale to ascertain the effectiveness of their input. Team managers told us that the teams used the HoNOS 65+ which is a scale particularly adapted for older people, to ensure that the interventions which they were providing were effective.

Collaborative and multi-disciplinary working

There was effective multi-disciplinary working across the teams. Two of the teams, in Merton and Kingston, had social workers based in them due to local arrangements made between the relevant local authorities and the trust. However two of the teams, in Sutton and Wandsworth, had had social workers removed from the teams where they had been previously present.

The teams in Sutton and Wandsworth told us that this impacted on the way the team had managed joint working with the relevant local authorities. In Sutton we were told that there had been increasing communication difficulties with the local authority but that this was improving and representatives from the local authority attended their multi-disciplinary meeting once a month.

In Kingston we were told that four of the social workers in the team were AMHPs (Approved Mental Health Professionals). This meant that they could ensure that when an older person needed a Mental Health Act Assessment, it could be done by someone who knew the resources available in the area and had experience of working with the client group.

Staff in the teams told us they worked with inpatient services. Staff in the Sutton and Merton team visited people on the 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.

Skill, experience and competence of staff

Staff had access to regular supervision. Some members of staff, particularly nurses, said they did not necessarily have separate clinical and managerial supervision. In Merton and Kingston we saw that specific team members took leads in specific roles. For example, in Kingston, one member of staff led on equality and disability and another led on mental capacity. In Merton someone led on care planning and safeguarding. This meant that staff were encouraged to use their knowledge and experience to support colleagues.

Staff gave us mixed feedback about access to training. All staff had access to internal training and we saw that most staff had completed their mandatory training across the teams. Some staff told us they always had access to external training but other members of staff told us that if they sourced external training that had a cost, they would have to pay for half of it. One member of staff told us they would "have to jump through hoops" to access external training.

We saw that staff had access to specialist training such as dementia training. We spoke with a member of staff who had joined the trust recently and they explained to us that they had had a corporate and local induction which had prepared them for their role.

Are services for older people caring?

Choice, decisions and participation

In all the teams we visited, staff told us that they would be happy to have a member of their own family referred to the team they worked in. [BJ1] We spoke with people who used the services and we received very positive feedback. People told us "I find the whole service helpful", "We have been involved in decisions about [family member]" and "I have always been kept up to date".

We looked at care plans and records in the services we visited. We found that most care plans indicated that people had been involved in their [BJ2] development. We saw that a separate and specific template for recovery goals had been devised for people with cognitive impairments who lacked the capacity to actively participate in goal planning. This meant that the service had recognised the specific needs of the user group and people they provided services to.

We saw that records had also recorded the views of family members, where it was relevant so that these were captured. We saw evidence that family members of people who used services had been offered carers' assessments or referred for carers' assessments by the local authority where it was deemed necessary or appropriate.

Services for older people

In Wandsworth, they ensured that people were copied in to all correspondence from doctors which was relevant to them meaning they were given information about the service and the support they received.

The trust did not have a specific reference or user group for older people and their carers which meant there was a risk that the voices of people who used the services in the community was not captured across the trust.

Effective communication with staff

People we spoke with told us they were kept informed by the staff who worked with them. One person told us "I like everyone in the team" and another explained that "the doctor is very kind". Staff in the teams told us they worked hard to ensure that communication was maintained effectively with people, their carers when relevant and with other agencies which were involved.

We saw feedback which had been given in one of the teams which stated that the staff had been understanding and approachable. In the Sutton and Merton team, staff spent time with people who used the service to get to know and make them feel relaxed and at ease during conversations.

Provision of necessary support

People were provided with the support they needed and they had access to specific services which met their needs effectively.

Each team had memory clinics however they were organised in different ways in each borough depending on the local commissioning arrangements. All the teams told us that referrals for memory assessments and clinics had increased over the last year. In Kingston we were told that the team was setting up a memory clinic but had not had specific funding from the CCG so the resources were coming from the CMHT (Community Mental Health Team). In Wandsworth there was a specific memory service which had a different pathway with a dedicated consultant and nursing time. This meant that people in different boroughs had access to different levels of support. In Wandsworth, Sutton and Merton there were specialist teams which provided support to people and staff teams in residential and nursing homes. These teams worked to ensure that hospital admissions could be prevented and worked to improve understanding about the needs of people with behaviour and communication needs. This ensured people which services found difficult to manage were provided with specialist support and understanding.

In Kingston, Sutton and Merton there were community mental health teams which worked with older people and people with cognitive impairments. In Wandsworth we were told that the adult home treatment team did not work with people with cognitive impairments so a gap in the service provision had been identified. In Kingston there was a specialist outreach team which had been established when day services closed locally and allowed staff to provide additional support to people in their own homes and communities.

Most people were provided with support that they required by specialist teams however there were some gaps due to differing commissioning arrangements between the boroughs.

Privacy and dignity

People we spoke with told us they were treated with dignity and respect by staff in the teams. Staff we spoke with displayed an understanding of the need to ensure people were treated with dignity at all times.

Are services for older people responsive to people's needs?

(for example, to feedback?)

Meeting the needs of the local community

We saw that people who were referred to services were seen within a set period by the teams. We were told that the teams had a 'triage' system so that people who needed to be seen immediately were prioritised. Staff visited people at home when they were not able to come to the service. The community mental health teams in Kingston, Sutton and Merton were able to provide a service out of working hours. Staff were enthusiastic about their work. Staff had an awareness of meeting people's cultural and religious needs and were able to give us examples of situations where they had ensured that the service was sensitive to needs and people's preferences.

In the Wandsworth Behaviour and Communication support service a member of staff told us how they had worked with a residential home when someone was not able to communicate in English and had been displaying behaviours which the home had found difficult to manage.

Services for older people

They had worked with pictures, phrases in their native language and photographs of flags and familiar things from their country and that this had been effective in helping staff communicate better with them.

Staff told us they were aware of the need to use interpreters and did so when necessary. The Challenging Behaviour team in Sutton and Merton provided specific training to care homes in areas such as dementia and sexuality and dementia awareness. This meant the service was able to meet the needs of local communities and was able to educate those providing care in best practice.

Learning from complaints/comments

We spoke with staff who told us that complaints, comments and other feedback from people who used the service or other agencies, such as the local authority, were discussed in team meetings to ensure that learning, where possible, could be facilitated. We saw that information about how to make complaints was visible in the areas that people had access to.

Are services for older people well-led?

Governance arrangements

Managers in the teams we visited told us the services were divided into boroughs and each borough had a lead who provided support to them. Staff told us they were aware of their managers and the borough leads locally. Team managers told us they attended meetings with their peers and managers to ensure consistency and support across the trust.

Engagement with patients

While the trust had user and carer groups, we were told that they did not have specific groups which were focused on the needs of older people. We saw that people were asked to complete feedback and some real time feedback was being used to pick up information from people who used the service.

Engagement with staff

Some staff told us that they did not feel there was much interaction with or from senior leaders in the trust. Some staff told us that they did not always feel that they were consulted fully on changes which took place in the service.

We asked staff about the Listening into Action initiative which had been used in the trust to increase staff engagement. Staff were generally very positive about it and were able to reflect on specific changes that had taken place as a result of it. For example, the Sutton and Merton Intensive Home Treatment Team had identified a specific concern about receiving referrals on a Friday afternoon. Through the Listening into Action programme they had suggested a better way of highlighting concerns on Thursdays and this had been actioned leading to them feeling positive.

