Good

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

Mental health crisis services and health-based places of safety

Quality Report

Building 15, 2nd Floor
South West London and St George's Mental Health NHS Trust HQ
Springfield University Hospital
61 Glenburnie Road
London
SW17 7DJ
Tel: 0203 513 3000
Website: www.swlstg-tr.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQYXX	Trust Headquarters	Richmond Home Treatment Team	SW15
RQYXX	Trust Headquarters	Kingston Home Treatment Team	KT6 7QU
RQYXX	Trust Headquarters	Wandsworth Home Treatment Team	SW17 7DJ
RQYXX	Trust Headquarters	Merton Home Treatment Team	SW17 7DJ

Summary of findings

RQY01	Springfield University Hospital	Health Based Place of Safety	SW17 7DJ

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

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

Where applicable, we have reported on each core service provided by South West London and St Georges NHS Trust and these are brought together to inform our overall judgement of South West London and St Georges 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?	Good
Are services effective?	Requires improvement
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 mental health crisis services and health based places of safety as **good** because:

The trust was providing crisis services which met the guidelines of the mental health crisis care concordat. The principles of this concordat were embedded in the service.

We saw excellent examples of interactions between staff and patients. All the staff we observed were caring, compassionate and kind. The service supported and treated the people using the crisis and home treatment teams and health-based place of safety with respect, warmth and professionalism.

Assessment and management of risk was of a high standard in the home treatment teams. Staff were well equipped to manage risk and skilled in identifying and mitigating risks for patients and staff. In addition, there were adequate numbers of staff to provide care and support to a good standard. The trust was addressing vacancies in permanent employed qualified nurses.

The environments were clean and well presented in all of the home treatment teams, and patients were seen at the home treatment locations if required.

Overall, care planning involved patients and carers and was recovery orientated. Discharge planning was evident across all of the services and collaborative crisis planning was taking place. The teams worked flexibly to engage and work with people in the community, adapting to meet the needs of people and ensuring that visits and appointments were kept. Home visits were rarely cancelled and if changes to visit times were made the teams communicated effectively with patients to share information and promote engagement.

The teams consisted of experienced and knowledgeable staff. Staff said they could access the training they needed to fulfil their roles and were encouraged by local management to access additional training for their development. Staff received feedback from their managers following incidents. This was discussed in supervisions, handovers and team meetings.

Staff had a good understanding of the trust's vision and values, and how these were implemented in everyday practice. The culture within the service was open and transparent, staff morale was good, and senior managers within the service were visible and accessible to staff and patients.

However, not all staff across the home treatment teams were accessing regular one to one supervision.

Patients we spoke with told us that there were sometimes inconsistencies in staff who visited their homes and this was a challenge for patients and impacted on the experience of care.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- The home treatment team environments were safe clean and well maintained.
- The teams had enough staff to visit patients on the caseloads according to need. Overall, the teams ensured planned appointments and visits were not cancelled.
- Risk assessments were completed on admission to services and most were updated regularly.
- A zoning system was used to grade the level of risks and to inform the frequency of visits and interventions.
- Risk assessments were reviewed on a daily basis during team handovers and after discussion of reviews and home visits.
- Protocols were in place across all of the teams to ensure the safety of staff conducting home visits.
- There were four serious incidents in the past twelve months, which were investigated. The outcomes and learning from the investigations had discussed in debrief sessions and staff were supported following incidents.

However, whilst staffing levels were safe the organisation of staff within the teams, meant that in some cases patients saw different staff at their appointments and they would have preferred more consistency.

Are services effective?

Requires improvement

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

- There was no formal individual supervision structure embedded across the services and some staff were not receiving regular individual supervision.
- Physical health checks of patients prior to commencing antipsychotic medications were being completed according to guidance, ensuring safe prescribing. However, supporting patients to have physical health checks was not done routinely for all patients on caseloads.
- The recording of care plans and risk assessments were not consistent and this could make it hard to find the current information.

However:

- Staff completed patient assessments promptly following referral.

Summary of findings

- Care and progress of patients was discussed in daily team meetings and daily handovers were taking place.
- The street triage team had enhanced working links between the police and crisis services, strengthening interagency working.

Are services caring?

Good

We rated caring as **good** because:

- We observed staff interactions with people who used service which were kind, respectful and supportive.
- When staff visited people in their home environments, they maintained the privacy and dignity of people by minimising awareness that staff from services were visiting.
- People who used the services fed back that staff were kind, listened to their concerns, and were easily accessible.
- Carers and families were supported, being provided with assessment and supporting interventions.
- The real time feedback provided by people who used the service demonstrated that staff were compassionate, supportive and upheld their dignity.
- People who used the health-based places of safety were able to access advocacy services.

However:

- Sometimes connectivity to the devices used to obtain feedback from patients was not good and the system did not work.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The mental health crisis services provided a 24 hours, seven day a week access and assessment service and people could access a service when required in a crisis
- The home treatment service had a 2-hour target which was met for the assessment of gatekeeping referrals for admission.
- The street triage team had made a positive impact on identifying and facilitating appropriate use of police detention powers under the Mental Health Act.
- Discharge planning was happening in each team.
- The mental health support line provided out of hours access for people in a crisis for both people already receiving care from all mental health services in the trust and as a referral point for people in crisis.

Summary of findings

- When people could not be seen regularly and there was disengagement from services, all of the home treatment teams took steps to engage and support people considering their individual risk.
- People who used the service were able to make complaints. At Wandsworth home treatment team a complaint about the length of time which staff spent at the person's home during a home visit had been discussed within the team and had led to changes in the way the team worked.

However:

- The team base for the Richmond home treatment team was very cramped.

Are services well-led?

Good

We rated well led as good because:

- Overall, the home treatment teams had a good level of morale and the teams were well supported by managers. Staff fedback and demonstrated an attitude of openness and transparency, explaining and discussing when something had gone wrong in a person's care plan and treatment. The staff working in the home treatment team were aware of the organisation's values.
- There were meetings taking place regularly in each team to discuss incidents, complaints and team issues. The team managers and consultant leads for home treatment teams met regularly to discuss operational developments.
- The home treatment team managers were engaged in a quality improvement process to review referral pathways into the service, aiming to improve response times and the experience of people using the service.
- In the Richmond and Wandsworth home treatment teams, an evaluation and audits of the effectiveness of the service and experience of patients were taking place.

