

**Good**

Central and North West London NHS Foundation  
Trust

# Community-based mental health services for older people

## Quality Report

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Date of inspection visit: 23 – 27 February 2015  
Date of publication: 19/06/2015

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/unit/team)              | Postcode of service (ward/unit/team) |
|-------------|---------------------------------|----------------------------------------------------|--------------------------------------|
| RV3EE       | Stephenson House                | Harrow older person CMHT                           | NW9 0PS                              |
| RV3EE       | Stephenson House                | Brent older person CMHT                            | NW9 0PS                              |
| RV3EE       | Stephenson House                | Brent memory Service                               | NW9 0PS                              |
| RV3EE       | Stephenson House                | Hillingdon older person CMHT                       | UB8 3NN                              |
| RV3EE       | Stephenson House                | Hillingdon memory service                          | UB8 3NN                              |
| RV3EE       | Stephenson House                | Kensington, Chelsea and Westminster Memory Service | W2 5PH                               |

# Summary of findings

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We gave an overall rating for community based services for older people as **good** because:

The support provided by the older persons' community mental health teams and the memory services was thoughtful, respectful and considered peoples individual needs. The teams also worked closely with carers and relatives.

The teams had appropriate staffing levels. Where there were recruitment challenges, there were plans in place to attract new staff. Bank and agency staff were used where needed. Staff had access to a range of training to perform their roles and felt well supported.

People using the service were assessed and had care plans and risk assessments in place. Further work should be done to ensure physical health needs are covered in

all care plans and the care plan format is accessible to people using the service and their carers. The staff were making very good use of the Mental Capacity Act to support people to make complex decisions.

Waiting times from referral to assessment varied between teams, with people referred to services in Hillingdon experiencing longer waits. People who made the referrals were advised they could contact the team again if the person's needs changed while they were waiting for an assessment. Services were delivered in a reliable and flexible manner to accommodate people's individual circumstances.

The teams were able to follow best practice guidance and there were examples of innovative developments.

# Summary of findings

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

### Are services safe?

We rated safe as **good** because:

The clinic rooms we saw were well-equipped with the necessary equipment to carry out physical examinations.

All services have reviewed the number of staff required and can adjust staffing levels by assessing the level of patient need on a daily basis.

People had individual risk assessments in place that were reviewed when needed.

All incidents are reported as necessary and staff had opportunities to discuss and learn from these incidents.

Good



### Are services effective?

We rated effective as **good** because:

People had a full initial assessment and personalised care plans although not all care plans included full physical healthcare management plans, despite physical health issues noted on initial assessments.

Staff were using NICE guidance when supporting people who used the service.

All staff were appropriately inducted and had access to on-going training and supervision, although the frequency of supervision needs to be maintained in some teams.

The teams were making good use of the Mental Capacity Act to support people with complex decisions.

Good



### Are services caring?

We rated caring as **good** because:

Staff were caring, supportive and respectful to people using the service and their carers.

People who use the service were supported to be involved in decisions about their care and staff had a good understanding of their individual needs.

The service encouraged people who used the service to give feedback about their care as a way of improving the work of the teams.

Good



### Are services responsive to people's needs?

We rated responsive as **good** because:

Good



# Summary of findings

The CMHT services had strong triage systems which prioritised and ensured assessment of urgent referrals. The whole teams were able to explain this process and reported it worked well in minimising risk and responding to urgent need. In Hillingdon there were longer waiting times from referral to assessment but referrers were told to contact the team if people's needs changed.

Most of the appointments took place in people's homes, but where people attended clinics these environments were accessible and provided the necessary facilities. Appointment times were flexible to fit in with people's individual circumstances.

The services recognised people's culture, religion and individual needs in terms of their disability and tried to ensure people received support in an appropriate manner such as through the use of interpreters.

People knew how to make a complaint. Informal concerns were not logged in one place so that areas for improvement were not collated.

## Are services well-led?

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

The teams all spoke passionately about the values of the trust as well as the service they were part of. They appeared to take pride in knowing the values of the trust reflected their professional values.

Staff spoke highly of their managers and their supportive team. They did speak of some high caseloads and pressure on the team, but overall they were confident in the ability of the service they worked for to cope with the demand and complex nature of the work.

