Good

South London and Maudsley NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV504	Maudsley Hospital	Croydon North & South CMHT (Older Adults)	SE25 6LL
RV504	Maudsley Hospital	Lewisham North & South CMHT (Older Adults)	SE13 7DW
RV504	Maudsley Hospital	Southwark North & South CMHT (Older Adults)	SE5 8RS
RV504	Maudsley Hospital	Lambeth North & South CMHT (Older Adults) Reay House	SW9 9NT

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
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 rated South London and Maudsley community-based services for older people as **good** overall because:

The teams were multi-disciplinary and provided staff appropriate for the service who were skilled and had a good understanding of the needs of the patients and carers they were supporting. The care provided reflected current best practice.

The staff were professional, caring and communicated well. The teams were well managed and staff had access to ongoing training and support.

Patients whose needs were urgent were seen promptly and the teams were aware of patients who might not engage and ensured they were supported.

There were some areas for improvement. Most importantly the transportation of medication and sharps between the bases and peoples homes needed to be made safe. Also risk assessments need to be completed to a consistently high standard so professionals can all access this information when needed.

Summary of findings

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

Are services safe?

Requires improvement

We rated the service as **requires improvement** because:

- There was inconsistency between the teams and individual workers around when a risk screen or a full risk assessment should be completed. The quality of the risk assessments was variable and they were sometimes tick-box style with little further information added.
- Many of the care records we reviewed did not contain clear, detailed crisis plans. Some of the carers and patients did not know how to contact someone in the event of a crisis out of hours.
- Medication and sharps were not transported safely between the team base and patients homes.
- Lone working procedures were not consistent or robust across the service.

However, the teams had safe staffing, mandatory training was up to date and risks were discussed by the teams even if they were not well recorded.

Are services effective?

Good

We rated effective as **good** because:

- The teams had a wide range of experienced and qualified staff. Staff across the teams were up to date with monthly supervision and most had received an annual appraisal.
- Access to a range of psychological therapies was available and care reflected best practice guidance.
- Clinical staff participated in a number of audits.

However, use of the Mental Capacity Act was variable and inconsistent across the service. We found that not all staff were confident with applying what they had learned in training to practice and documentation of assessments was limited.

Are services caring?

Good

We rated caring as good because:

- The majority of patients and carers we spoke with were happy with the care they received from the service. People said that

Summary of findings

staff were polite, caring and respectful and tried to promote their independence. People said they were treated with dignity and compassion. Staff had a good understanding of people's individual needs and social support systems.

- Carers spoke positively about the kindness, compassion and responsiveness they received from all staff.

However, most people we spoke with said that they had not been given copies of their care plans and other documentation.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Each team had capacity to undertake routine and urgent referrals. The duty systems were particularly robust meaning that patients could be seen quickly when in crisis.
- Patients, carers, and other professionals, we spoke with, confirmed that calls were returned in a timely manner.
- Complaints were well managed by staff and action taken. We saw examples where learning had taken place.

However, some furniture in interview rooms was not appropriate for older people and some rooms did not provide sufficient sound proofing for confidential discussions.

Are services well-led?

Good

We rated well led as good because:

- Staff knew the organisation `s vision and values. Overall, most staff felt that senior managers were visible and knew who they were.
- The teams all held weekly meetings, where a range of quality and safety issues were discussed.
- Staff participated in a range of research projects.
- Staff, across all teams, spoke positively about the support they received from their managers and colleagues.

Summary of findings

Information about the service

We inspected four community mental health teams for older people providing specialist assessment, diagnosis and treatment. The teams were situated in Lambeth, Southwark, Lewisham and Croydon. Each team was made up of psychiatrists, community psychiatric nurses, occupational therapists, social workers, psychologists and administrative staff.

The service was offered to adults aged 65 and over who were living in the community with mental health difficulties and anyone under the age of 65 with progressive memory problems, such as dementia.