Summary of findings

Information about the service

South West London and St Georges NHS Trust provide crisis mental health services across the London boroughs of Richmond, Kingston, Wandsworth, Sutton and Merton

The home treatment teams, are based in each of the boroughs covered by the trust. They operate slightly different hours in each borough. Out of hours access to crisis services is offered by psychiatric liaison services based at local accident and emergency departments.

The home treatment teams offer assessment and services to any person in crisis, experiencing mental health problems which may necessitate admission to inpatient hospital, between the ages of 18 and 65. The aim of the home treatment teams is to provide assessment, care and treatment at home or in the community as an alternative to hospital admission. The teams accept referrals from community mental health teams, GPs, accident and emergency departments, acute inpatient admissions wards as well as out of hours from the psychiatric liaison teams. The teams act as gatekeepers for the trust's inpatient beds. They also facilitate discharge from the trust inpatient wards.

The trust has access to two health based place of safety facilities, which are located at Springfield Hospital

The trust also provides a mental health support line that operates out of hours, providing support and advice for people who are engaged with services provided by the trust or were seeking help in a crisis. This team responds to people in crisis with telephone support, signposting to services for support, and triages urgent out of hours crisis assessments.

The crisis services and health based place of safety were last inspected in March 2014. They were found to have met the fundamental standards of care required.

Our inspection team

The team that inspected the crisis services and health-based place of safety consisted of two inspectors, two specialist advisors with experience of working in crisis services, and one expert by experience. The team visited the home treatment teams, the trust wide health based place of safety and the mental health support line service.

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 patients, 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 nine focus groups.

During the inspection visit, the inspection team:

- visited four of the home treatment teams at their bases and looked at the quality of the environment in which they saw patients

Summary of findings

- visited the health based place of safety and observed one patient being admitted to the place of safety
- visited the mental health support line service and spoke with two support workers working on the support line
- spoke with eight patients who had recently used the home treatment team service and two carers
- spoke with the team leaders for each of the home treatment teams
- spoke with 19 other staff members; including nurses, consultant psychiatrists, support workers, family recovery worker, administration staff and social workers
- interviewed the community matron for the home treatment teams and the team leader for the acute care coordination centre
- attended and observed four hand-over meetings, and one multi-disciplinary meeting
- looked at 18 patient care records and 28 prescription charts
- 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

People that used the service Patients told us that they found the staff in the home treatment teams kind, responsive and that they had a respectful attitude. When staff had to cancel appointments, these were promptly re-arranged. The people we spoke with said that they would feel comfortable raising any complaints they had, and that staff listened to them. People told us that they knew whom to contact in an emergency or crisis, and the teams had provided the number of the mental health support line.

However, some of the feedback from people was that it was sometimes difficult speaking to different members of staff due to the nature of the shift patterns and this was a challenge for patients when feeling unwell. We also received feedback that patients and carers did not feel listened to when calling the crisis line and sometimes were redirected to contact the police or to attend accident and emergency departments to access an assessment.

Good practice

- Richmond home treatment team had set up a teaching session involving simulated learning using facilities at Springfield Hospital. The training session enabled staff from all disciplines and grades to take part in sessions working with scenarios, which represented common situations. It was an opportunity for staff to learn together and develop skills and competencies in assessment. The team planned to make this a regular event and repeat this again in the future.
- The home treatment team managers were engaged in a quality improvement process to review referral pathways into the service, aiming to improve response times and the experience of people using the service.
- Merton home treatment team had achieved accreditation under the Home Treatment Accreditation Scheme (HTAS) run by the Royal College of Psychiatrists.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that an individual 1:1 supervision structure is embedded in the home treatment teams and that staff have access to regular individual supervision.

Action the provider SHOULD take to improve

- The trust should ensure that the technology and systems used to obtain views of and feedback from people using the services work consistently and staff are able to use the mechanisms to obtain views and feedback.
- The trust should ensure that the home treatment team based in Richmond has sufficient space and access to equipment in the office base to carry out their role.
- The trust should ensure as much as possible, that patients who use the service receive support from the same staff in a continuous manner.
- The trust should ensure that records of care plans and risk assessments are stored consistently so they can be located when needed.

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

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Richmond Home Treatment Team	Trust Headquarters
Kingston Home Treatment Team	Trust Headquarters
Wandsworth Home Treatment Team	Trust Headquarters
Merton Home Treatment Team	Trust Headquarters
Health Based Place of Safety	Trust Headquarters

Mental Health Act responsibilities

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

- Accessing an AMHP for a referral for Mental Health Act assessment was good, and there was not a significant waiting time from referral to assessment. Both Wandsworth and Merton home treatment teams employed social workers who where also AMHP qualified and could be accessed quickly to make a Mental Health Act assessment if required.
- Independent mental health advocacy (IMHA) services were provided by the IMHA working on the acute ward and staff knew how to support patients to access this advocacy service.

Detailed findings

- Staff reported that they could seek advice on the Mental Health Act from a nominated lead within the trust, and from MHA administrators and could seek advice from approved mental health professionals employed by the trust.
- Training on the Mental Health Act was part of the mandatory training on consent. Staff had a good understanding of their responsibilities under the Mental Health Act and the Mental Health Act Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training relating to the Mental Capacity Act was part of the mandatory training on consent.
- Staff we spoke with had a good understanding of the principles of the Mental Capacity Act and had access to policies.
- The service was not providing care for people where a deprivation of liberty safeguards authorisation (DoLS) would be required and there were no DoLS in place for any patients.