Staff described the whistleblowing process, and said they would speak with their manager or senior staff if they had concerns.

**Good**



# Summary of findings

## Information about the service

The community services for older people we inspected were based at Fairfield House in Brent and The Woodlands Centre in Hillingdon.

The Harrow community mental health team (CMHT), Brent CMHT and Brent Memory service was based at Fairfield House.

The Hillingdon CMHT and the Hillingdon memory service was based at The Woodlands Centre.

The Kensington & Chelsea and Westminster memory clinic was based at 42 Westbourne Park Road.

The community teams supported people with a primary diagnosis of dementia (this excludes traumatic brain

injury and Korsakoff's). They supported people with a mental disorder and significant physical illness or frailty which contributed to or complicated the management of their mental disorder, this may include people under the age of 60 years.

The community teams also supported people with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by an older peoples' service. This would normally include people over the age of 70 years.

The memory clinics provided assessment and diagnosis of dementia and provide on-going support and information to people with memory problems.

## Our inspection team

The team that inspected the community based services for older people with mental health problems consisted of 14 people: two experts by experience, four inspectors, two Mental Health Act reviewers, two nurses, two psychiatrists, one occupational therapist and one

dietician. Five people on the team visited Fairfield House, five people visited The Woodlands Centre and two people visited the Kensington, Chelsea and Westminster Memory service.

## Why we carried out this inspection

We inspected this trust as part of our on-going comprehensive mental health inspection programme.

## How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited 3 community mental health teams at the two sites and visited 3 memory services. We looked at the quality of the environments and observed how staff were supporting people using the service.
- Spoke with 10 people who were using the service and five carers
- Spoke with the managers or acting managers for each of the teams
- Spoke with 9 staff members including occupational therapists, nurses, support workers and student nurses

We also:



# Summary of findings

- Looked at 19 care records of people who used the service.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

We spoke with people who were using the services. They were all positive about the service provided by the community teams. They told us that they found the staff to be passionate, caring and respectful.

## Good practice

Brent and Kensington & Chelsea and Westminster memory clinics are accredited by the Royal College of Psychiatrists as 'excellent' as part of their memory service national accreditation programme.

The Brent memory service had introduced five primary care dementia nurses (PCDN). The PCDN was developed from the Admiral Nurse model which is patient and carer

focused and described as having 'one foot in the memory service and one foot in GP surgeries'. The role was intended to support GPs to better manage patient care and reduce referrals to the service as well as enabling people who use the service to stay in their own home with support for longer.

## Areas for improvement

### **Action the provider SHOULD take to improve the community-based mental health services for older people**

- The care plans should include a full physical healthcare management plan where physical health issues noted on initial assessments.
- The teams should explore if care plans can be provided in a more accessible format.
- The services should ensure all staff have access to regular formal supervision
- The services should collate informal verbal complaints so that lessons can be learnt from these.

## Central and North West London NHS Foundation Trust

# Community-based mental health services for older people

### Detailed findings

#### Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---------------------------------------|---------------------------------|
| Brent older person CMHT               | Fairfield House                 |
| Harrow older person CMHT              | Fairfield House                 |
| Brent Memory Service                  | Fairfield House                 |
| Hillingdon older person CMHT          | Woodlands Centre                |
| Hillingden Memory Service             | Woodlands Centre                |
| Kensington and Chelsea Memory Service | 42 Westbourne Park Road         |

#### Mental Health Act responsibilities

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

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

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

# Are services safe?

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

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

## Summary of findings

We rated safe as **good** because:

The clinic rooms we saw were well-equipped with the necessary equipment to carry out physical examinations.

All services have reviewed the number of staff required and can adjust staffing levels by assessing the level of patient need on a daily basis.

People had individual risk assessments in place that were reviewed when needed.

All incidents are reported as necessary and staff had opportunities to discuss and learn from these incidents.