Effective leadership

All the staff we spoke with were positive about the support they received from their own line managers. Most staff gave us positive feedback about the CEO and felt that he was visible, accessible and was interested in making positive changes in the trust. Some staff told us they felt that older adults services were not given a voice within the trust and were not prioritised by the trust as there was a focus on services for working age adults. One member of staff told us “we have to shout really loudly to be heard”. We asked staff what they would like the senior management to know about their team and one manager told us “I’d like them to know how dedicated the staff team is. They do lots of work in their own time”.

Services for people with learning disabilities or autism

Information about the service

Sutton and Merton Mental Health Learning Disabilities provide a specialised service for people with a dual diagnosis of learning disability and mental health needs living in the community. The team includes psychiatry and community nursing and can access specialist learning disabilities services provided by the Merton and Sutton Community Mental Health Learning Disabilities Team.

Wandsworth Community Mental Health Learning Disability Team is located at the Joan Bicknell Centre on the main Springfield Hospital site. The team includes community nursing, psychiatrist, and psychologist and can access other health professionals provided by the Wandsworth Community Learning Disabilities Team.

Wandsworth Child and Adolescent Mental Health (CAMHS) Learning Disabilities Service is located in Queen Mary's Hospital in Roehampton. The team includes a consultant psychiatrist, two clinical nurse specialists, a psychologist, a social worker, a speech and language therapist and a team manager. The team works closely with adult mental health learning disabilities services to arrange discharge.

Local commissioners stopped commissioning South West London and St George's Mental Health NHS Trust to provide a specialist mental health learning disability service in August 2012. Patients' with learning disabilities that require inpatient services are admitted on general mental health wards or are admitted to inpatient facilities provided by external providers.

Summary of findings

Staff told us that they were confident tin raising concerns about practice of other staff and were confident that actions would be taken by the managers of the community teams. This meant that processes were in place to safeguard people who used the service from harm and abuse. Staff demonstrated a good understanding of what they required to do to make improvements to the treatment and care provided to people who used the service.

Staff told us that they were able to access training specific to people with learning disabilities, ensuring they met people's needs. There were vacancies in Merton and Sutton Community Mental Health Learning Disabilities Team for a clinical psychologist and one community learning disabilities nurse and at Wandsworth Community Mental Health Learning Disability Team two trainee psychologists and one community learning disabilities nurse. The team managers told us that this had been difficult, but "everybody pulls together and we manage."

The trust uses a computerised system with all care plans, risk assessments and notes for people who used the service kept electronically. We viewed six randomly selected care plans which were found to be comprehensive and demonstrated how staff supported people who used the service and showed that people who used the service or their carers were involved in the formulating of care plans and the review processes. Regular health checks were carried out where required ensuring people's wellbeing and physical health was monitored. Overall the records we viewed were of a good standard, regularly updated, comprehensive and well maintained.

Staff told us that they worked together as a team with other professionals, which ensured people's mental health and physical health needs were met holistically. People who used the service told us that they were always involved in their care and were able to discuss any issues with members of the teams. Staff told us us that they were able to access other professionals available from community teams managed by local authorities, however they told us that at times this was very challenging.

Services for people with learning disabilities or autism

Merton and Sutton and Wandsworth Community Mental Health Learning Disability Teams were fully accessible for people who have mobility problems and information was available in a format accessible to people who were not able to read.

We did not monitor responsibilities under the Mental Health Act 1983 at Merton and Sutton and Wandsworth Community Mental Health Learning Disability Teams; however we examined the providers responsibilities under the Mental Health Act 1983 at other locations and we have reported this within the overall provider report.

Are services for people with learning disabilities or autism safe?

Learning from incidents

Staff told us that incidents were recorded electronically by individual members of the team on 'Rio'. The manager of each team would escalate any incidents to the trust's incident team, who looked at the incident and passed their findings and suggestions back to the team managers. All incidents were discussed during weekly team meetings and management plans were put into place to reduce further similar incidents from reoccurring. Staff told us they would discuss incidents during monthly supervision sessions, however staff told us if they wanted to discuss any incidents prior to their supervision, they had the option to arrange meetings to debrief and discuss any incidences. Both teams advised us there had been very few incidents over the past year.

Safeguarding

Training records indicated that staff received training and mandatory updates in safeguarding adults. Staff spoken with confirmed they had received training relating to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We asked staff in regards to their role relating to adult protection and staff told us that they would escalate it to their team manager, who would contact the safeguarding team at each local authority for action. One of the team managers told us that at times the response from the London Borough of Sutton was very slow and required them to chase the local safeguarding team for a response. This meant that people who used the service could be confident that any decisions were made in their best interest and were reviewed in line with appropriate guidelines.

Safeguarding concerns raised with the CAMHS team were dealt with and managed by social workers in the team. This ensured concerns were dealt with and young people and children were protected appropriately.

People who used the service told us they felt safe with staff and raised no concerns that their liberty had been deprived and were confident that staff would help them to deal with any safeguarding issues.

Safe environment

Merton and Sutton Community Mental Health Learning Disabilities Team was accessible for people with learning

Services for people with learning disabilities or autism

disabilities who also have a physical disability. A lift was available and in good working order, corridors were spacious to easily manoeuvre wheelchairs and disabled toilet facilities were available. An external contractor ensured the building was well maintained.

Wandsworth Community Mental Health Learning Disability Team was located on the main Springfield Hospital site within the Joan Bicknell Centre, which was on the ground floor and fully accessible.

Risk management

Risks posed to people who used the service were carried out during their initial assessment and reviewed or updated during care plan review meetings or if peoples' needs had changed.

Staff told us that they had a lone working policy and if a person presented a risk to the service or staff a separate risk assessment was put in place. This ensured that risks to people who used the service and staff were dealt with and minimised.

Medication

The teams did not administer medicines to people who used the service. Regular reviews of medicines were prescribed to people who used the service by the consultant psychiatrist of the team in liaison with the GP of the person. We saw in people's care plans that this was carried out frequently and one person told us, that he discussed medicines regularly with the psychiatrist and over time medicines had been reduced while his metal health was improving. We also observed during a home visit that medicines were discussed and staff clearly explained to the patient why they were prescribed certain psychotic medicines.

Whistleblowing

Staff told us that the team followed the trust whistleblowing procedure and it was evident that staff felt listened to by their line manager and felt confident they could raise concerns and that they would be dealt with.

Managing risk to the person

All care plans viewed had comprehensive risk assessments and risk management plans in place. Risks were clearly documented and regularly reviewed when people's needs changed. People who used the service told us that they had been consulted in the assessment of risk and were able to contribute during their Care Plan Approach meeting.

Safe staffing levels

The team manager of the Merton and Sutton Community Mental Health Learning Disabilities Team told us that they currently had a vacancy of one community learning disabilities nurse and one psychologis but the team was managing and work was shared between staff. Clinical support in the form of psychology could be obtained from the community learning disability team, however we were advised that the service varies between teams. The team could also access the Improving Access to Psychology Therapies (IAPT) team, which was located in the same building, however their admissions criteria was not very wide and the majority of referrals had been refused.

The manager of the Wandsworth Community Mental Health Learning Disability Team told us that they currently had a vacancy for a community learning disabilities nurse and two assistant psychology posts had been frozen. The manager told us that the frozen posts made it on occasions difficult to provide suitable psychology input and people who used the service had to wait longer then expected until they were supported by a psychologist. Staff spoken with, including the line manager, had not been told why the posts had been frozen but believed it was a cost saving exercise by the trust, during the ongoing review of the overall learning disabilities provision by the trust.