Good

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

Home Treatment Teams

Safe and clean environment

- The rooms and facilities in the home treatment teams were clean. Audits and checks of the cleaning of premises were being completed. Infection control audits were undertaken and signs reminding staff about hand washing were displayed in the office and clinic rooms. Staff carried alcohol hand gel when working in community environments and home settings to reduce the risk of spread of infection between home visits.
- The clinic rooms that we inspected at the home treatments teams were well equipped. Each of the clinic rooms contained necessary medical equipment, and appropriate storage facilities for sharps and contaminated items.
- The interview rooms at Kingston and Richmond home treatment team had alarm systems that were located on the walls, which provided safety and security for staff and patients. If a patient was seen at Wandsworth home treatment team, staff booked a room in clinical area on the hospital site where an alarm system was operational.

Safe staffing

- People who used the service had access to a psychiatrist rapidly within office hours (9-5pm) and had access to psychiatric liaison teams which included psychiatrists outside of these hours.
- Kingston home treatment team had not had a consultant psychiatrist in post for almost a year. During this time period, the team had received medical cover from the consultant psychiatrist working in the community mental health team. Plans were in place to recruit a full time consultant psychiatrist to the team in April 2016. The trust said an appointment was made after the inspection.
- Staffing levels varied across the home treatment teams. In Wandsworth home treatment team there was an establishment of 26 members of staff with a total vacancy rate of 37.5%. Richmond home treatment team had a staffing establishment of 14 staff and a total vacancy rate of 17.6%. Kingston home treatment team had an establishment of 12 members of staff and a total vacancy rate of 35.7%. This was as a result of the crisis team services being extended and the vacancy rate being inflated while new staff were appointed. This resulted in regular use of bank and agency staff to ensure there were enough staff on a shift to maintain quality and safety. During the period 1 September 2015 to 30 November 2015 a total of 943 shifts were covered across the whole service by bank or agency staff to cover sickness, absence or vacancies. We saw that the teams used temporary staff that were familiar with the service. Bank and agency staff received an induction to the service and supervision. This helped to create continuity and safe staffing for the team and people using the service.
- The trust was aware that recruitment of staff to the home treatment teams was a challenge and there were staff vacancies. A development programme had recently been implemented to increase the number of staff working across the service. The service had focussed on recruiting eight newly qualified nurses who were mentored by senior nurses over a twelve month period, to develop competencies to work autonomously in home treatment teams. We spoke with two staff on this development programme. They reported that the development programme was working well.
- Each of the home treatment teams had different levels of staff working on the shifts. Staffing levels were estimated according to the caseload and frequency of visits that were being made in the team. Team managers and nursing staff were able to access additional staff if required. We reviewed the past three months duty rotas for the teams and saw that shifts were being covered with staffing levels which were appropriate to the caseload and team.
- The home treatment teams managed and co–ordinated the care of patients using a keyworker system where an allocated member of staff would be responsible for the overall co–ordination of care.
- All of the home treatment teams had an allocated shift coordinator. The coordinator was responsible for screening referrals, liaising with outside agencies, and speaking to patients and carers over the phone.

Good

Are services safe?

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

- The experience of receiving care and treatment for people using the service was mixed. Some people commented that the service had been great, and very helpful. However, the majority of people who used the service commented that having different staff on each shift was difficult when they were feeling unwell and there was a lack of continuity of staff at times. Wandsworth home treatment team was in the process of considering alternative shift patterns to improve this aspect of care for patients.
- Overall, the training completion rates for mandatory training across the home treatment teams had met the target of 95% completion rate. However, the home treatment teams had not achieved the target rate of 95% in adult basic life support (community) and medicines management (community) training. The completion rate for adult basic life support was 62% and for medicines management this was 33%. We spoke with team managers, who fedback that the trust were aware of the completion rates for these areas of mandatory training. The lower numbers had been attributed to the online medicines management training not capturing when staff completed training and a recent change in the nominated lead for basic life support training in the trust. Managers in the home treatment teams were aware of the lower completion numbers for these areas of training and this was also being followed up by the trust, to ensure that training was being completed in each team, and this was being recorded accurately.

Assessing and managing risk to patients and staff

- The service had recently implemented a standardised assessment proforma across the home treatment teams. This helped to ensure that assessment and reviews were consistent across all of the services.
- Risk assessments were regularly updated in the care records we reviewed. The structured risk assessment proforma documented the risks of self harm, self neglect, harm to other people and of exploitation by others. Staff reviewed the risks at each home visit or patient contact, and risks were updated in care records. The designated sections for risk assessment in the electronic care records were not completed regularly, although the risk assessments were updated in progress notes in the care records.
- The service planned to implement a new care planning template, which mirrored the assessment proforma and would provide continuity in care planning. This had recently been proposed, and the template was being developed to be integrated into the RIO electronic care records.
- The teams recognised and responded to warning signs and deterioration in people's health. There were regular discussions taking place in team meetings about changes in risk and people's wellbeing. A 'zoning' system to assess risk was being used and this helped to determine the frequency of visits to the patients. The three zones were 'red', 'amber' and 'green', with the highest risk and most frequent contact needed in the 'red' zone, and the lowest risk and least frequent contact needed from the team in the 'green' zone. We observed that risk was discussed in the daily handovers. At Richmond and Wandsworth home treatment teams the staff updated daily action plans for each patient in the electronic care records following the handover meeting, which meant that information was discussed and recorded clearly.
- Collaborative crisis care plans were developed with patients, to prepare people for discharge from services. These were recovery orientated, collaborative and provided a plan to support the prevention of relapse. These plans also included information about the individual warning signs of deterioration in health, positive support factors and contact numbers of services and how to access help and support in future.
- There was a good implementation of the trust lone working policy across the home treatment teams. Staff had regular access to trust mobile phones to communicate when working in the community. Two home treatment teams had recently introduced a mobile alarm system, which staff carried with them on home visits. The system was connected to a central call centre. Each home treatment team used a system for staff to record their movements from the home treatment team base to visits. This enabled staff to know where colleagues were in community. Where there were concerns around safety joint working and joint home visits took place as an alternative to lone working.
- Complex or higher risk situations could be escalated and taken for review at the trust virtual risk team. Staff we spoke with fedback that this happened and we observed the discussion of a referral to the virtual risk team in a handover meeting.