- The trust had a robust strategy for managing recruitment across the services and we were informed by the service managers that recruitment was a priority. We heard about targeted recruitment that was taking place. We also saw that staff rotas were managed electronically and cover was arranged when staff were not working.
- At Fairfield House we found that bank members of staff were covering vacant roles. Bank staff were expected to complete the same mandatory training as the permanent staff. The impact on the team and workload due to the vacant posts was regularly monitored by the team manager and the service manager.
- At Hillingdon CMHT we found the service used agency staff on a regular basis. The manager reported that it was difficult to always get the same staff who were familiar with the service.

## Our findings

### Safe and clean environment

- The majority of visits are conducted in the community in people's homes. If people who used the service came to the building, it was expected that the staff member would risk assess this and discuss any concerns about safety with senior staff members to agree how safety for both the person that used the service and staff would be managed.
- The clinic rooms we saw were well-equipped with the necessary equipment to carry out physical examinations.

### Safe staffing

- All services had reviewed the number of staff required and could adjust staffing levels by assessing the level of patient need on a daily basis. All of the CMHT services reported having problems recruiting to posts.
- Brent CMHT included a home treatment team (HTT). This was unable to provide a full service because it had not been possible to recruit to the vacancies. One member of staff was providing a limited service. This person had been given clear guidance regarding expectations and their workload was manageable.

### Assessing and managing risk to patients and staff

- Staff completed a risk assessment of every person at the initial assessment and updated this regularly. We were informed all risk assessments were reviewed at least annually depending on the level of risk.
- We reviewed care records and found the initial risk assessments were thorough. However, we saw two examples of risk assessments which had not been reviewed or updated for a year. This was reported to us as being due to the people being low risk.
- Staff were able to articulate how they would work with advanced decisions. However, there were none currently on record.
- Safeguarding training was a mandatory training. The service managers were the safeguarding leads. All staff interviewed were able to discuss what constituted a safeguarding concern and how to make a referral to the local authority safeguarding team or escalate to their manager as appropriate.
- In Hillingdon the service operated a safe working system to support lone workers. Staff members kept their diaries up to date and this could be monitored

# Are services safe?

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

supervisors. At the Woodlands Centre staff return times from home visits were not formally monitored. Staff were able to tell us they would contact their colleagues by phone if there was a problem on the visit.

- Harrow CMHT administered injectable medications on the premises and had a fridge to store medication. This was checked and found to comply with proper medication management standards. Brent CMHT did not keep medication on site. In the other services they made recommendations to the GP and medication was dispensed by the district nursing service.

## Track record on safety

- There were no serious untoward incidents in the last year associated with these services.

## Reporting incidents and learning from when things go wrong

- All staff we spoke to knew how to report incidents through the electronic recording system. Team managers reported they felt the team were highly knowledgeable regarding matters of safeguarding and reporting incidents.
- Staff members were aware of the trust process for investigating incidents and cascading the information

and learning through bulletins and emails to team managers. Staff received feedback from incidents from other parts of the trust and were able to discuss recent incidents where change in practice had resulted.

- There were good procedures in place for feedback and discussion regarding incidents which occurred within the service across the three services visited. This included the multi-disciplinary team (MDT) debrief sessions and reflective practice sessions. Staff members reported they felt encouraged to discuss incidents and learning in formal supervision. Staff told us they could access informal supervision as required. Referrals to counselling for staff were available.
- There was evidence both CMHT team managers were closely involved working with staff in relation to concerns raised by people who use the service and carers. In one incident Brent CMHT team manager conducted a joint visit with the staff member to meet with a carer who expressed dissatisfaction with the support provided. This resulted in a referral to the Local Authority for a carer assessment and the team manager feeding back to the team regarding the importance of listening to carers, giving them time and making referrals to other agencies when appropriate.

# Are services effective?

Good 

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

## Summary of findings

We rated effective as **good** because:

People had a full initial assessment and personalised care plans although not all care plans included full physical healthcare management plans, despite physical health issues noted on initial assessments.

Staff were using NICE guidance when supporting people who used the service.

All staff were appropriately inducted and had access to on-going training and supervision, although the frequency of supervision needs to be maintained in some teams.

The teams were making good use of the Mental Capacity Act to support people with complex decisions.

an alternative. The services try not to prescribe anti-psychotic medication and would only consider it as a last resort. We saw evidence of staff monitoring people who used the service and were prescribed anti-psychotic medication.