Are services for people with learning disabilities or autism effective?

(for example, treatment is effective)

Use of clinical guidance and standard

We saw in two care plans, that the teams, in particular the clinical psychiatrist, reviewed people's medication regularly. This was clearly linked to the National Institute for Health and Clinical Excellence guidance on 'Medicines adherence 2009'.

Monitoring quality of care

Merton and Sutton and Wandsworth Community Mental Health Learning Disability Teams undertook in October 2013 an audit titled 'Learning Disabilities Practice in Community Mental Health Team'. The audit highlighted the shortfalls in accessible information for people with learning disabilities and the lack of confidence of some teams within the trust of working with people with learning disabilities. This audit formed part of an overall review of all

Services for people with learning disabilities or autism

learning disabilities services at the trust. During our visit to both locations we noted that a wide range of accessible information was on display in the reception areas and clinical areas, which staff told us was an improvement.

The trust are currently reviewing the provision of training in learning disability awareness, this will now be included in the trust induction of new staff.

Collaborative multi-disciplinary and multi-agency working for assessments, care planning and access to health services

Staff told us that the main obstacle they faced was that the community teams they worked with used different IT systems to that of the trust. They told us that this has led to information not being shared appropriately and staff from community teams and from the mental health learning disabilities teams were not responding swiftly enough when people's mental health deteriorated.

During the audit 'Learning Disabilities Practice in Community Mental Health Team' in October 2013 it was highlighted that within adult mental health and learning disabilities teams there was little collaborative work as people who used the service were either with the learning disabilities team or community mental health team. Some suggestions were made within the report that there should be greater communication from the learning disabilities team. It was also suggested within the audit report that this would improve if a link worker were put into place to liaise between both teams. This had not been put in place during our inspection.

Staff at the Merton and Sutton Community Mental Health Learning Disabilities Team told us that they found it difficult to access additional clinical support such as speech and language therapy, dietician and other community services from one of the local authorities. This had been raised with the trust senior management team, but so far no improvements were noted by team members we spoke with. However the team manager told us that on the other hand they worked very well with the other local authority and a link worker from the community team attended team meetings regularly.

Staff at Wandsworth Community Mental Health Learning Disability Team told us that they worked very well with other community teams, and this could be because the community team were located in the same building.

Staff at the Wandsworth CAMHS Team told us that they worked closely with adult learning disabilities services in particular when young people were discharged. Staff told us that young people were not discharged from CAMHS services until adult services accepted the referral. This meant that young people received continuous care.

Are staff suitably qualified and competent

Staff told us they found it easy to access mandatory training provided by the trust, however the provider may wish to note that only 88% of staff at the Merton and Sutton Community Mental Health Learning Disabilities Team had attended mandatory training, which is below the 95% trust target. Staff told us that they found it easy to discuss training with their supervisor and two staff we spoke with told us that they currently undertook external training to improve their knowledge and skills when dealing with people who presented challenging behaviours. People who used the service and carers told us that staff were "fantastic", "very professional" and "they definitely know what they are doing."

Staff at the Wandsworth CAMHS Team spoke very positively about the opportunities they had in accessing training. One member of staff told us that there were good opportunities to access training and the trust was very supportive.

Are services for people with learning disabilities or autism caring?

Choice in decisions and participation in reviews

People who used the service told us that they were involved in care plan reviews and comments when users were asked who owned the care plan were, "This is my care plan" and "I am always asked what I want and tell them what to do." Another person told us, "that he would tell staff if he did not agree with anything in his care plan."

During our visit to the Merton and Sutton Community Mental Health Learning Disabilities Team we observed a clinic during the afternoon, which was attended by people who used the service independently or together with their carers. It was evident during our observations that clinicians explained everything to the person in a language they understood and people were encouraged to make contributions to their care plan and the treatment discussed.

Services for people with learning disabilities or autism

We viewed a number of care plans during our visit to both sites and noted that care plans were very comprehensive and detailed. Staff told us that the IT system used by the trust was not allowing them to use easy read format in their care planning processes and any easy read documents had to be separately scanned, which made the process time consuming and not user friendly.

Effective communication with staff

Staff told us that they met every week for a team meeting, during which individual people who used the service were discussed and issues relating to the community team. The team meeting at Merton and Sutton Community Mental Health Learning Disabilities Team was attended by a representative from the Merton Community Learning Disabilities Team, which ensured that people who used the service received input from the multi-disciplinary team. We viewed records of the team meetings which confirmed that meetings happened regularly and involved all staff working on the teams. All staff confirmed they had received regular monthly supervisions, with the exception of the team leader who told us that he had only received six monthly supervision each year. Records viewed showed us that all staff received monthly supervision the majority of the time. Staff told us that supervisions were some times missed due to sickness or annual leave.

We saw in both teams a picture board which displayed photographs of staff working at the teams. This ensured that people who used the service knew who was working if they visited the teams.

Do people get the support they need

Staff spoken with demonstrated sound understanding of the needs of individual people who used the service. We observed a clinic and a home visit and staff were sensitive to people's needs and involved them in the planning of their care. For example one person wanted to get more information regarding the anti-psychotic medicine prescribed and we observed staff explaining it to the person in a language and pace so meeting the person's needs.

Recovery services

On the main Springfield Hospital site the trust established a Recovery College, for people who used the service. People from the Merton and Sutton and Wandsworth Community Mental Health Learning Disability Teams could access the college every Wednesday when it ran a session specific to people with a learning disability.

Privacy and dignity

We observed that staff were courteous and respectful to people who used the service. Clinics were held in a designated room and we observed doors to be closed ensuring people's privacy was maintained. We observed similar procedures during the home visit, where team members met the person in private, enabling them to discuss issues relating to their treatment and care in private and without interruption.

Restraint

Staff and people who used the service told us that restraint was not used by the teams. Staff spoken with told us that "if people demonstrated challenging behaviours, we would refer them to the challenging behaviour team, who would formulate a positive behaviour plan together with the person."

We saw such a plan in two care plans we viewed. This addressed the person's behaviour proactively by using diversion techniques. This ensured people's challenging needs were met in the least obstructive and intrusive way.

Are services for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Service meeting the needs of the local community

Staff told us that they meet the needs of people who used the service in the local community. We saw evidence of this in care plans viewed during our inspection. For example on one occasion a relative contacted the team in the morning and the person was visited by a member of the team for assessment in the afternoon.

However staff raised concerns about the lack of specific learning disabilities inpatient facilities for people who used the service if placements broke down. People were admitted to general inpatient wards, where staff lacked training and experience of working with people with learning disabilities or were placed out of borough, which made it very difficult for people who used the service to maintain contact with their families and friends.

Services for people with learning disabilities or autism

During an interview with the service director for Sutton and Merton we were told that the provider had no plans to provide specific inpatient services for people who used the service.

Work of the teams reflects equality, diversity and human rights

People who used the service, who had communication difficulties, were supported with a range of tools.This included documentation and information in easy read format, use of sign language and input from speech and language therapy support if available. In addition the teams had access to occupational therapy support or a psychologist if required. People who used the service told us that staff respected their cultural needs.

Providers working together during periods of change

Staff told us that their main problem was the lack of learning disabilities specific inpatient facilities. They told us that if placements broke down due to deterioration of people's mental health, they were admitted to general mental health wards. Staff at these wards, as noted in the findings of an audit carried out by the provider in October 2013, lacked confidence in working with people with learning disabilities and there was a need to provide learning disabilities specific training.