Older adults requiring specialist mental health services were referred directly from their GP. Access to the service was determined by the needs of the individual as well as their age. The teams worked closely with social care staff, voluntary and statutory organisations to ensure that everyone received a level of treatment and care that was appropriate and effectively coordinated to help maintain health and independence where possible. The contact that these teams had with patients, carers and relatives varied depending on the individuals level of need and their treatment plan. Care was delivered in the person's own home or in outpatient clinics.

This service was part of the mental health of adults and dementia clinical academic group (CAG). The CAG delivered recovery based practice for older people.

The community mental health teams worked closely with a range of other services including the home treatment teams which supported people in crisis to remain at home by offering short, intensive treatment; the memory services which provided specialist assessment, investigation and diagnosis and care home intervention services, which were specialist services who supported patients with challenging behaviour living in nursing or residential homes . These services were not part of this inspection but the inspection team did look at how the community mental health teams worked alongside them.

These teams had not been inspected before.

Our inspection team

The inspection team who inspected community-based mental health services for older people consisted of an inspector, a consultant psychiatrist, a community psychiatric nurse, a psychologist and an expert by experience

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

Summary of findings

During the inspection visit, the inspection team:

- Visited four community teams.
- Spoke with 25 patients and carers who were using the service.
- Attended a service user group.
- Reviewed feedback from 87 friends and family tests.
- Spoke with four team leaders.
- Spoke with 21 other members of staff including doctors, nurses, social workers, psychologists and occupational therapists.
- Attended and observed two multi-disciplinary meetings and two duty meetings.
- Observed four home visits and outpatient appointments.
- Reviewed 43 patient records.
- Looked at eight sets of supervision records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Carried out a specific check of the medication management and storage at the four sites.
- Had a tour of the premises at each location.

What people who use the provider's services say

All the patients we spoke with were happy with the care they received from the service. We were told that staff were caring , respectful and interested in promoting their independence and wellbeing. Patients said they were treated with dignity and compassion and seen in a timely manner.

Carers spoke positively about the service they received from staff at the teams we visited. Carers said they were given information about the service and were involved with their relative's treatment and reviews.

However, patients told us they were not given copies of their care plans and other documentation, or information on how to access support outside of office hours.

Good practice

- The Trust actively supported research innovations. In Lambeth a research nurse visited the team weekly to recruit participants for research projects and we saw that members of the teams were actively involved in research projects as a result. For example, in Southwark the team operated a 'consent for contact' initiative where every patient was asked if they would like to be contacted about research and their names were then added to a database.
- In Lewisham, the team were utilising the skills of psychology graduates through recruiting them as recovery enablers, to help patients complete their support and recovery plans. This is a project promoting recovery, with Lewisham being an early implementer.

Areas for improvement

Action the provider MUST take to improve

- The trust should ensure that a consistent approach is used to complete risk screens and risk assessments on the patient records system so they can be located by all care professionals.
- The trust must ensure that there are safe systems for transporting medication, medical waste and sharps.

Action the provider SHOULD take to improve

- The trust should ensure that comfortable seating is available at all bases.
- The trust should ensure arrangements for lone working are implemented across the teams.
- The trust should ensure staff can confidently apply the Mental Capacity Act.

Summary of findings

- The trust should ensure that managers understanding of the safeguarding alert process is cascaded to all staff.
- The trust should ensure that patients and carers know who to contact out of hours in an emergency.
- The trust should ensure patients and carers have copies of care plans.

South London and Maudsley 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
Croydon North & South CMHT (Older Adults)	Maudsley Hospital
Lewisham North & South CMHT (Older Adults)	Maudsley Hospital
Southwark North & South CMHT (Older Adults)	Maudsley Hospital
Lambeth North & South CMHT (Older Adults) Reay House	Maudsley Hospital

Mental Health Act responsibilities

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

Two of the teams were meeting the trust target of 85% completion of Mental Health Act training. The Southwark team fell below the standard with a 75% completion rate, and the Croydon team was substantially below the target with only 40% having completed the training. However, staff were able to describe a good working knowledge of the Mental Health Act.