Good

Are services safe?

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

- Medication was stored securely in a locked cupboard. Each team had processes for checking medication in and out of the team. All of the prescription charts reviewed were clear, signed and dated.

Track record on safety

- There were four serious incidents requiring investigation across the service in the previous 12 months.
- We reviewed the report of an investigation of a serious incident in Richmond home treatment team. Learning and recommendations from the incident were identified clearly in the report. The report recommended that the home treatment team needed to review access to psychological therapies and that patients should have access to therapies.

Reporting incidents and learning from when things go wrong

- The staff we spoke with were clear about their roles and responsibilities for reporting incidents, and there was an emphasis on reporting incidents in the teams. Incidents were reported through the trust electronic incident reporting system.
- Staff told us they were debriefed appropriately following serious incidents, and could access the reflective practice groups, which met monthly in each home treatment team. Staff told us they received feedback on the outcomes of serious incident reviews and we saw this was discussed in team business meeting minutes.
- Following a serious incident in the Richmond home treatment team, staff attended a series of supportive reflective sessions and were able to take forward lessons learnt from the incident.

Health Based Places of Safety

Safe and clean environment

- The environment of the place of safety was good. The section 136 suite was a self-contained unit, on the ground floor, separate from the psychiatric intensive care unit (PICU). There was direct access to the suite via a driveway, leading up to the entrance to the section 136 suite. Emergency vehicles could back up to the entrance door to the suite. This helped ensure the privacy and dignity of patients brought to the suite. A gate could be closed enabling the courtyard to the entrance to be secure. A wooden fence provided privacy and a level of security in the enclosed courtyard area. The suite contained two place of safety rooms. Each one was similar in layout, and included a suitable anti-ligature mattress and chair. Each room had an ensuite toilet, sink and shower, with anti-ligature fixtures and fittings. A blind could be pulled down over the bathroom window to maintain the patient's privacy and dignity while using the bathroom facilities.
- The trust had conducted an environmental risk assessment to identify and manage risks. Appropriate measures were being taken to minimise these risks. At the time of our visit, the trust was installing a mirror in each of the observation rooms, to further improve the lines of site because it had identified a blind spot in each of the rooms beneath the observation window. Patients were always supervised in areas where ligatures existed. There was also a separate room available for family members or patients that did not require observation in one of the place of safety rooms. As there were potential ligature risks in this room, we were told that staff supervised the room at all times if a patient was present.
- Staff were able to view patients using an observation mirror located in a staff area. This room was in between both patient observation rooms. One staff member was always on duty for observations of each room.
- The place of safety was equipped with an emergency alarm system so that staff were able to immediately request assistance when required from their colleagues in the adjacent PICU.
- All emergency equipment and drugs in the place of safety, including for resuscitation, was regularly checked to ensure that it was working and up to date. Ligature cutters were in the staff room between the two observation rooms and all staff knew where these were.
- The environment, including the rooms for patients was visibly clean and well maintained.
- Facilities for conducting any physical examinations of patients were available on the adjacent PICU ward.

Safe staffing

- Whenever a patient was admitted to the place of safety there were always two members of staff working there. These staff worked on the PICU and when they were required to work in the place of safety the trust booked extra staff for the PICU. We interviewed three staff. All said that there were enough staff working at the place of safety to keep it safe for staff and patients at all times.

Good

Are services safe?

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

- The trust did not use bank or agency staff in the place of safety.
- All staff working in the place of safety had to complete an induction before working there. This included the procedures and protocols for receiving admissions and documentation of admissions.

Assessing and managing risks to patients and staff

- Staff working in the place of safety received appropriate training in preventing and managing aggression and in de-escalation techniques.
- Whenever staff needed to physically restrain a patient, they recorded this as an incident. We looked at the records regarding three patient restraints. The records showed that staff had undertaken restraints in accordance with policy and procedure.
- Staff rarely administered rapid tranquilisation to patients. Staff explained that it was common for those arriving at the place of safety to be heavily intoxicated and therefore they did not perform this procedure in those circumstances as it was not safe. The records showed that where staff undertook this procedure they did so according to trust policy and procedure.
- Staff undertook risk assessments of patients on admission. Assessments were completed by the approved mental health professional (AMHP) and approved doctors in accordance with the Mental Health Act. We examined three risk assessments and saw that staff had completed them appropriately.
- Where required, staff raised safeguarding alerts concerning patients to the local authority so that they could investigate them.

Reporting incidents and learning from when things go wrong

- We spoke with three staff members who demonstrated that they knew how to report incidents and learn from them. For example, following an incident where a patient had jumped off a narrow windowsill inside one of the patient's rooms, staff had replaced the flat sills with angled ones so that it was not possible to jump from them.

Are services effective?

Requires improvement

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

Our findings

Home Treatment Teams

Assessment of needs and planning of care

- Comprehensive initial assessments including patients' mental, physical and emotional needs were taking place across the home treatment teams. The service had recently introduced a standardised assessment template. This included a comprehensive mental health assessment, referral and background information, social assessment and mental state examination. Staff told us there had been some initial resistance to this being implemented but acknowledged that it had brought about consistency in the assessment process.
- Overall, the care plans reviewed showed that most care planning incorporated the views of the patients. Most care plans were also updated regularly. The majority of care plans were recovery orientated and focussed on the patient's strengths and goals. At the Wandsworth home treatment team, there were inconsistencies in the updates of care plans. Some of the care records were not updated on the care planning tab in the care records system but on the progress notes. This meant that there was a risk that information on care planning was stored in different areas on the care records, leading to a potential for miscommunication or errors. The trust planned to introduce a new care planning template, which would be used within the electronic care record system to assist in the care planning process.
- Care records were stored securely and recorded on the trust's electronic notes system. All services within the trust had access to care records patients being supported by home treatment teams and information sharing was effective and timely.