- A range of speciality psychological interventions are available for people who use the service.
- It was evident that clinical staff were involved with audits for all three CMHT services. Staff spoke to us about clinical audits currently taking place and future plans to complete an audit on prescribing medication with more junior doctors.

### Skilled staff to deliver care

- All new staff completed a corporate and local induction. There was also mandatory and statutory training available. We saw training records for all services and these were up to date.
- We were told that supervision should take place once a month. However staff told us this did not always happen as frequently as required. The staff reported the manager and team leader to be approachable and always available to talk through any issues.
- Specialist training was available and staff reported they could discuss their training needs in supervision. This was included in staff's personal development plan. Those staff members who completed training were encouraged to share learning with the team. We were informed of recent training regarding "hoarding" run by the local authority and attended by a number of people from the Brent team who fed back to the team about this learning. There was evidence of a strong occupational therapy network in the trust and good opportunities for individual and shared learning. At the Woodlands centre we found specialist training was available, for example the home treatment team manager was providing dementia training for the team. Staff told us they would benefit from physical health training as they do not feel they have adequate knowledge.
- There were no staff being performance managed across the services at the time of the inspection.

## Our findings

### Assessment of needs and planning of care

- Comprehensive initial assessments were completed for each person including an assessment of their physical health. For example Harrow CMHT arranged ECG and blood tests at the initial assessment at Northwick Park Hospital.
- Care plans were up-to-date and person centred. However, not all care plans included full physical healthcare management plans, despite physical health issues noted on initial assessments. For example one patient record stated that the patient had a stroke but the corresponding care plan did not mention this in the physical health section. Another patient had a record of concerns by carers that they were losing weight but there was no record of how this had been followed up. Staff said there was good partnership working with GPs and district nurses in relation to peoples' physical health.

### Best practice in treatment and care

- Staff we spoke with from all three CMHT were aware of NICE guidance and how to access this on the trust intranet. Staff gave us an example of requesting the GP to stop prescribing anti-psychotic medication to a patient with dementia and replace the prescription with

# Are services effective?

Good 

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

## Multi-disciplinary and inter-agency team work

- The teams included or had access to a range of mental health professionals required to support the people using the service. This included psychiatrists, psychologists, nursing and therapists. There was access to pharmacy input.
- In some teams the social workers were based in the same building but were not integrated into the team. In Hillingdon the social workers were in a different building but the team said the links worked well. Concerns were raised regarding the lack of integration in Brent and the challenges this can present, particularly in relation to safeguarding. There have been occasions when a safeguarding referral has been made to the local authority but they did not investigate and closed the referral. The team manager has escalated these concerns and will continue to do so.
- Multi-disciplinary team (MDT) meetings took place in each service weekly and were well attended by staff from all disciplines. Staff members reported the meetings were well chaired, with different people taking the chair and they found them useful and supportive. We observed an MDT meeting at the Woodlands Centre and at the Harrow team and found them to be very inclusive, taking all staff contributions into account and people's needs and risks were discussed respectfully and thoughtfully.
- Good working relationships and information sharing were reported by all three services with other organisations including the crisis team, inpatient services, GPs and district nursing. Community team members attend meetings on the inpatient wards.

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

- Staff were trained in and had a good understanding of the Mental Health Act (MHA) and the code of practice and the guiding principles although in the Brent CMHT the team manager felt that staff knowledge could be developed further.

- Staff told us they felt well advised and supported by management regarding the implementation of the MHA and the code of practice.
- There was one patient on a community treatment order (CTO) for both Harrow and Brent CMHT. The records were looked at in detail and found to be kept to a high standard.
- People who used the service had access to the Independent Mental Health Act (IMHA) service. Leaflets were provided to people who used the service and were easily accessible in the reception area of the buildings. The team leader of the IMHA service in Hillingdon was invited to the team meeting to inform staff about their service and how to access them.