There were very few patients subject to community treatment orders (CTOs) across the service. In Lambeth, details regarding any CTOs were noted on the zoning board to remind staff when a renewal was due. The teams were invited to discharge planning meetings at the hospital and made aware of anyone being discharged onto a CTO.

Staff receive good support if necessary from the trusts Mental Health Act administrators but that they also seek advice from the approved mental health professionals for case discussions.

Detailed findings

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

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were meeting the trust standard of 85% completion of Mental Capacity Act training, with the exception of the Croydon team which fell below the trust standard at 53%. The training itself was either e-learning or a classroom session every three years. This meant that where changes in case law had occurred staff might not be updated.

The Mental Capacity Act was discussed in multi-disciplinary team meetings and some individual staff we spoke to demonstrated a good knowledge of the 5 principles of the Act. Some of the individuals and managers felt that the teams lacked confidence in applying what they had learned to practice.

Copies of the flowchart to guide staff or a code of practice relating to the Act were not available as hard copies in any of the teams. There is a policy on the intranet which staff can access.

Across the four teams, compliance with the Act was variable. Out of the 43 records we reviewed, 14 had a capacity assessment in place and of these, the quality was inconsistent. Many of the assessments we did see were a tick-box style with very little further detail added. There were a number of cases where issues were arising in the patient records where a mental capacity assessment would have been expected, but were not available.

Staff said it is usually the doctors or social services who take the lead role in assessing capacity. This potentially highlighted a lack of understanding about the role of the care coordinator as decision maker.

There was variable understating about local systems for coordinating DoLS assessments. In Lambeth staff we spoke to did not know who undertook DoLS assessments locally or if there was a dedicated team.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Each team offered outpatient appointments in interview rooms. We inspected the interview rooms for all of the teams, except for the Croydon team where patients were offered outpatient appointments in Purley. All of the interview rooms had fixed alarm systems. In Lambeth, the alarm was triggered by pressing a button which was mounted to the wall some distance from the door. As this door was the only way out of the room the member of staff would need to sit away from the exit, potentially compromising their safety.
- The clinic rooms we inspected were clean and well maintained and cleaning rotas were up to date. We reviewed the maintenance records for medical equipment which were also complete. Drugs cupboards were locked and tidy. Hand gel was available in the clinic rooms, waiting areas and interview rooms.

Safe staffing

- Staff vacancies were generally low and where vacancies had arisen they were mainly due to retirement or maternity leave. Despite the low number of vacancies, staff said that in busy times such as school holidays when there were less staff available they felt pressured.
- Each team had undergone a restructure which included merging the North and South teams, which had previously been organised separately. This had meant that the services had been streamlined and a number of substantive posts had been lost. This had resulted in a change in the intensity of the caseloads and more people were seen who were in crisis or considered high risk. Although caseload numbers were not generally excessive, most staff said that they felt under greater pressure.
- All of the teams commented on the loss of the support workers following the merger and felt that this had impacted negatively on both patients and staff. The patients were no longer able to access practical support such as assistance in claiming benefits. This created a reliance on third sector agencies such as Age UK. Staff at Lewisham commented that this was not always efficient and that there were waiting lists of up to eight weeks at times.
- Caseload numbers were mainly under 30.
- Sickness rates were low across the service, at 3 percent and that there were very few unfilled vacancies. Where vacancies had arisen posts were being actively advertised.
- In Lewisham two maternity posts were being filled by agency staff. Other than this, there was little use of bank or agency staff across the four teams.
- All of the teams we inspected were able to provide rapid access to a psychiatrist. In three of the four teams, the doctors attached to the teams took part in the duty rota and therefore were available to respond to emergencies very promptly.
- We reviewed the training records across the service and found that most members of staff were up to date with mandatory training. Where staff members were not up to date with training, the team managers showed us evidence that they had reserved spaces on the next available training session.
- The Trust used an electronic database called WIRED for recording training. However staff told us that the system was inaccurate and unreliable and therefore the teams operated their own internal systems for recording training and issuing reminders. In most cases the team administrators recorded training and reminded staff that their training was due because the electronic database was not considered reliable.