Learning from complaints

Merton and Sutton Community Mental Health Learning Disabilities Team had received two complaints in the past year. Complaints were recorded by the team manager and forwarded to the providers' complaints team. We viewed both complaints and were satisfied with the actions taken by the provider and team, which ensured the complainants were informed of the outcome of their complaint and measures put into place to reduce similar complaints from reoccurring.

Complaints leaflets were available in accessible format and people who used the service told us that the knew how and whom to complain to if they needed to.

Are services for people with learning disabilities or autism well-led?

Governance arrangements

We viewed the providers integrated clinical governance report from January 2014, which stated that the provider established a working group to identify actions to improve the experience and outcome for people who used the service and carers with learning disabilities. The report covered the time from October to December 2013 and identified thirteen inpatients with a learning disability in September 2013. However during our inspection in March 2014 we found it very difficult to get information from the provider of how many inpatients with a learning disability were currently placed.

The report also highlighted that easy read materials were not always available in wards. The team manager of the Merton and Sutton Community Mental Health Learning Disabilities Team told us that easy read information was developed by his team and provided to inpatient services. It also highlighted the difficulties in working with specialist learning disabilities teams and the lack of confidence and training of of staff working in general mental health wards with people with learning disabilities. We were however not able to find out actions taken by the provider to address these issues.

Engagement with people who use the service

Feedback from people who used the service was sought during appointments. The team leaders acknowledged that a more formal system to obtain feedback was required to catch peoples' views about the service provided. People who used the service spoke very highly about it and said that the "service is excellent" or "fantastic" or "without the help of the team I wouldn't know what I would do."

Engagement with staff - community teams to board

Staff told us that they felt disengaged and forgotten by the board. They told us that the provider did not give sufficient consideration to the needs of people with learning disabilities and the teams providing support. Staff also told us that the provider had carried out, over the past 16 months, a review of the learning disabilities services provided, but they felt they had not been involved and informed about this review. Comments made by staff included, "the trust does not care about people with learning disabilities and is only interested in mental health care provision." We looked at the providers new mission statement, which did not mention people with learning disabilities at all, which possibly confirmed the fears of staff spoken with.

Services for people with learning disabilities or autism

Effective leadership

Staff told us that the team managers were very supportive and approachable. Regular team meetings and supervisions provided opportunities for staff to raise concerns and discuss overarching issues.

Adult community-based services

Information about the service

Community mental health teams (CMHTs) provide community based services to adults who are experiencing mental health issues. The teams are multi-agency teams consisting of different mental health professionals such as community mental health nurses, social workers, occupational therapists and recovery workers.

We visited the community-based mental health teams for Kingston North and South.

Summary of findings

The care delivered was in line with clinical guidelines the community mental health teams used the Functional Assertive Community Treatment model (FACT) which was adopted after research showed services using the model had significantly fewer hospital admissions.

The Early Intervention Service worked to a recovery model tailored to the needs of younger people and documented evidence-based strategies that they used to work with people. Staff showed a good awareness of how this model worked in practice. The service also carried out relapse prevention and family work.

There were examples of collaborative working and records showed that referrals were made in a timely manner when input was required from other services. Before referrals were made, they were discussed within the multi-disciplinary team.

We found examples of effective communication the progress notes showed that staff listened to what people said and took their views into account. We found several examples of interactions where people using the service had asked for and received information about their care.

Peoples needs were supported we saw that people had access to physical health assessments and mental state examinations. Where these indicated the need for specialist input or treatment, this was planned and provided. This was clearly recorded in progress notes but had not always been indicated in assessment records.

We also found positive examples of communication between services, with evidence of meetings held to discuss the continuity of people's care. The Early Intervention Service met with approved mental health professionals (AMHPs) monthly and discussed AMHP and Mental Health Act involvement during team meetings.

Staff in both teams told us there was a supportive culture and that they could rely on colleagues and

managers for help when needed. Managers were aware of improvements they could make to services. They were open and honest about where improvements were needed and had a clear vision for change.

Are adult community-based services safe?

Learning from incidents

Staff told us they had opportunities to discuss and learn from incidents by debriefing and by discussing near misses at staff meetings, which were weekly in the CHMTs and twice weekly for the Early Intervention Service. Incident reports were escalated to the risk management team who provided feedback to managers. Staff said this process was used to discuss good practice rather than as a blame exercise and showed good awareness of the incident reporting process.

Staff were open about areas for improvement, which included a lack of action planning from formal feedback after incidents.

Keeping people safe

The teams had a joint safety improvement group, attended by the multi-disciplinary team and used to discuss positive risk taking. Staff were able to raise concerns about safety in weekly clinical meetings.

Staff worked in pairs when visiting people and were tracked by using diary books and logs so that the team manager knew where each staff member was at any time. People who had a history of causing harm to others and were identified as having high risks were seen at the team's base rather than at home.

Risk management

Staff described the zoning system and how it was used to manage risks. There was some inconsistency in descriptions of what each zone signified and staff felt it may be helpful to have more clear definitions. There was a multi-disciplinary team meeting three times a week to discuss people who used the service and their zoning.

People's progress notes showed the teams were giving thoughtful and consistent consideration to risks. Notes were thorough and showed a good awareness of individual people's risk factors and management. Staff were able to describe contingency plans for people they worked with. However, we found that risk management plans were not apparent for several people on the RiO electronic system and the risk assessment process was unclear. Sometimes, risk information gathered at the core assessment was not translated into the risk assessment process. For example,

one person had identified that they were a recovering drug addict but staff told us this had not been included in their risk summary because they had not asked for support in this area. One person had told staff on a number of occasions that they felt suicidal, but their risk assessment stated that the person was not suicidal without any information about how the conclusion had been reached. Similarly, people's risk management plans gave risks as 'low' across the board despite information indicating that risks might be higher, and the process for deciding risk ratings was not clear.

Although progress notes demonstrated that risks were being comprehensively identified and managed, there was no clear continuity on the system between the identification, assessment and management of risks. There was therefore a risk of this information being 'lost' in several months' worth of progress notes and not being relayed to other services involved in people's care.

Safe staffing levels

The teams had recently gone through changes meaning each member of staff had a larger caseload than previously. Staff felt they were still able to deliver good care despite this, although it was difficult to keep up with paperwork demands.

Are adult community-based services effective?

(for example, treatment is effective)

Use of clinical guidelines and standards

The CMHTs used the Functional Assertive Community Treatment model (FACT) which was adopted after research showed services using the model had significantly fewer hospital admissions. This method works by integrating assertive outreach and CMHT functions into one team. The Early Intervention Service worked to a recovery model tailored to the needs of younger people and documented evidence-based strategies that they used to work with people. Staff showed a good awareness of how this model worked in practice. The service also carried out relapse prevention and family work.

Collaborative and multidisciplinary working

Care and treatment records showed clear pathways for people entering the service with documented referrals and records of events leading up to referral. However, we found that the RiO electronic data system did not facilitate accurate and complete record-keeping that was a true reflection of the care provided and sometimes it was difficult to see how different members of the multi-disciplinary team had worked together to produce care plans. This meant that other services may struggle to obtain an accurate picture of what a person's care looked like on the ward. We asked staff about this, and they told us that collaboration between services was often difficult once people had been admitted to inpatient services.

The teams discussed risk factors with people's general practitioners (GPs) and shared information to ensure people's care was being managed consistently. We saw evidence in people's notes of collaboration with police, GPs and local authorities.