## Good practice in applying the Mental Capacity Act

- Staff were trained in the Mental Capacity Act 2005 (MCA) and demonstrated a good understanding of the MCA and the five statutory principles.
- There was a policy on MCA on the staff intranet which staff could access and staff were able to tell us this and show us the policy.
- Capacity assessments were done on a decision-specific basis for significant decisions. People who used the services were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity.
- Capacity issues were discussed at the MDT meetings and the team supported one another with complex decisions. We saw a number of patient records including thorough details of capacity issues and assessments carried out. For example, a person who used the service declined a referral to the falls clinic. A capacity assessment was appropriately carried out and it was agreed that the patient had capacity to decline the referral.
- Best interest meetings took place and included the involvement of family members. We received good feedback from carers about how they had been involved in the assessment and decisions about care and no concerns were reported.



# Are services caring?

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

## Summary of findings

We rated caring as **good** because:

Staff were caring, supportive and respectful to people using the service and their carers.

People who use the service were supported to be involved in decisions about their care and staff had a good understanding of their individual needs.

The service encouraged people who used the service to give feedback about their care as a way of improving the work of the teams.

## Our findings

### Kindness, dignity, respect and support

- During community visits we observed the staff to be caring, respectful and supportive. On one occasion a staff member supported the person to have their voice heard during a multi-disciplinary team (MDT) visit with outside agencies. This resulted in their physical health needs being addressed.
- Positive feedback was received from people who we met during community visits and from those we spoke to by telephone.
- We observed a staff member comforting and reassuring a new patient who had just received their diagnosis of dementia, encouraging them to engage with support and signposting them to the people who use the service community group and advocacy services.
- The services adhere to the trust's policy on confidentiality. People who used the service informed us they felt their information was treated confidentially.

### The involvement of people in the care that they receive

- People were involved in their care planning and participated in care programme approach (CPA) reviews. This was noted on people's care records and people told us they felt listened to and that they were involved in their care.
- Care plans for those people who used the service and were not on a care programme approach (CPA) consisted of a letter, written to the patient and copied to

the GP. The letter stated the support currently provided and changes to medication. We were informed the letters would contain all relevant information for the person including known support from other agencies, as would be expected on a full care plan.

- Feedback received from local focus groups suggested some people who use the service did not like receiving a care plan in the letter format, or did not understand why this was the policy of the CMHT services and felt it was not a proper care plan. The CMHT team managers were not aware of any people who used the service who had expressed this view.
- Families and carers were also supported and involved. This was also highlighted as a challenge on some occasions when the relationship with the person receiving care was positive, but the carer presented a risk or challenged decisions. Staff spoke of this challenge respectfully and stated they had good support from the senior team with these cases and would strive to develop a good relationship with the carer.
- The teams also worked with staff in care homes. One relative we spoke to told us that their mother's community psychiatric nurse (CPN) advised staff at the care home where she lived on how to respond to her mother's repeated requests to go home in order to alleviate her distress.
- People who used the service were given information about advocacy services and how to contact and access them. However, this was noted by team managers as an area to be discussed with the team because there appeared to be low numbers of people using advocacy support and it was assumed in many cases the family or carer took this role.
- There were service user involvement groups and service users had the opportunity to sit on recruitment panels for the services.
- The trust completed patient surveys and collated the results centrally. The service received a report detailing the feedback. There were low numbers of surveys completed in both Harrow and Brent CMHT. This has been prioritised in Harrow and staff members now inform the administrator when they had given a survey to a patient to log the numbers of forms being given.

# Are services caring?

Good 

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

The feedback on the report was all positive for the services, but it was limited and as it was collated centrally across the trust it was difficult to pick out the specific data relating to the individual services.



# Are services responsive to people's needs?

Good 

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

## Summary of findings

We rated responsive as **good** because:

The CMHT services had strong triage systems which prioritised and ensured assessment of urgent referrals. The whole teams were able to explain this process and reported it worked well in minimising risk and responding to urgent need. In Hillingdon there were longer waiting times from referral to assessment but referrers were told to contact the team if people's needs changed.

Most of the appointments took place in people's homes, but where people attended clinics these environments were accessible and provided the necessary facilities. Appointment times were flexible to fit in with people's individual circumstances.

The services recognised people's culture, religion and individual needs in terms of their disability and tried to ensure people received support in an appropriate manner such as through the use of interpreters.