Assessing and managing risk to patients and staff

- All four teams operated a zoning system. Patients who were considered to be at risk were rated either red or amber and were highlighted on a zoning board. The zoning boards were reviewed daily to ensure that patient's individual risks were being monitored. We attended one zoning meeting and reviewed the minutes of another and saw that this was safely managed. Staff across the service told us that this system worked well.

Requires improvement

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- The teams used a secure electronic patient record system. There were two types of risk assessment which could be completed on this system. One was a risk screen and the other was a full risk assessment. We found disparity around the circumstances under which, each risk assessment should be completed. Some staff always completed the risk screen and only completed the full risk assessment for patients who were under care programme approach (CPA) or where additional risks had been identified, others always completed the full risk assessment. We saw examples of patients under CPA without a full risk assessment.
- In addition to this the quality of the risk assessments was variable. Of the 43 records we reviewed we found examples where the assessments were not holistic. They were often brief and used a tick box style with little additional information added. We also saw an example where a care plan had not been updated following the death of a patient's family member which had resulted in changes to their mental health.
- In Lambeth the risk assessments were updated every six months, unless there was a change in circumstances or a new risk had been identified, in which case they would be updated at this point. There was no prompt on the electronic system to remind staff that the risk assessment was due for renewal which meant that the care coordinator would be responsible for remembering to do this.
- There were both mental health crisis plans and recovery support plan proformas on the electronic system and staff told us that they could use either. We were told that although the recovery support plan was personalised and recovery focused, in many cases it was not fit for purpose with this patient group. It focused on how patients were when they were ill. As a large number of patients lacked insight and did not think that they were ill, this form was often not appropriate for the patients. The mental health crisis plans were more traditional and written from a professional perspective. These were completed more often but there was little evidence of patient involvement within them. We were told that a working group is now looking into this issue across the clinical academic group (CAG).
- The CPA was a way that services were assessed, planned, co-ordinated and reviewed for patients with mental health problems or a range of related complex needs. In Lewisham 8 out of 10 patients records we looked at were under CPA. Across the other teams, plans were in place to increase numbers and this was happening in practice.
- The records contained no examples of advance decisions.
- The majority of the staff were up to date with safeguarding adults training, but some had lapsed in their safeguarding children training. These staff members were booked onto sessions in the near future. Safeguarding cases were an agenda item and were dicussed at the MDT meetings and information regarding safeguarding processes was displayed on the walls in the team offices. Most staff knew who the trust's safeguarding lead was. However, not all staff understood the local safeguarding procedures, and what their responsibilities were. For example, the team managers were able to tell us the process for making an alert but some staff were unclear about the process.
- We found that lone working protocols were not consistent across the service. In Lambeth we were told that staff relied heavily on their judgement of the patient when assessing the risks associated with lone working and that they generally did not visit high risk patients towards the end of the day. Administrative staff were responsible for checking the whereabouts of the team at the end of the day. Not everybody we spoke to was clear about what the system was and about whether the administrative staff would follow it up if they did not return to the office as expected. In Lambeth, the team operated a signing in and out book, but this contained handwritten notes about the whereabouts of the staff and often did not clearly indicate an expected time back. There were no signing in and out boards at Lambeth to provide a quick reference as to staff whereabouts. In Lewisham they operated a similar system and a member of staff said they were not sure if the book was checked regularly. Another member of staff told us that they felt the system needed to be reviewed. In Croydon not all staff had been given work mobile telephones. This meant that these staff were not always contactable, raising issues around their safety.
- In Southwark, we found that the system for transporting medication was not safe. A member of staff demonstrated how the team transported depot injections to the patient's home in a disposable kidney

Requires improvement

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dish with no specific bag for transportation. The member of staff then indicated that sharps and any clinical waste would be brought back to the site for disposal in the sharps box. This raised issues in terms of carrying sharps, cross infection and the safe disposal of clinical waste.