Best practice in treatment and care

- Medication prescribing was in accordance with NICE guidance and prescribing guidelines. Prescribing of antipsychotic medication was within prescribing limits. There was minimal use of as and when required medications to aid sleep or treat symptoms of anxiety. Alternative strategies were employed such as stress reduction and relaxation techniques, rather than use of pharmacological interventions.
- When a physical health assessment and examination were required prior to commencing antipsychotic medication such as clozapine or lithium treatment this was routinely completed and documented.
- All of the home treatment teams provided close support and monitoring of patients commencing on antipsychotic medications, while the correct levels were being determined.
- There were challenges in patients who were in crisis and being supported by home treatment teams accessing psychological therapies. There were no psychologists working in the home treatment teams. Each team had a proportion of the nursing staff trained in psycho-social interventions. The usual role of the home treatment teams was to wait for the crisis to subside before therapy was continued or the client is assessed for therapy. Richmond home treatment team had plans to develop an in-house training of psychological therapy skills such as mindfulness, anxiety management and brief solution focussed therapy. This meant that people in the service might not access psychological support promptly.
- Patient reported outcome measures (PROMS) were not used routinely. However, teams used the health of the nation outcome scale (HoNoS) to capture and measure clinical outcomes.

Skilled staff to deliver care

- Staff working in the home treatment teams were experienced and skilled. Each home treatment team had a slightly different skill mix and different number of mental health professionals working on the team. Kingston and Richmond home treatment teams were staffed with qualified nurses and a consultant psychiatrist. Merton and Wandsworth home treatment teams both had two social workers, qualified nurses, and support workers employed. There were plans to employ occupational therapists in Wandsworth and Merton home treatment teams.
- Group reflective practice sessions took place every four to six weeks across the four home treatment teams. These sessions formed a group supervision for the home treatment teams. A psychologist or the community modern matron facilitated the group sessions. The sessions were well attended by staff, who told us the sessions were supportive and useful.

Are services effective?

Requires improvement

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

- The trust policy and target on clinical supervision highlighted that junior nurses should receive supervision no less than once every fortnight during their first year. Senior nurses should receive supervision for at least one hour per month and on at least 10 occasions per year. In Richmond home treatment team, the team manager was responsible for the managerial and clinical supervision of 10 staff members. This meant that supervision took place on an ad hoc and more informal basis. Supervision meetings in Richmond were recorded and held in the team, and also shared with staff. The team was meeting the target for clinical supervision. Staff in Merton home treatment team had access to regular supervision on a monthly basis individually as well as reflective practice sessions which were not formally recorded but provided additional support. In Kingston home treatment team there had been plans to implement a supervision tree, though there were no records of this happening. The supervision records, which were reviewed, showed that during the period Sept 2015 – March 2016, five out of nine members of staff had received individual 1:1 clinical supervision on only one occasion. Some staff in Kingston home treatment reported receiving individual supervision whilst others reported individual supervision was sporadic.
- The service had identified that staff required further training and development of skills for working with people who presented as having a high risk of self-harm or suicide. Following a serious incident in November 2015 the service had planned to deliver training on interpersonal and relational assessment and engagement with people who are at high risk of self harm or suicide. The aims of this proposed training was to improve the quality of care, raise staff awareness, improve risk assessment, improve safety, and also improve patient experience of care provided by the home treatment teams. We were told that this training had not yet started but the trust planned to start it soon. After the inspection the trust said the training had started.
- The mental health support line was a telephone call service staffed by non-qualified staff that had experience and background in working in mental healthcare. Patients and members of the public who were in a crisis and wanted advice or support, were able to call the support line and speak to member of staff on the support line team. Staff working on the mental health support line received support and training before commencing their roles. The training included interventions for harm minimisation, assessment of suicidality and risk, assessment of overdose, and mindfulness and coping strategies. Staff working in this part of crisis service received clinical supervision from senior nurses working in the acute care coordination centre. Staff told us that this happened regularly and it was helpful.
- Overall, the service had a 73% completion rate of appraisals for non medical staff.

Multi-disciplinary and inter-agency team work

- Relationships and joint working with other community services were effective. The home treatment teams were attending the CMHT weekly zoning meetings weekly, enabling regular discussion and joint working, to enhance the referral process between the teams. Patients who had been supported by the team for a sustained period of time (14 – 28 days) were reviewed jointly with a care coordinator where possible to help facilitate discharge.
- Each home treatment team had an allocated discharge coordinator based on the acute admission ward. They worked closely to plan and coordinate discharges from the ward. The crisis and home treatment teams visited and communicated with the wards regularly.
- Overall, there were good examples of interagency working. Staff discussed and clarified the role of other services including GP and social services with patients and carers.
- We reviewed two discharge letters to primary care services and GPs. The information shared was comprehensive and detailed. The letters included updates on progress and treatment, risk assessment, diagnosis, patients wishes, and crisis planning.

Adherence to the MHA and the MHA Code of Practice

- Accessing an AMHP for a referral for Mental Health Act assessment was good, and there was not a significant waiting time from referral to assessment. Both Wandsworth and Merton home treatment teams employed social workers who where also AMHP qualified and could be accessed quickly to make a Mental Health Act assessment if required.

Are services effective?

Requires improvement

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

- Independent mental health advocacy (IMHA) services were provided by the IMHA working on the acute ward and staff knew how to support patients to access this advocacy service.
- Staff reported that they could seek advice on the Mental Health Act from a nominated lead within the trust, and from MHA administrators and could seek advice from approved mental health professionals employed by the trust.
- Training on the Mental Health Act was part of the mandatory training on consent. Staff had a good understanding of their responsibilities under the Mental Health Act and the Mental Health Act Code of Practice.

Good practice in applying the MCA

- Training relating to the Mental Capacity Act was part of the mandatory training on consent.
- Staff we spoke with had a good understanding of the principles of the Mental Capacity Act and had access to policies.
- The service was not providing care for people where a deprivation of liberty safeguards authorisation (DoLS) would be required and there were no DoLS in place for any patients.