Records showed that referrals were made in a timely manner when input was required from other services. Before referrals were made, they were discussed within the multi-disciplinary team.

Staff qualifications, competence and experience

Levels of mandatory training for staff were, in general, met. However, specialist training relating to their area of work was lacking for some staff members, although we received positive feedback about training on the recovery model in particular.

There were some concerns raised about knowledge of drug and alcohol management issues. The service was able to access specialist services operated by another trust. However, staff felt the lack of local services and experience caused problems when working with people who were at risk from ongoing use of drugs or alcohol.

Some staff said they had to pay for their own specialist training due to limited resources.

Are adult community-based services caring?

Choices, decisions and participation

People's views were clearly documented in their notes. This included direct quotes from people about how they felt and what they wanted. This gave a clear picture of how people were involved in their care planning. Staff had

recorded when they had offered people choices about their care, for instance whether to attend an appointment or wait until they could be seen by a doctor, and their wishes were taken into account.

Care plans appeared to be generic and did not always reflect people's own views. However, we saw from progress notes that care was delivered in accordance with people's wishes. Although the progress notes and care planning meetings demonstrated how people were consulted about their views and proposed care was explained, care plans did not always reflect this. The 'client's view' section in the care plan was sometimes not filled in or did not correspond with the care that was being provided. This meant that people's views, goals and wishes might not be communicated effectively to other services involved in their future care although there were examples of good care plans with recovery goals. However, we did find that attempts had been made to include people's views in the restrictive templates and we found examples of how people's families were involved.

Effective communication with staff

Progress notes showed that staff listened to what people said and took their views into account. We found several examples of interactions where people using the service had asked for and received information about their care.

It was clear from the notes that people who used the service felt able to contact the team whenever they felt they needed support and had done so frequently when they needed to. Sometimes people had to wait for referrals to go through or for the team to allocate staff to them. During this time, the service maintained and recorded contact with people and their families and ensured they were kept informed about what was happening with regard to appointments and referrals. Sometimes there was a delay in allocating staff to people, which meant that there was little or no continuity in terms of who had contact with the person and little opportunity to build trusting relationships. Two people whose notes we looked at had commented that they felt they were being passed around several people without anyone taking direct responsibility for their care. One of these people had been under the care of the team for six weeks before a coordinator was allocated. However, the comprehensive progress notes meant that information was shared efficiently among staff and they were able to access this so people did not have to repeat themselves.

We saw an example of a case where the relationship between a person who used the service and their allocated nurse had broken down and the service had allocated another member of staff and recorded that the person was happy with this.

Support for people's needs

People who used the service had core assessments, which contained information about their history, current situation and needs. These were then used to inform care plans and risk assessments. Although progress notes were thorough and of good quality, information from these was not always present in care plans, which as a result did not give a clear picture of people who used the service and how their needs were supported. Because of missing information, it was difficult to see how the care being recorded in progress notes related to information gathered at assessment and agreed with people in the care planning process.

People had access to physical health assessments and mental state examinations. Where these indicated the need for specialist input or treatment, this was planned and provided. This was clearly recorded in progress notes but had not always been indicated in assessment records.

Records of conversations between staff and people who used the service showed that staff were aware of people's needs and what support they wanted. However, sometimes it took some time for those needs to be met and reasons for delays were not documented. We saw records for one person who had repeatedly telephoned the service requesting an appointment with a doctor, but there were no recorded appointments for almost a month and no clear explanation for the delay.

Staff we spoke to all told us that they and their colleagues went out of their way to provide a caring service, such as by spending extra time with people. Records showed that staff took time to explain important information to people, repeating this if required.

Adult community-based services

Are adult community-based services responsive to people's needs?
(for example, to feedback?)

Meeting the needs of the local communities
Care documentation showed that there was thoughtful planning around meeting needs that local services were unable to provide for. We saw that the teams were aware of what specialist services were available and that care was planned around supporting people to access these.

We found that the services had considered how best to communicate with different people, for example by sending text messages or making phone calls.

Working together in periods of change
We saw examples of how the teams had worked with other services when people experienced periods of crisis or change. There were protocols for working with accident and emergency services in times of crisis. When a person who used the service experienced crisis and presented at A&E, staff had discussed their care plan with them and made changes based on their choices. There were, however, some concerns raised around continuing input from community-based teams into people's care after admission into inpatient services and there were communication difficulties between the CMHTs and the home treatment team. For example, we attended the zoning meeting where it was apparent that a patient had been discharged from the CRHT into the care of the CMHT, who were not aware of this beforehand. The team did not discuss how to resolve this issue at the time.

We also found positive examples of communication between services, with evidence of meetings held to discuss the continuity of people's care. The Early Intervention Service met with approved mental health professionals (AMHPs) monthly and discussed AMHP and Mental Health Act involvement during team meetings.

People's notes contained copies of referral letters from other services so that the teams were aware of issues and support needs specific to each person. These were used to formulate care plans.

Learning from concerns and complaints
We noted that when people raised concerns about their care, this was documented in their progress notes. However, it was not always clear how the service planned to learn from these concerns although it was apparent that staff responded by providing reassurance and taking prompt action to resolve them.

Are adult community-based services well-led?

Governance, vision and culture
Staff in both teams told us there was a supportive culture and that they could rely on colleagues and managers for help when needed. Managers were aware of improvements they could make to services. They were open and honest about where improvements were needed and had a clear vision for change.

Effective leadership
Staff felt that the appraisal system was helpful and effective. They had the opportunity to review their goals from the previous year and assess whether they were met. This included training plans, which staff told us were sometimes difficult to complete due to resources. We found that some appraisals were overdue although most staff told us theirs were up to date.

We saw evidence that staff had regular supervision and staff we spoke with confirmed that they had monthly sessions to discuss their caseload and progress. There were also meetings for staff in specific roles to discuss areas relevant to them.

Staff engagement
Staff fed back that they had been involved in the restructuring process and had opportunities to attend regular meetings and give feedback during and after the process.

We were told by staff that the teams' restructure had gone more smoothly than expected. Larger teams meant more resources on a team level and staff felt the changes made it easier to access other services. Staff told us management had used the merger to create new opportunities for staff training.

Community-based crisis services

Information about the service

Kingston Home Treatment Team provide treatment to people in an acute crisis in their own home as an alternative to hospital admission. The team work closely with Lilacs Ward to allow early discharge from hospital. Referrals come from Community Mental Health Teams, GPs or Kingston Hospital. People who have previously used the service may be able to self-refer.

Wandsworth Crisis & Home treatment Team and the Merton Home treatment Team provide 24/7 treatment to people in their own home. They provide an alternative to hospital admission for people in an acute crisis or it can allow early discharge from hospital. People are referred through Community Mental Health Teams as well as duty doctors and GPs out of hours only.

Summary of findings

We found evidence that the teams worked with people to keep them safe. Risk assessments were completed at the first visit along with care plans. We saw people were supported with comprehensive risk management plans.

Staffing levels varied significantly in the teams. Merton team was fully staffed and the team included social workers (AMHPs). All staff we spoke with on this team said they felt the team was well staffed. Whilst Kingston and Wandsworth had vacancies for staff. Staff we spoke with felt that these teams were understaffed even when they had their full complement of workers.

People records we viewed clearly demonstrated collaborative working with MDT's such as district nurses, CMHT's and hospital wards.

We saw that paper care plans were completed during the initial assessment visits with people who used the service. They were then scanned into the trust database system. Most care plans we checked were signed by people and/or their relatives.