- In Lewisham, staff said that they had raised concerns to their managers and to the nursing council around the lack of pharmacy input into medication management. This meant that they had to oversee the process themselves. This included taking stock orders to Lewisham hospital pharmacy, then collecting boxes of depot medication without a receptacle, transporting it across car parks and then back to the community mental health team base. In Lewisham, nursing staff had not been provided with containers or bags to transport depot equipment to patient's homes and therefore some staff were using either pencil cases or spectacle cases they had provided themselves, to transport the ampules and syringes.

Track record on safety

- There were five serious untoward incidents reported in the last 18 months for all the older peoples mental health community teams.

Reporting incidents and learning from when things go wrong

- Staff were clear as to how to report an incident and as to which incidents needed to be reported. Managers were able to produce copies of the DATIX reports and these evidenced that a wide range of incidents were reported, from IT failures through to patient deaths and these were acted on in a timely way.
- All of the staff were aware of the principles of the duty of candour.
- Staff received feedback from investigations and incidents at the multi-disciplinary team and business meetings and that this was followed up in supervision if necessary. They also received update bulletins via email across the trust following incidents.
- In Lambeth and Southwark where there had been serious untoward incidents, the learning from these incidents had been shared amongst the teams and applied to practice. In Southwark one of the recommendations following a serious untoward incident was to increase the number of patients who were under CPA. Staff at Southwark had increased their CPA numbers from around 30% to around 50% over a two month period. We saw that an action plan had been developed and shared with staff.
- Following a recommendation that came from a serious incident in Lambeth, staff had changed their practices around recording discussions about risk. The minutes of the MDT meetings which focused on patient risks were recorded on electronic records contemporaneously.
- Staff were given support and a debriefing if they had been involved in an incident.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We reviewed 43 records and found that the assessments were comprehensive, holistic and completed in a timely manner. However, the location of the assessments on the system varied and therefore the assessments were not always easy to locate.
- All four teams were moving towards a paperless system. In Croydon, some historic paper files were stored in one room in unlockable filing cabinets. We were told that this room was kept locked, however we observed it to be open at the time of the inspection. In Lambeth there were no historic files and notes were only kept until they had been inputted onto the system, after which they were shredded. They were kept in unlocked drawers until they were inputted. The offices were lockable but were accessed out of hours by domestic staff for cleaning.
- The Trust used a electronic patient records system to record assessment of needs and planning of care. Staff said this system was slow and cumbersome. Staff commented that this impacted on the service they provided as inputting information took a long time and had to be duplicated in several areas. None of the teams had been given laptops to update care plans on home visits. Some of the IT itself was outdated and we observed a clinician in an outpatients department take approximately 30 minutes to load his computer up. We were told that the IT across the trust was being upgraded.
- Social workers who were co-located in the community mental health teams for older people could not access the electroinc system and three different local authority electronic records systems were used across the borough. Deprivation of Liberty Safeguard assessments were stored on local authority systems and were not accessible by the community mental health teams. Although they could share information due to being in the same building, this did create the potential for duplication of assessments and for important information being inaccessible to some staff.

Best practice in treatment and care

- Patients who used the service had access to national institute for health and care excellence (NICE) recommended therapies including cognitive behaviour therapy, family therapy, psychodynamic and group therapies. Staff told us that they received regular updates on NICE guidance and were supported to follow best practice. Across the four teams, access to psychological therapies was good and there was a range of psychological therapy available. Waiting lists were relatively short, usually around six weeks from referral to initial assessment and that there was no further waiting list from assessment to treatment. This meant that patients could commence their treatment soon after they had been assessed. Feedback from patients on psychological therapy was good. One patient we spoke to commented that they had very quick access to a psychologist and were very satisfied with theire care and treatment .
- NICE guidance was followed by the teams in relation to the use of antipsychotic medication in dementia patients. A number of audits were being completed by clinical staff including collecting data on triaging of duty referrals, antipsychotic medication in dementia and stepped care for depression.
- Staff used a variety of recognised rating scales and assessment tools including the health of the nation outcome scale, the Addenbrooke's cognitive examination and the standardised mini mental state examination.
- Physical health care was incorporated into the care plans. GPs were responsible for undertaking annual health checks. Discussions about physical health care took place at the MDT meetings.