People knew how to make a complaint. Informal concerns were not logged in one place so that areas for improvement were not collated.

service at Brent, work was being done to identify when it would be suitable for other agencies or professionals to lead on diagnosing dementia. This would include GPs, hospital clinicians and the CMHT teams.

- All the CMHTs we inspected had a 10 working day target from referral to assessment for non-urgent cases. In Harrow we were informed urgent cases would be seen within 24 hours. However, in Hillingdon this target is usually not met and the average waiting time was approximately 15-20 working days. In Hillingdon staff do not actively monitor the people who use the service on the list for any changes in levels of risk. This is mitigated by staff contacting the referrer and explaining the waiting time and inviting them to contact the team if there are any changes in the person's level of risk.
- The memory clinics at Brent and Harrow had a target of 30 working days in line with national targets from referral to assessment. It was reported in most cases this was being met, but might take longer where the team is waiting for information from an external agency. The teams target is to reduce the average waiting time to 15 working days, but there is not yet a plan in place to achieve this.
- The Hillingdon memory clinic had a target of 30 days from referral to assessment but the process can often take up to 90 days. The service had a temporary doctor starting mid-March to help with the backlog of referrals.
- The CMHT services had strong triage systems which prioritised and ensured assessment of urgent referrals. All the teams were able to explain this process and reported it worked well in minimising risk and responding to the urgent needs of people.
- Brent CMHT was commissioned to provide a home treatment service, which should have 4 staff members but currently only has one in post who is new to the team. This is due to problems recruiting to the posts and this has been escalated as a concern and risk.
- The team are able to respond to patient phone calls in a timely manner. All calls for Harrow CMHT come through administration and will be passed to the appropriate person. If a member of the team is not available people who use the service can speak with a duty worker.
- The teams follow up DNA appointments, contacting the person to find out the reason for non-attendance and

## Our findings

### Access and discharge

- The CMHT services were aimed at people of any age with a primary diagnosis of dementia (this excluded traumatic brain injury and Korsakoff's), people with mental disorder and significant physical illness or frailty which contributed to, or complicated the management of their mental disorder. Exceptionally this may include people under the age of 60 years. People with psychological or social difficulties related to the ageing process, or end-of-life issues, or who feel their needs may be best met by an older people service. This would normally include people over the age of 70 years.
- The remit of the memory service was to diagnose primary dementia (this excluded traumatic brain injury and Korsakoff's). Due to high demand for the memory

# Are services responsive to people's needs?

Good 

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

offering a new appointment. None of the services operated any policies that offered a maximum number of attempts to make contact before closing the case. Decisions about closing a case when the patient had not engaged were made on an individual basis and would usually involve the MDT.

- The services took patient's individual circumstances into account when arranging appointments and would offer flexibility where possible to accommodate these. Staff members managed their own diaries and could book regular appointments with those who need them and offer flexible times as required.
- The people who used the service told us that visits were not often cancelled. Staff told us that cancelled visits would usually only happen in an emergency or due to staff sickness. All the teams had good working relationships and arranged to cover each other during leave. Information about the number of cancelled appointments for each of the teams was not available.
- The people who used the service with whom we spoke did not report late visits, but staff members stated if they were going to be late they would call ahead or ask someone to do this on their behalf.
- Harrow CMHT had strong working relationships with Ellington ward at Northwick Park and could make referrals when a person's mental health deteriorated. Brent also had a dedicated inpatient unit at Northwick Park with access to 12 beds on Ellington ward. There were also four beds accessible for Brent residents at the two older people wards at St Charles.
- Staff from Harrow CMHT reported some problems discharging people who used the service on anti-psychotic medication back to some GPs because of a lack of a shared agreement between the service and GPs. This issue had been escalated to the team manager. The same issue was not reported by Brent CMHT or the memory service.

## The facilities promote recovery, comfort, dignity and confidentiality

- The reception area at Fairfield House was clean, welcoming and staffed at all times. There was a good selection of leaflets and information available for

people who use the service. The rooms used for consultations or patient meetings were clean and comfortable. They were private and maintained dignity and confidentiality.

- The CMHT and memory clinic at Hillingdon shared a reception area with an inpatient ward. This area was clean, with comfortable seating, information boards and plants.
- We were shown around the buildings we inspected and all the areas we observed were appropriate for the range of treatments offered onsite.