The manager told us staff had access to specialist training. Some staff told us they completed CBT training and a recovery worker said they had applied to be seconded to train as a nurse.

We saw that information about the trust complaints system was contained in the welcome packs that people were given.

Community-based crisis services

Are community-based crisis services safe?

Learning from incidents

The managers told us incident reports were completed and sent to the risk management team who provided feedback to managers on a quarterly basis.

We were told, when serious incidents took place, there was an immediate de-briefing with the staff involved. Learning from incidents was discussed during team meetings which occurred weekly in most teams. Staff said they focused on 'how they could avoid the situation happening in the future'. They would also discuss any contingency plans that had to be put in place.

We saw that when people were due to leave a hospital ward and needed support with their medicines, a referral was made, and their medicines and prescription charts were transferred to the home treatment team. We saw that care plans were in place and detailed the type of support needed, for example whether staff needed to supervise people with their medicines, or administer medicines or injections. We saw that care plans included an assessment of the risks associated with medicines, and that care records were updated when people were ready to self-administer their medicines.

Safeguarding

All staff we spoke with told us they had safeguarding training for children and vulnerable adults as part of their annual mandatory training delivered by the trust. They were able to describe the different forms of abuse and how they would respond to any allegation of abuse and this was consistent with local policy.

We were told all safeguarding incidents or concerns were discussed in MDT meetings. We saw copies of notes from these meetings to confirm this. The teams had allocated safeguarding leads. However staff told of occasions where they had raised alerts directly with the council's safeguarding teams directly. We saw examples were this had been done.

Staff in the Merton team told us that it was useful having special workers as part of the team as it allowed for quicker, supportive and robust management of safeguarding issues.

Risk management

We were told that referrals would come with information about risk attached. The teams would then decide whether the initial assessments should be carried out by one or two staff. Full risk assessments were completed at the first visit along with care plans. We saw people were supported with comprehensive risk management plans.

Teams also operated a zoning system which identified the level of risk people presented and the support people needed to manage the risk including any lone working arrangements.

Records we looked at showed initial risk management plans were reviewed and updated when people's needs had changed.

Safe staffing levels

Staffing levels varied significantly in the teams. Merton team was fully staffed and the team make up consisted of nurses, recovery workers, social workers and a full time consultant. All staff we spoke with on this team said they felt the team was well staffed.

Wandsworth team had been managed by a temporary manager for the past six months. The team had three vacancies, one of which was being covered by agency staff. The manager told us the extra work was shared between staff. The team were made up of a part time consultant (four days), nurses and recovery workers. They did not have social workers attached to this team. Staff we spoke with felt that the team were understaffed even when they had their full complement of workers. This team was also responsible for staffing the out of hours emergency line which equated to one member of staff a day.

Kingston team did not have a manager at the time of our visit. We were told the full team establishment was 16 workers. There were six permanent staff in post and four agency staff. Staff we spoke with told us the additional work was being shared out amongst the team. They said that workers in the team felt very stretched and that staff had recently left the team due to stress.

We saw there were different levels of need in teams and we were unable to see that the trust was benchmarking needs against resources.

Are community-based crisis services effective?

Community-based crisis services

(for example, treatment is effective)

Collaborative and multidisciplinary working

There were clear referral notes on file indicating people's care and support needs as well as identified risks. Referrals came from the Community Mental Health Teams, GPs and hospitals.

Peoples' records that we viewed clearly demonstrated collaborative working with MDT's such as district nurses, CMHT's and hospital wards.

We saw that teams had a good interface with wards on a regular basis which included weekly meetings. There was also cross cover arrangements in place where consultants from the home treatment teams covered for ward consultant's absences and vice versa.

People used the services for approximately six weeks after which they either went back to CMHT's, were admitted into hospital or discharged back to the care of their GP. We noted that teams did not have processes in place to follow up on people who had been discharged back to their GPs. Therefore there was the potential for people to get lost and only come back in contact with services when they became very unwell.

Staff qualifications, competence and experience

All staff we spoke with told us they had access to regular mandatory training. Managers told us all staff on the wards were up to date with their mandatory training. Staff we spoke with told us they were up to date with their training and hey received alerts when they were due.

The manager told us staff had access to specialist training. Some staff told us they had completed CBT training and a recovery worker said they had applied to be seconded to train as a nurse.

All staff told us they had regular one to ones. We saw copies of some notes to confirm staff had been supervised at least every six weeks. Staff on the Kingston team told us they had not had a one to one since December 2013. However, they said they had weekly team meetings and daily hand overs.

Are community-based crisis services caring?

Choices, decisions and participation

We saw that paper care plans were completed during the initial assessment visits with people who use the service. They were then scanned into the trust database system. Most care plans we checked were signed by people and/or their relatives. Care plans clearly showed the views of people and how they would be involved in achieving goals identified.

We found that most people were seen more than once a week initially and that discussions took place with people about whether to decrease or increase these visits. We saw from the notes people's views were clearly taken into account. However, there were some occasions when workers had to make decisions against the wishes of people using the service. When this happened the reasons why were clearly documented and were discussed with people's relatives.

We noted that staff we spoke with had a good understanding of the Mental Capacity Act. We saw evidence that capacity was assessed when staff expressed concerns. We saw capacity assessments on the systems and these were carried out by nurses and consultants.

Effective communication with staff

Staff in all teams told us team meetings took place weekly. They said they discussed people's care packages and any changes to risk zones and/or visit frequencies. We saw notes from some of these meetings and saw they were usually attended by all staff

We were told teams did not operate a keyworker system. Cases were allocated on a daily basis and as such progress notes always had to be up to date. Staff we spoke with showed us they checked progress notes, risk assessments and tried to have conversations with colleagues who had last seen the person they were visiting that day.

Support for people's needs

People's referral notes and initial assessments contained information about their history of treatment, support and physical health needs which were then used to inform the care plans.

Community-based crisis services

We saw that where physical health issues were identified staff clearly made referrals to relevant medical professionals such as GPs, dentists and opticians. We saw that where someone was suffering from a serious illness staff had supported them at hospital appointments.

Merton and Wandsworth team offered alcohol detox and clozapine initiation to people whilst living at home. This was very closely monitored with people receiving three or four visits a week.

Are community-based crisis services responsive to people's needs?
(for example, to feedback?)

Meeting the needs of the local communities
Staff told us they very rarely supported people who were not from their catchment area. They said on occasions they had to send people to other boroughs if they had to access hospital beds when people became very unwell.

We saw information in offices about local specialist services and found that staff had a good knowledge of local resources.

Learning from concerns and complaints
People were made aware of the complaints system at their initial assessment. Staff told us they always informed people about how to make comments and complaints. We saw that information about the trust complaints system was contained in the welcome packs people were given.

Staff said few formal complaints were made as many issues were resolved informally in a co-operative manner. We saw in records that people had requested not to be supported by certain workers. Reasons were always fully explored, however on most occasions changes were made.

We were told all formal complaints were recorded by the team managers and forwarded to the trusts' complaints team. They would then investigate and respond directly to the complainant and send a copy to the team managers.

We saw that complaints were a standing item on team agendas at their weekly meetings. Staff told us that complaint analysis reports sent out by the trust were also discussed at team away days.

Are community-based crisis services well-led?

Effective leadership
Staff in all teams told us they felt their managers were knowledgeable, supportive and approachable. We found that team managers were aware of the development needs of staff and the support needs of people who used the service.