Skilled staff to deliver care

- All four teams were staffed with the full range of mental health disciplines required to care for the patient group, including nurses, OT's, psychologists, doctors and social workers. All of the teams had experienced and qualified staff.
- Aside from the mandatory corporate induction, we also found that the teams operated their own robust induction programmes. In Lewisham, the team manager

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had introduced a buddy system for new starters. This had been developed to break down barriers between newly qualified staff and those who had been in post for a long time and to share knowledge and best practice.

- Supervision records were comprehensive and included discussions around caseloads, safeguarding, training, continuing professional development and human resource issues.
- Over 85% of staff across the teams had received an annual appraisal.
- There was opportunity for developmental training. For example, in Lambeth three members of the team were undertaking masters degrees; one in psychotherapy and two in dementia practice. We were told that there was very good provision for specialist training for those who have worked for the trust for over a year.
- We saw that staff were monitored to ensure they completed patient records. If they were repeatedly not completed, then this was addressed initially in supervision and then under performance management procedures.

Multi-disciplinary and inter-agency team work

- MDT meetings were comprehensive and well attended by a range of professionals. The teams worked effectively and collaboratively to plan and deliver appropriate care, with other health, social and voluntary agencies. Care records evidenced good communication between the teams. The teams had good links with various third sector agencies. Social workers were either partially integrated into the teams or were co-located and this provided the opportunity for collaborative working and shared knowledge, information and best practice. Psychiatrists were available for joint visits to patients.
- Staff also told us that they had good access to patients acute hospital records via portals.The transition between services for patients had been well coordinated and well documented.
- Staff described good working relationships with the home treatment teams. In Lambeth and Southwark some staff members worked part-time for both the CMHT and the home treatment teams and managers told us that this helped to ease any potential barriers between the teams when discussing and accepting referrals.

Adherence to the MHA and the MHA Code of Practice

- Two of the teams were meeting the trust target of 85% completion of Mental Health Act training. The Southwark team fell below the standard with a 75% completion rate, and the Croydon team was substantially below the target with only 40% having completed the training. However, staff were able to describe a good working knowledge of the Mental Health Act.
- There were very few patients subject to community treatment orders (CTOs) across the service. In Lambeth, details regarding any CTOs were noted on the zoning board to remind staff when a renewal was due. The teams were invited to discharge planning meetings at the hospital and made aware of anyone being discharged onto a CTO.
- Staff receive good support if necessary from the trusts Mental Health Act administrators but that they also seek advice from the approved mental health professionals for case discussions.
- Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.

Good practice in applying the MCA

- Staff were meeting the trust standard of 85% completion of Mental Capacity Act training, with the exception of the Croydon team which fell below the trust standard at 53%. The training itself was either e-learning or a classroom session every three years. This meant that where changes in case law had occurred staff might not be updated.
- The Mental Capacity Act was discussed in multi-discplinary team meetings and some individual staff we spoke to demonstrated a good knowledge of the 5 principles of the Act. Some of the individuals and managers felt that the teams lacked confidence in applying what they had learned to practice.

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.

- Copies of the flowchart to guide staff or a code of practice relating to the Act were not available as hard copies in any of the teams. There is a policy on the intranet which staff can access.
- Across the four teams, compliance with the Act was variable. Out of the 43 records we reviewed, 14 had a capacity assessment in place and of these, the quality was inconsistent. Many of the assessments we did see were a tick-box style with very little further detail added. There were a number of cases where issues were arising in the patient records where a mental capacity assessment would have been expected, but were not available.
- Staff said it is usually the doctors or social services who take the lead role in assessing capacity. This potentially highlighted a lack of understanding about the role of the care coordinator as decision maker.
- There was variable understating about local systems for coordinating DoLS assessments. In Lambeth staff we spoke to did not know who undertook DoLS assessments locally or if there was a dedicated team.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- All of the interactions between staff and patients were kind, respectful, supportive and compassionate.
- Reports by patients of how staff behaved towards them were almost universally positive.
- In all four teams, patients were given information packs at the initial assessment stage. In Lewisham and Southwark we saw evidence that these were personalised to the individual needs of the patient. The packs contained information about medication and treatments including potential side effects and information on how to make a complaint.
- Patient feedback on the service overall was generally very good. In Southwark the results of the friends and family test from June 2015 to August 2015 showed that 91 percent of the respondents thought that staff were kind and caring and that 79 percent felt involved in their care.