Health Based Places of Safety

Assessment of needs and planning of care

- Staff assessed the physical health needs of patients before admission to the place of safety. The trust had also begun a pilot scheme called 'street triage'. This was following a pilot undertaken earlier in various parts of the UK, which had shown some success in reducing patient admissions to hospital. The purpose of street triage was for staff to make assessments about someone's needs before the police brought them to hospital in order to respond to those needs more quickly and effectively. The street triage team operated in Sutton and Richmond from Thursday to Sunday nights and in Wandsworth from Thursday to Monday nights. There were commissioning plans for Kingston and Merton. Before the scheme began the usual process was for police to inform the mental health place of safety that they were bringing someone to them that they had found in a public place who was unwell. Staff would then assess that person's needs once they had arrived at the place of safety. Sometimes police also took unwell people to police cells for their protection if no places of safety were available. Under the scheme staff now responded to a call from the police concerned about the safety of someone by going through a series of questions to determine that person's needs and whether it was necessary to bring them to a mental health unit. For example, if staff assessed that someone required assistance with their physical health they would advise the police to take that person straight to A&E. Staff questions included whether the person concerned had self-harmed, was currently using services, or had a carer. Staff said that the scheme was working well, emphasising that many calls from police involved people who were intoxicated and who were therefore inappropriate for admission. By identifying, those who had a real need for a place of safety staff said that they were able to better meet their needs as well as reduce pressure on services.
- Where staff admitted minors into the place of safety a serious incident report was completed immediately, and the team informed the local child and adolescent mental health service in order to assess the needs of the minor, in accordance with trust policy.

Best practice in treatment and care

- When patients arrived at the place of safety, a duty doctor reviewed their physical and mental health needs. Staff monitored patients' physical healthcare at a minimum of daily but more regularly if required and recorded observations using a modified early warning score system. This meant that whenever a patient's physical health observations deteriorated, this triggered an immediate referral to a doctor.

Skilled staff to deliver care

- Staff working at the place of safety were always staff who worked on the psychiatric intensive care unit (PICU). In addition to their PICU training, which included training in the management of violence and aggression, staff for the place of safety also completed training in child safeguarding. Staff performing the 'street triage' role did not undertake specific, additional training. Instead, they had visited other trusts where this scheme was in operation in order to observe how it was provided. They had also received advice and guidance from the modern matron responsible for the place of safety.

Are services effective?

Requires improvement

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

- Staff received monthly clinical and managerial supervision. Additional supervision was also available for staff if it was required. Staff said that they felt well supported.

Multi-disciplinary and inter-agency team work

- The trust had been working with the police, local authority and other agencies to develop effective policies and protocols for the use of the places of safety to ensure the principles of the crisis care concordat work were firmly implemented.
- Records showed that staff liaised with police and other agencies when discussing the circumstances and needs of someone possibly requiring admission. Staff also had a checklist of questions they asked police when assessing peoples' needs, including their level of intoxication and whether they had self-harmed.
- Staff met on a monthly basis with other agencies involved in supporting patients admitted to places of safety, including the police, social services and representatives from the five London boroughs covered by the trust.

Good practice in applying the Mental Health Act (MHA) Code of Practice

- We reviewed in depth three patient records and saw that staff had correctly completed all the paperwork in relation to patients' admissions.
- All staff working in the place of safety had completed training concerning the MHA. However, one member of staff said that they had not yet completed training on the revised codes of practice.
- Records showed that staff appropriately informed patients of their rights under the MHA following their admission to the place of safety.

Good practice in applying the Mental Capacity Act

- Staff demonstrated an understanding of the main principles of the Mental Capacity Act.

Good

Are services caring?

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

Our findings

Home Treatment Teams

Kindness, dignity, respect and support

- Patients told us that staff were very caring and kind. They said the team was supportive and made an effort to instil hope and positivity. Patients felt the staff they met with empowered them and supported them to get better in their own way.
- In the handover meetings we observed, staff demonstrated an understanding of the needs of the patients.
- During the home visits we attended, we saw information about care and treatment provided to people using the service and their family members, where appropriate. We observed the delivery of sensitive recovery focussed care. We also saw care planning which considered the persons social needs taking place in Richmond home treatment team.
- Staff helped to maintain the confidentiality of people who received clinical visits in the community by keeping their staff badge out of sight until they got into the door

The involvement of people in the care they receive

- A patient information leaflet had been developed in Kingston home treatment team and this was clear, informative and easy to read. It included information on how the team worked, how to access services in an emergency and support helplines. This leaflet was provided to people who had been referred to the service, and families or carers. This leaflet was also being produced for each borough and was due to be with the teams by mid-June 2016.
- All the patients that we spoke with told us that they felt involved in treatment decisions and were aware of their care and treatment plans. We spoke with two carers who told us that they had been involved in the care planning of their relative and felt involved in decision-making.
- The majority of people we spoke with said they had received a copy of their care plan and agreed with its content. Three people using the service told us they hadn't seen their care plan. However, they were happy with the support they were receiving.
- Patients were able to give feedback using the real time feedback system. Discussion of feedback took place in team meetings. Real time feedback collected from patients was reported monthly. However, in two of the home treatment teams staff reported that the tablets used to gather the real time feedback often did not connect properly or were not working. This meant that the feedback was not being captured, and patients were not able to provide feedback comments.
- The Merton home treatment team has developed links with the Merton Carers and Young carers link workers to ensure that information could be shared. The team referred to the local authority for carers' assessments, and were aware of the need to support carers. Carers could be offered visits themselves if additional support was required.
- Staff in the Merton home treatment team had received carers awareness training.
- A family recovery worker worked across the home treatment teams. Patients and families were contacted by phone during the initial assessment. Advice and information on support services and carers assessments were provided. The family recovery worker made home visits and became involved in discharge planning where required, ensuring continuity of family and carer support. The family recovery worker also worked closely with families and carers to help understand and familiarise them with collaborative crisis plans. This enabled the support and empowerment of these support networks to be an active part in relapse prevention work for people using the service.
- Patients and carers were involved in the recruitment process for new staff although this was not happening as consistently as it could be.