Most staff we spoke with felt disconnected from the senior managers at the trust and could not comment as to whether they felt the trust was well led.

Specialist eating disorder services

Information about the service

The eating disorders outpatient service provides assessment, diagnosis and treatment to people suffering with moderate to severe eating disorders including anorexia nervosa, bulimia nervosa and binge eating disorder. It is primarily a local service for those who live in the five boroughs that the Trust serves: Merton, Sutton, Wandsworth, Kingston and Richmond. The service operates a 'hub and spoke' model across the five boroughs so that it is accessible for people who use the service and key stakeholders, such as the community mental health teams and GPs. The service currently has 200 people using the service.

The adult day unit provides a five day service, Monday – Friday, for up to 10 people with a diagnosis of an eating disorder who require a more intensive treatment programme. Treatment is offered via groups and individual sessions, including community based activities, to assist in transferring skills to home and social environments. A range of professionals work in the multi-disciplinary team including nurse, doctor, occupational therapist, psychotherapist, dietician and outreach workers.

We spoke with staff, including doctors, nurses, managers, outreach workers and therapists. We observed a multi-disciplinary team meeting. We spoke with people who use the service and looked at care and treatment records.

Summary of findings

Care and treatment was provided to people in a way that was safe. Individual risks were assessed and plans were in place to manage identified risks. Staff understood the trust's safeguarding policy and procedures and made appropriate referrals to local authority safeguarding teams. There were sufficient staff in the out-patient team and day service to ensure people were cared for appropriately and safely.

People`s care and treatment reflected relevant research and guidance. Use of evidence-based practice was evident in terms of the assessment and management of people's needs. There were clear pathways of care between services which ensured people's needs were met in a seamless manner. Recent evaluations of both services showed that people who use the services benefitted significantly in terms of improvement in health and quality of life. Staff were appropriately trained and supported to provide high quality care and treatment. They were described as flexible, open and non-judgemental.

People told us they felt respected by staff and involved in making decisions about their care. People's needs were assessed and care and treatment was tailored to their individual needs. Care plans were reviewed regularly to ensure they remained appropriate to people's needs. Staff respected the privacy and dignity of people using the service.

The services were flexible and responded to people's needs. People's religious, cultural and other individual needs were addressed. The eating disorders services worked well with other teams and providers at times of transition, such as a person's transfer or discharge from the service. This helped ensure appropriate support was in place before a person was discharged. There was an effective complaints process in place.

The services were well-led, the culture open and staff were encouraged to reflect upon their practice. People were regularly asked for their opinions about the service and action was taken to improve services in response to feedback. Staff knew about developments in the trust as a whole but often felt disconnected from the trust board

and senior management. Many staff told us they doubted the trust board fully understood the needs and complexity of the eating disorders service and did not think their views were represented at board level.

Are specialist eating disorders services safe?

Safe environment

People who use the eating disorders day service were cared for in a safe and secure environment. Staff we spoke with were aware of the trust's lone working policy and arrangements for maintaining safety in the community.

Learning from incidents

Staff knew the types of events, near misses and incidents they needed to report and how to report them. There was evidence that learning from incidents in other trust services was shared with staff in both individual supervision sessions and within team meetings. Appropriate changes were implemented to minimise the risk of incidents reoccurring.

Safeguarding

Staff had undertaken training in safeguarding vulnerable adults and knew how to respond appropriately to any allegation of abuse. There were detailed policies and procedures in place in respect of safeguarding to support staff to respond appropriately to concerns. Staff knew where to refer safeguarding concerns and where to obtain safeguarding advice if needed. Staff provided examples of appropriate referrals they had made to local safeguarding teams. People we spoke with told us they felt safe using the service.

Whistleblowing

All staff we spoke with were aware of the trust's whistleblowing process. Staff felt confident in raising concerns and knew how to escalate these if necessary.

Managing risk to the person

There were procedures in place to identify and manage risks to people who use the service. Patient safety was taken into account in the way care and treatment was planned. The day unit had good links with the local acute hospital and staff were able to obtain the results of blood tests promptly. A dietitian monitored re-feeding programmes to ensure these were completed safely. The service liaised with the inpatient unit to ensure people could have blood tests at the weekend if needed. The physical health needs of people were well managed.

We reviewed the electronic records of three people who use the day service, including their care plans and risk

assessments. We saw that there were individual risk assessments in place related to people's assessed needs. There were clear risk management plans in place for the risks identified.

Risk management

Regular meetings were held to review risks to overall service delivery. Key performance data was analysed and reported to the monthly directorate performance review. This information included areas considered to be possible warning signs including staff changes and levels of compliance with statutory and mandatory training.

The outpatient and day services used a system of zoning in order to manage risk and prioritise resources. The zoning system identified people's levels of risk and ensured resources were targeted according to the level of risk identified. For example, those people assessed as being at greater risk were categorised as red and were reviewed more frequently. Those people who were stable and required less intensive support were categorised in the green zone. We saw that people's progress notes in their electronic records identified which zone they were in and consequently how any identified risks were to be managed. Zoning was reviewed weekly at multi-disciplinary team meetings and ensured people's safety needs were met.

Safe staffing levels

We found that there were enough members of staff to care for people who use the outpatient and day service safely, although staff told us there had been a recent reduction in staffing which had led to the cancellation of some therapeutic groups.

Are specialist eating disorders services effective?

(for example, treatment is effective)

Use of evidence-based clinical guidance and standards

People`s care and treatment reflected relevant research and guidance. Staff followed National Institute for Health and Care Excellence (NICE) guidelines in respect of eating disorders when providing care and treatment. Use of evidence-based practice was evident in terms of assessment and management of people's needs in a multi-disciplinary team meeting we observed in the outpatient service.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

There was evidence of effective multi-disciplinary team (MDT) working. People who use the service had access to nursing and medical staff as well as psychologists, psychotherapists, occupational therapists, social workers and a dietitian. We saw that care plans included advice and input from the different professionals involved in people`s care. People who use the service told us they worked closely with a number of different professionals as part of their care plan.

The outpatient service had close links with the eating disorders inpatient service and day unit services and could refer people to these services as needed. We observed evidence of clear pathways of care between the outpatient team, day service and inpatient ward during a multi-disciplinary team meeting. The service supported community mental health teams to provide care and treatment to people with complex needs and a co-morbid diagnosis of eating disorder. The service worked jointly with complex care teams when people had a dual diagnosis of eating disorder and personality disorder. Joint working was described as effective by staff.

People`s health, safety and welfare was protected when more than one provider was involved in their care and treatment. Care programme approach (CPA) meetings took place and were attended by other health care providers, for example, the person`s community care co-ordinator. People's records showed when CPA meetings had taken place and the decisions made regarding people's care and treatment.

People who were close to discharge told us there were clear plans in place to manage their care and treatment in the community. Key health professionals supporting them in the community were identified in their discharge plan. Staff told us that discharge planning started early in the course of treatment and a date for discharge was set so that people knew what they were working towards.

Monitoring the quality of care

The day unit had conducted an evaluation of the service and produced a report on its effectiveness in February 2014. People who use the service had been asked to complete a set of questionnaires at the start and end of treatment. Results showed that people experienced fewer

eating disordered thoughts and behaviours post treatment. People were also at lower risk and experienced a better quality of life post-treatment. The results were fed back to the staff team to inform ongoing service development.

An evaluation of the outpatient eating disorders service was carried out in February 2014. Data from 66 people who use the service was analysed and results showed similarly positive results. People experienced a significant decrease in eating disordered thoughts and behaviours post-treatment. They also experienced better functioning and quality of life and were considered to be at lower risk.