The involvement of people in the care they receive

- Although verbal feedback from patients indicated that they felt involved in their care planning only six out of the 43 records we reviewed recorded the fact that copies of the care plan had been offered to the patient. Very few of the carers and patients we spoke to said that they had been offered a copy, across the four teams. This was confirmed when we reviewed care records which showed that care plans were not routinely offered to patients. However, we noted that if care plans were offered to patients later then the electronic system could not be edited to reflect this. During home visits we saw examples of carer support for example arranging carer assessments.
- One patient we interviewed over the telephone told us that they had not wanted to go into hospital and that the team had been very supportive of their wishes and arranged care services to enable them to remain at home.
- However, access to advocacy appeared to be variable. The majority of the patients and carers were not able to tell us how they would access an advocate. Staff we spoke to were unclear about how to access advocacy services.
- Staff worked with patients and carers from the user group and they helped with staff interviews.
- Patients were able to give feedback on the service they received in a variety of ways. One of these was by using the patient experience data information centre. This involved entering a code into a mobile phone and then completing a survey. Numbers of people using this system was generally very low. Staff had worked to inprove the feedback rates. For example, in Croydon, the team manager had created a paper based system which had been more successful with encouraging older people to give feedback.
- Staff had responded to feedback from patients. For example, in Lewisham, the teams displayed the findings from the “you said, we did” survey in the waiting/ reception area. We saw an example where patient feedback indicated that they had found one of the windowless consulting rooms claustrophobic during a long session. In response, the team had indicated that this particular room would no longer be used for therapy sessions and only for short interviews.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The Trust standard for seeing new non urgent referrals was 10 days. Although the team in Lambeth told us they were meeting this target, the other teams fell short of this. In Croydon we were told that new, non urgent referrals are seen within 20 days and in Lewisham we were told they were seen within 15. Despite this, none of the teams operated waiting lists which was positive. In addition, all of the teams were able to respond very quickly to urgent referrals, usually the same day.
- In all four teams, there was a quick response to crisis situations and the duty systems appeared to be working well. This was particularly good in Southwark, where a dedicated duty "sub-team" comprising a duty person, a duty back-up, a duty manager and a duty doctor where available to respond each day. We also saw minutes of the duty handovers and they were comprehensive and robust in relation to team response to crisis.
- The four teams offered services to adults aged 65 and above with mental health difficulties and adults of any age with dementia. Those with memory problems were referred to the memory service. Those in crisis requiring more than one visit per week were usually referred to the home treatment teams. Across the teams, the referral process between the services was generally well organised.
- All of the teams told us that they were proactive in trying to engage with those who were reluctant to accept involvement from mental health services. For example, in Southwark the team used creative ways to engage, such as going to see patients in public places where they were likely to be, or offering patients alternative appointment times. In Lewisham, the team manager had developed a new 'no reply' protocol in response to improvements following a serious incident some years ago. The protocol outlines what staff need to do in the event that a patient does not answer the door for a visit as expected. We reviewed this protocol and it appeared to be very robust. The staff we spoke to within the team were aware of the protocol and felt that it worked well.
- The teams operated a service 9am and 5pm, Monday to Friday service. However, all of the teams told us that they would offer flexibility to meet patients needs and to reduce risk. In our review of MDT minutes in Lewisham we saw that Muslim patients were offered their depot injections after sundown during Ramadan.
- In all of the teams we inspected we were told that appointments usually run on time and are only cancelled in exceptional circumstances. Patients said they are informed if appointments are running late.