Health Based Places of Safety

Kindness, dignity, respect and support

- We observed the admission of one patient to the place of safety and saw that staff treated the patient with care and compassion and demonstrated concern for the dignity of patients.
- Staff demonstrated an awareness of how to meet the individual needs of patients. For example, staff on one occasion assessed an individual with autism as not requiring admission to the ward, but supported their return home. They contacted their housing provider who came to collect them. In another example, staff

Good

Are services caring?

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

usually supported minors admitted to the ward by nursing them in the family room, rather than an observation room, as this area had a more open and relaxed environment.

The involvement of people in the care they receive

- Records showed that as part of their assessment staff sought the views of patients.
- Patients were able to access an independent advocacy service to give them advice and support about their rights.
- We saw during a patient's admission that their carer also attended and staff interviewed the carer about the patient's needs and recorded their comments.

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

Home Treatment Teams

Access and discharge

- The home treatment services and mental health support line provided a service that was accessible 24 hours per day and 365 days per year.
- Each of the teams had a gatekeeping function where assessments for an inpatient hospital admission would be conducted by the home treatment team to review whether home treatment could be provided as an alternative to hospital admission. The service had a target time of 2 hours from referral to assessment. This target was being met across the home treatment teams and the response time from referral to initial assessment was good.
- The home treatment teams had a seven day follow up visit target for patients who were discharged from hospital to the care of the home treatment team. This period represents a time where patients require more support, engagement and period of transition in care. In Wandsworth home treatment team there was good oversight of the figures for this target and this was discussed in the team business meeting minutes we reviewed.
- When home treatment teams received referrals from other agencies for support and treatment, each referral was discussed and reviewed on an individual basis. We saw that this was happening promptly and referrals were being discussed in home treatment team meetings. The operational policy for the service did not provide a target time from referral to assessment. Each of the home treatment teams reviewed referrals on an individual basis. All referrals were screened and prioritised according to the presented risk. All assessments were arranged within 24 hours of referral and home treatment teams often made telephone contact with patients in advance of the planned assessment to facilitate engagement.
- Referrals to the crisis and home treatment teams were triaged and assessed by a shift coordinator and the team manager in each of the home treatment teams. Referrals were received from GPs, community mental health teams, local drug and alcohol services, housing providers, assertive outreach teams, early intervention teams and the acute inpatient wards. People who had previously accessed the service were able to self-refer.
- The home treatment teams operational policy outlined the referral criteria. Overall, this worked well across the home treatment teams though staff told us there were sometimes referrals that were made out of hours and accepted for home treatment services, which were not suitable or appropriate for the service. Staff fedback that the impact of this was that people were often taken on for home treatment services when a more prompt referral to other service or agencies would have been more appropriate.
- People who were not appropriate for the service, for example people who had alcohol or drug use as a primary problem, were supported by working proactively with external agencies to ensure they could access help.
- The home treatment teams operated a 24 hour shift pattern. Out of hours services were covered by the acute psychiatric liaison service working in the local accident and emergency department and one member of nursing staff from the home treatment team. The home treatment teams alternated the responsibility for staffing the out of hours services using a rotating shift system.
- Patients were able to access telephone support 24 hours a day, 7 days a week, with an additional mental health support line operated from 9pm – 5am on weekdays and 24 hours at the weekend, providing an access point for people in crisis. An initial assessment was provided and brief advice or signposting, if required. When people were identified as requiring an urgent mental health assessment, staff advised people to attend a local accident and emergency department.
- Staff worked flexibly to see people in community settings, which were sometimes different from the person's home if required. This helped to promote engagement with people using the service and respond to the person's needs and wishes. In the Wandsworth home treatment team, we observed a clinical handover meeting where the team proactively discussed a person who had been discharged from hospital with complex needs. The team worked together to suggest and propose plans to engage and work with this person to maximise contact and engagement.
- If people disengaged from the service for an extended period of time, there was a clear protocol outlining the steps which should be taken, and how to escalate concerns. This protocol included involvement of the police and other health services if there were concerns

Are services responsive to people's needs?

Good

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

about a person's welfare. During the handover meetings we observed, staff routinely discussed risk and challenges of working with people who were difficult to engage.

- People we spoke to told us that there was a good level of involvement in their discharge from the home treatment teams. People fedback that information had been provided and the discharge had been smooth and well supported.
- All staff we spoke with told us the major challenge for home treatment teams was sourcing an inpatient bed when required. The service had plans to open a seven bedded crisis house to provide an alternative to hospital admission. In addition, the trust had developed the acute care coordination centre that the home treatments teams worked closely with when planning an inpatient admission.

The facilities promote recovery, comfort, dignity and confidentiality

- The office environments at Kingston and Wandsworth home treatment team were large, spacious and had enough room and space for team members to work and walk around the office. The Richmond home treatment team was located within an acute inpatient ward. The office was small but well maintained and clean. However, we observed that when all team members were present for a handover meeting there was very little space to sit or to move around, and the office was very cramped. We also observed that there was very little space in between desk and computer areas in the office. This meant that individual working space was restricted and the office space was small. Staff we spoke with told us that the office was not big enough for the team but they had got used to working in the room.

Meeting the needs of all people who use the service

- All of the home treatment teams had access to medication information leaflets stored on the trust intranet. The medication leaflets were available in different languages.
- All of the home treatment teams were able to access an interpreting service quickly if this was needed for the assessment and review of a person using the service.

Listening to and learning from concerns and complaints

- Between December 2014 – November 2015, 20 complaints were made about this service. One of these complaints was upheld and five of complaints were partially upheld.
- The patients we spoke with felt comfortable and able to make a complaint if needed. One carer fed back that they were about to make a complaint and had been supported and informed by staff of how to proceed with the complaint.
- We reviewed business meeting minutes for the previous three months at Wandsworth home treatment team and saw that complaints and the outcomes of complaints were being discussed and shared in a fortnightly team business meeting. We also saw that complaints from patients were being emailed to the team regularly, ensuring that staff were kept informed of complaints, and the actions which were put in place following complaints. For example, complaints about the length of time staff spent with patients led to a focus on ensuring that the duration of home visits was appropriate.
- There were four complaints made in the Merton home treatment team last year of which, none were upheld. The team manager had a good understanding of the complaints which were made, and although they were not upheld, was able to reflect on changes which could have been made relating to communication and people's experiences of care by the team.
- Staff were aware of how to handle complaints and tried to resolve issues raised locally where possible.