The day service programme was modified in response feedback from people who use the service. For example, groups were removed if they proved unpopular with people.

Suitably qualified and competent staff

Staff received appropriate training, supervision and professional development. Staff told us they had undergone recent training pertinent to their role including in safeguarding vulnerable adults. Most staff were up to date with statutory and mandatory training requirements. New staff undertook a period of induction and shadowed other staff for several days before being included in the staff numbers. This helped ensure staff were able to deliver care to the people safely and to an appropriate standard.

There were suitable arrangements in place to ensure that staff received appropriate professional development and so were able to provide high quality care and treatment to people with eating disorders. Some additional specialist training was available to staff usually involving discussion during team meetings and shadowing other staff, although staff told us it was difficult to obtain funding for external courses. Staff we spoke with understood the needs of people they supported.

Staff were supported and supervised to provide care and treatment to people. Staff told us that they received regular individual and group supervision and had completed an annual performance appraisal. Staff commented that professional supervision was particularly good. Reflective practice groups took place every two weeks which enabled staff to share good practice with others and consider alternative approaches to care.

People who use the service told us that staff were knowledgeable about eating disorders and mental health in general and provided a high standard of care and treatment. Staff were described as flexible, open and non-judgemental.

Are specialist eating disorders services caring?

Choice in decisions and participation in care

People told us they felt respected by staff and involved in making decisions about their care. Assessments were made in respect of a person`s capacity to make specific decisions. We saw that care plans reflected individuals' needs and choices.

People who use the service understood the care and treatment choices available to them.

Care and treatment plans were developed with the person using the service. People were included in a review of their care plans and their views were recorded.

Effective communication with staff

People who use the service told us that they felt well informed about their treatment. They felt able to ask questions about their care and treatment and information was provided in a way they understood. People we spoke with told us they felt listened to by staff.

People had an individual therapy programme which addressed their individual needs. There were community meetings several times a week where people could raise any concerns they had about the service. People wrote letters which were submitted to care plan reviews outlining their views on their progress and identifying any changes to the treatment plan they wished to make.

People receive the support they need

People`s needs were assessed and care and treatment was tailored to their individual needs. Records showed that risks to physical health were identified and managed effectively. We reviewed several care plans and these showed that individual person-centred plans were in place which addressed people's assessed needs. Care plans were detailed and included the views and comments of people who use the service. Staff provided examples of how people's cultural, religious and other individual needs were met. These needs were reflected in people's care plans.

Specialist eating disorder services

A range of therapies were available depending upon people's assessed needs, including cognitive behavioral therapy, dialectical behavior therapy and family therapy. Outreach workers supported people`s recovery in the community, including accompanying them for social eating and helping with budgeting and shopping for food. People in the day service met weekly with a named member of staff to review their progress, care plans and ensure they remained appropriate to their needs. These meetings were led by people who use the service.

People were very positive about the staff who supported them. We observed staff interacting with people in caring and compassionate ways.

Recovery

The service used a recovery approach to working with people. Recovery goals were clearly stated in people's care plans. People identified their own goals and what they hoped to achieve during their admission to the day service.

Privacy and dignity

People`s privacy and dignity were respected. People who use the service told us staff treated them with respect. Individual sexual orientation was respected and people told us they had not experienced any discrimination from staff or others. Staff talked about people who use the service respectfully during a multi-disciplinary team meeting we observed.

Are specialist eating disorders services responsive to people's needs?

(for example, to feedback?)

Meeting the needs of the local community

The outpatient service and day unit provided a service to people in the local community with eating disorders. The service was flexible and responded to people's needs. For example, transport to the day service was provided for some people depending upon their specific needs and particularly when their body mass index was very low.

The specific cultural, religious and individual needs of people were met. The service was able to respond effectively to the religious needs of a person using the service and ensure an area for prayer was available and requests for same-sex therapists were met where possible.

Providers working together during periods of change

There were good links with the adult eating disorders inpatient service. A nurse on the ward acted as the main liaison between the inpatient and outpatient services and people were able to move effectively between services in a gradual manner. People who were to be discharged from the ward to the day unit usually attended the service during the day and slept on the ward at night to ensure a smooth transition prior to their final discharge from the inpatient service.

The service worked jointly with community services such as the home treatment team and complex care team to enable people to be discharged safely. GPs were invited to people's care programme approach meetings, although staff noted they were not always able to attend. GPs were sent discharge summaries when people completed treatment with the service. Staff worked with people to increase independence and reduce input from the service in preparation for discharge. Everyone received a seven day follow-up after discharge to ensure that the necessary support arrangements were in place.

Learning from complaints

There was a system in place to learn from complaints. The complaints procedure was displayed in the day unit and people who use the service told us that they knew how to raise concerns and make a complaint. Alternatively they could raise concerns at service community meetings or would approach individual staff. People told us this was usually effective. For example, a person who had raised a concern with staff said the problem had been resolved promptly. Everyone we spoke with told us they were happy with the service and did not have any complaints.

Are specialist eating disorders services well-led?

Governance Arrangements

There was a clear governance structure in place that supported the safe delivery of the services. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust. A staff member told us they were kept informed of developments within the trust through a regular trust bulletin called 'Insight.'

Specialist eating disorder services

Staff and therapists in the service were concerned that the modern matron, who had many years of experience in eating disorders, was the matron for the inpatient adult eating disorder service only. The management of the eating disorders care pathway was split between different modern matrons and staff considered this a lost opportunity in terms of best use of the expertise available. However, we noted that the inpatient and outpatient services were managed jointly at an operational management level, which helped ensure the eating disorders pathway was effective.

Engagement with staff

Staff told us they considered the trust board and senior management did not fully understand the needs and complexity of the eating disorders service. They felt the trust wanted the service to fit into standard trust systems, some of which failed to acknowledge the complex needs of people with eating disorders. For example, the trust required that each person using services had two recovery goals written in a certain way. Staff told us that people using the eating disorders service already had recovery goals which they identified for themselves. Senior clinicians in particular did not feel listened to by senior trust managers. Communication with the trust board was not seen as a two-way process and staff did not think their views were represented at trust board level. This view was not recognised by a senior manager we spoke with who highlighted the involvement of senior clinicians in a review of eating disorders services. However, the senior manager said they planned greater engagement with staff to ensure communication was more effective.

Engagement with people who use the service

The service regularly asked people for their opinions about the service provided. There were community meetings where people were able to raise issues and concerns about the service. Concerns were fed back via local governance structures. Where action had been taken to address people's concerns they were informed of the outcome. People in the day service told us that they were asked for their views. An 'ideas box' was placed in the service where people could post suggestions for changes or improvements in the treatment programme and these were acted upon.

An evaluation of the day service in February 2014 showed that most people were satisfied with the service they received. Most people considered the treatment was suitable and the majority reported it had been successful. A similar evaluation of the outpatient eating disorders services indicated that people felt their treatment had been suitable and successful and were very pleased with the service they received.

Effective leadership

We found that the day unit and outpatient team were well-led and there was evidence of clear leadership from the managers and senior clinicians, which was demonstrated in a multi-disciplinary meeting we attended.

The culture on the day unit was open and encouraged staff to reflect upon their practice. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by senior managers.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows: Comprehensive management plans were not consistently being put in place for people using the service where a risk to themselves or others had been identified. This was a breach of Regulation 9(1)(b), 9(2)