The facilities promote recovery, comfort, dignity and confidentiality

- All of the interview rooms contained comfortable furniture, with the exeption of Lambeth where the furnishings in the interview rooms did not promote comfort and were not appropriate for older people or people with disabilities. The chairs were low and therefore difficult for a person with reduced mobility to get in and out of. In addition, the furniture itself was dated and the walls were bare. We observed a patient with back problems who was sitting in the waiting room and was in pain due to the unsuitable chair.
- The interview rooms contained leaflets with information about the service and treatments.
- The buildings were accessible, with the exception of the outpatients department at the Maudsley which had steps up to the building, after the ramp.

Meeting the needs of all people who use the service

- Despite the ethnic diversity in the local area, none of the teams we inspected had leaflets readily available in different languages. The team managers across the four teams told us that they could be ordered through the intranet, but we did not observe that this was happening in practice.
- The team managers described how interpreters and signers could be arranged by the team administrators via an external agency. Some individual staff within the teams however told us that they would use families as interpreters.

Are services responsive to people's needs?

Good

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

Listening to and learning from concerns and complaints

- Patients were given details on how to make a complaint in the information packs handed to them at the initial assessment stage and this was also available in the reception areas we inspected.
- There were eight complaints for the older person`s community services over the past 12 months, four of these were upheld and one was referred to the health ombudsman who did not uphold the complaint.
- The service listened to and learned from complaints. For example, there had been a complaint about a member of staff using inappropriate language on the telephone and the team manager showed us evidence that they arranged training for the staff member around this issue and had written to the family to apologise.
- Complaints were discussed during MDT and business meetings and any learning was shared with the team. They were also discussed during supervision.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff were able to tell us what the Trust's five commitments were and we saw them displayed in locations around the sites we inspected.
- In Lewisham, the team manager had produced a team mission statement which was also displayed in the office.
- Staff knew the senior managers and confirmed that they had visited the services. Staff described more positive engagement from the executive team in recent months.

Good governance

- Each teams held weekly meetings and managers attended monthly directorate meetings, where a range of quality and safety issues were discussed.
- The clinical directors for the clinical academic group (CAG) issued quarterly newsletters informing staff of any changes to the service and this was perceived to be helpful by the staff we spoke to.
- There were governances processes for disseminating learning and each MDT meetings had slots for incidents and complaints.
- We saw evidence of a range of clinical audits being undertaken by staff and outcomes of audits with evidence of improvement.
- Key Performance Indicators (KPI's) were being used to monitor the performance of teams.

Leadership, morale and staff engagement

- In Southwark, the team had recently developed a system for monitoring staff stress. Staff members were asked to indicate their stress levels each day and at the end of the month, this was displayed in a diagrammatic form and discussed at the team meeting. This system had only been in operation for a few months, but the results indicated that high stress levels were less than 30 percent for the months we reviewed.
- Sickness rates across the four teams we inspected were generally low at 3 percent
- We were not made aware of any cases of bullying or harassment in any of the teams we inspected. In all of the teams we inspected, the staff told us they felt able to raise concerns if necessary. In Lewisham the whistleblowing procedure was laminated and displayed on the wall in the office.
- Morale across the teams was generally good. Some individuals told us that they felt extra pressure since the teams merged and posts were lost. Despite this, the teams appeared to be cohesive and supportive. Staff were supported to undertake leadership courses.Team members were motivated and enthusiastic about their roles and team managers spoke very highly of their teams.

Commitment to quality improvement and innovation

- In Lewisham we were told about the teams "project group". This group met monthly to look at ways to improve the service. The 'no reply' policy started in this forum. Staff in all teams told us they were supported to contribute to service development. In Lambeth we were told that the team was visited weekly by a research nurse, who would seek to recruit participants for research projects. At the time of the inspection some of the team members were taking part in a research project around whether psychodynamic staff supervision alleviates work stress.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way and the trust done all that was reasonably practicable to mitigate the risks. Medication and sharps were not transported safely between the team bases and patients homes. Risk assessments were recorded inconsistently in different places and were not always completed thoroughly to reflect patient risks. This was a breach of Regulation 12 (1)(2)(a)(b)(d)