Health Based Places of Safety

Access and discharge

- If someone arrived at the place of safety and both observation rooms were already occupied that person remained in the care of police in the lounge until a room was available where the staff could assess them. Staff said it was rare for this to happen. When we looked at the admission records for the past month we saw that this had occurred on only one occasion. Staff were able to plan and manage admissions in good time as the police usually called them in advance to alert them that they were with someone who required a place of safety. Staff said that occasionally the police arrived unannounced seeking to admit someone, but they hoped the new concordat arrangements would help ensure that notice would always be given.

Are services responsive to people's needs?

Good

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

- Staff always assessed patients within the first 72 hour period of their detention in the place of safety to determine whether the patient required further assessment or treatment under the Mental Health Act. Any delay to the assessment of patients was usually due to their intoxication, but there were no instances where assessment was delayed beyond this period.
- Sometimes where staff had assessed patients as requiring admission to a mental health ward for further assessment or treatment, patients had to wait in the place of safety for a bed to become free on a ward.

The facilities promote recovery, dignity, comfort and confidentiality

- The place of safety was separated from the rest of the mental health unit. It had its own dedicated entrance within the hospital, which included a private area outside the main entrance accessible by locked gates. This allowed for vehicles to enter this area so that a passenger inside them requiring admission could go into the unit without being seen. A short corridor that connected the two patient rooms and the staff room in between had a large window on one side. This window looked out on a courtyard sometimes used by patients from the PICU ward when undertaking recreational activities. However, staff reassured us that the glass in the window was tinted to make it difficult for people to look into the suite.
- The rooms for the patients had mattresses on the floor. These were of a design and type which supported patient comfort and safety. As these rooms had no chairs, where a patient's risk assessment permitted they could sit down in the adjacent lounge area.
- Each patient room had an intercom to allow communication with staff. Each room also had a hatch allowing staff to pass food and drink from the adjacent staff observation room, as well as a large window to help maintain staff-patient contact. From both rooms patients could view a clock on the wall in the staff observation room. The temperature of the rooms, as with all parts of the hospital, was centrally controlled. Staff in the place of safety could control the water running in the ensuite toilet and shower room beside each patient room. This was to prevent any flooding from taps left open. Staff also externally controlled lighting in the patients' rooms and were able to dim the lights, where required.
- There were facilities for staff to make drinks for patients.

Meeting the needs of all people who use the service

- The place of safety had disabled access.
- A variety of information was available for patients. This included local organisations such as drug and alcohol services, independent advocacy and a mental health support line. There was also information regarding patients' legal rights in a variety of languages as well in respect of mental health treatments and religious observance rules.
- Religious support services were available from a variety of faiths.
- Information was available regarding how patients could make a complaint.

Listening to and learning from concerns and complaints

- We looked at four records of patients' complaints and how staff responded to them. In each case the records showed that staff responded promptly to patients' concerns and that they took appropriate action where necessary.

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

Home Treatment Teams

Vision and values

- Staff were aware of the values of the trust and how these values related to their work.

Good governance

- A bimonthly meeting of the home treatment teams leads across the trust promoted joint working and collaboration between the teams. This was a forum for sharing best practice and learning from incidents and complaints across the teams.
- Staff demonstrated that they knew how to report incidents and learning following incidents was taking place
- The teams used the trust reporting system to collate information about the team's performance. These identified areas where the teams needed to improve. This ensured that the team and trust management were aware of incidents and staffing related issues throughout the service.

Leadership, morale and staff engagement

- Overall, the teams were managed well. Morale and teamwork across the four home treatment teams was good. Staff felt empowered to do their jobs and enjoyed working in the services.
- Staff reported no current bullying or harassment cases within the teams.

Commitment to quality improvement and innovation

- The home treatment teams were in a period of change as part of the development of the acute referral pathway. All of the home treatment teams were engaged in a quality improvement project using a methodology to review the process for referrals from acute liaison psychiatry and accident and emergency departments. The team managers were committed to improving the delivery of care and experience of patients, and identifying barriers to discharge from the home treatment teams.
- The Merton home treatment team had achieved accreditation through the home treatment accreditation scheme run by the Royal College of Psychiatrists. This was the first team in the trust to achieve accreditation. Staff told us the process of becoming accredited led to a greater understanding of potential improvements, which could be made in the service and was a positive learning experience.
- Some staff in the team had undertaken accreditation visits to other home treatment teams, which had enabled them to identify good practice and areas in which they could improve.

Health Based Places of Safety

Vision and values

- Staff demonstrated an awareness of the values of the trust.

Good governance

- Staff had received appropriate mandatory training to permit them to undertake their duties and also received regular managerial supervision. There were sufficient levels of appropriately qualified and experienced staff to ensure that the unit was safe and met the needs of patients.
- Staff demonstrated that they knew how to report incidents, what types of situation qualified as a serious incidents as well as how to learn from these events.

Leadership, morale and staff engagement

- Staff said that they felt very well supported, not only in terms of supervision but also in respect of their own personal development. For example, one nurse said that their manager had agreed to their request to undertake additional training in psychosocial interventions. Another member of staff said that they had worked in the place of safety for over 11 years and got personal reward from seeing unwell people admitted who then recovered.
- Staff said that if they had any concerns or complaints they would feel confident that they could raise these with senior managers. One staff member gave an example of how they had raised a concern regarding the time-keeping of a colleague who was frequently late for their shift. They said that the manager then promptly resolved this concern in an appropriate and professional way.
- Good morale and job satisfaction was evident among all the staff we spoke to. Staff felt mutually supported and said that the work they did made a difference to people's lives.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust had not ensured that staff had the appropriate supervision and support to enable them to carry out their duties they are employed to perform. The trust had not ensured that staff were receiving regular supervision to enable them to carry out their role. This was a breach of Regulation 18 (2)(a)