## Meeting the needs of all people who use the service

- All services inspected were wheelchair accessible and it was possible to arrange to meet with people who used the service at other venues if they wished to.
- We saw good evidence on people's records of the use of sign language and access to interpreting services, including one person who required a Dari speaking interpreter. The interpreter was involved closely in all aspects of the support provided and care planning.
- Good use was made of culturally diverse staff teams by the allocation of staff who could speak the language of people who used the services. During a home visit we observed the staff member conducting a follow up assessment with a Punjabi speaking person. Staff informed the person that they would ask their Punjabi speaking colleague to visit them next week, in order to improve the communication.

## Listening to and learning from concerns and complaints

- The people we spoke to knew how to complain about the service and they would speak to their named worker in the first instance or contact the manager. Leaflets were available in the reception and staff members told us they provided this information during the initial assessment.
- There had been very few complaints in the previous 12 months. Staff we spoke to had a good understanding of how they should respond to a complaint. Staff informed us formal complaints are very rare as staff feel they respond to patient concerns in the first instance to prevent the issue becoming a complaint. The Brent

# Are services responsive to people's needs?

Good 

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

CMHT manager spoke of an occasion when she completed a joint visit with a member of the team to respond to a concern from a carer that could have escalated to a complaint, but the carer was satisfied with the response. There was no recording of informal concerns or complaints.

- We did not see a system for recording the informal concerns/complaints other than in the patients notes.

# Are services well-led?

Good 

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

## Summary of findings

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

The teams all spoke passionately about the values of the trust as well as the service they were part of. They appeared to take pride in knowing the values of the trust reflected their professional values.

Staff spoke highly of their managers and their supportive team. They did speak of some high caseloads and pressure on the team, but overall they were confident in the ability of the service they worked for to cope with the demand and complex nature of the work.

Staff described the whistleblowing process, and said they would speak with their manager or senior staff if they had concerns.

- There were no bullying and harassment cases at the time of our inspection.
- Staff described the whistleblowing process, and said they would speak with their manager or senior staff if they had concerns. The staff members stated they felt they would always be encouraged and welcome to do this and also knew where to go if they did not feel able to speak to their direct manager.
- Staff spoke highly of their managers and their supportive teams. They spoke of high caseloads and pressure on the team, but overall they were confident in the ability of the service they worked for to cope with the demand and complex nature of the work.
- The service provides opportunities for leadership development and continuing professional development. We heard about staff who had been able to take a masters in dementia care, funded by the trust.

## Our findings

### Vision and values

- Staff spoke of the organisations' values of wellbeing for life, partnership and recovery. They felt these reflected the work they did and the values of the services they worked for. Staff were happy to promote these values and discussed them with people who used the service.
- Staff knew the senior staff within the trust and their roles within the organisation.

### Good governance

- The teams had information available to support them in managing their services such as staff training, records of staff supervision, records of incidents.
- The trust collated information on key performance indicators so they would know if risk assessments or aspects of care plans were outstanding.

### Leadership, morale and staff engagement

- Overall there were no concerns about high sickness rates, but there were individual instances of high long term sick leave and return to work needs being managed by team managers.

### Commitment to quality improvement and innovation

- The Brent memory clinic was accredited by the Royal College of Psychiatrists as 'excellent'. They had developed a primary care dementia nurse (PCDN) role. The PCDN was developed from the Admiral nurse model which is patient and carer focused and described as having 'one foot in the memory service and one foot in GP surgeries'. The role is intended to support GPs to better manage patient care and reduce referrals to the service.
- The Kensington & Chelsea and Westminster memory service had won the Royal College of Psychiatrists psychiatric team of the year award for older-age adults.
- The Hillingdon memory clinic was not accredited by the Royal College of Psychiatrists (unlike Brent and Kensington & Chelsea) due to staffing levels however the team leader is keen to look into identifying obstacles to accreditation and developing an action plan.
- The teams were not currently involved in any research however the home treatment team in Hillingdon were due to start a project looking into evidence based best practice among crisis teams working with older people, with a view to involvement in research in the future.