Good

South London and Maudsley NHS Foundation Trust

Mental health crisis services and health-based places of safety

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)
RV502	Lambeth Hospital	Lambeth Home Treatment Team Lambeth Health Based Place of Safety	SW9 9NU SE13 6LW
RV509	Ladywell Unit	Lewisham Home Treatment Team Lewisham Health Based Place of Safety	SE13 6JZ SE13 6LW

Summary of findings

RV505	The Bethlem Royal Hospital	Croydon Home Treatment Team Croydon Health Based Place of Safety	CR0 1XT BR3 3BX
RV504	Maudsley Hospital	Southwark Home Treatment Team Southwark Health based place of Safety	SE5 8BB SE5 8BB

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	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 mental health crisis services and health based places of safety as **good** because:

- Staff working for home treatment teams were supporting patients with their physical health needs.
- Staff in the home treatment teams were very experienced and had access to training to support them develop specific skills to undertake their roles.
- Home treatment teams had multi-disciplinary teams that worked well together and worked well with other teams in the trust.
- Communication between the police and the health based places of safety had improved.
- Staff in the home treatment teams were polite, respectful and kind in their approach.
- People who used the service told us that they received high quality care from the teams and that they felt that staff empowered them to reach recovery in their own way. We also spoke with carers, who reported high quality care.
- Staff in the health based places of safety were very aware of the need to try and support patients in a manner that maintained their dignity.
- Overall there was good morale within the home treatment teams. Staff were aware of the organisations values and reflected these in their work.
- Both services used a range of data to monitor their performance.
- The trust had made a proposal to commissioners to change the model of provision for the health based places of safety as they were aware that improvements were needed.

However, the facilities at the Lambeth place of safety were not safe due to the risks from ligature anchor points and the environment was not fit for purpose. Lewisham health based place of safety had blind spots in both the observation window and the CCTV camera angle that meant that patient safety could not be guaranteed. Personal and emergency alarm systems at Orchard House where the Lambeth home treatment teams were co-located with other teams were not regularly checked to ensure that they were working in the event that staff needed to request assistance. There were inconsistencies in where risk assessments completed by home treatment teams were held in electronic care records, which meant that it is was possible for staff (especially in other teams) to miss updates in risk information. The environments at the Lambeth and Maudsley health based places of safety did not promote the privacy, dignity and recovery of patients using these facilities. These issues included the location of the nurses office in relation to the room people who used the service would be in, and a lack of soundproofing. The place of safety at Maudsley hospital had a large observation window that did not allow the privacy and dignity of the person using the unit. People who used the health based place of safety at Lambeth hospital did not have access to showering facilities. Access to specific health based places of safety could not be guaranteed. Patients may have to be transported to a health based place of safety which was not in their area or borough by police, which could have impacted on their experience of care.

The trust had made a proposal to centralise the health based places of safety on the Maudsley site with a dedicated team of staff. However in the interim three of the four environments were unsafe or did not promote privacy and dignity.

Summary of findings

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

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- The facilities at the Lambeth place of safety were not safe and the environment was not fit for purpose
- Lewisham health based place of safety had blind spots in both the observation window and the CCTV camera angle that meant that patient safety could not be guaranteed.
- Personal and emergency alarm systems at Lambeth home treatment team at Orchard House were not regularly checked to ensure that they were working in the event that staff needed to request assistance.
- There were inconsistencies in where risk assessments completed by home treatment teams were held in electronic care records, which meant that it is was possible for staff (especially in other teams) to miss updates in risk information.

However, we found that staff conducted in-depth discussions of risk in handovers. The majority of rooms used for clinical appointments were clean and well maintained and we saw staff maintained good practice in infection control measures. Staff were aware how to report incidents and learning from these was discussed and changes in practice made to help reduce them from occurring in future.

Are services effective?

Good 

We rated effective as **good** because:

- Staff working for home treatment teams were supporting patients with their physical health needs.
- Staff in the home treatment teams were very experienced and had access to training to support them develop specific skills to undertake their roles.
- Home treatment teams had multi-disciplinary teams that worked well together and worked well with other teams in the trust.
- Communication between the police and the health based places of safety had improved.

However further work was needed to ensure all patients being supported by the home treatment teams knew their crisis plans. The use and recording of mental capacity assessments needed to improve. The home treatment teams needed to be assured that

Summary of findings

patients they were supporting who were detained under the Mental Health Act had the correct arrangements in place to support their section 17 leave and this had been clearly communicated from the inpatient ward.

Are services caring?

Good

We rated caring as **good** because:

- Staff in the home treatment teams were polite, respectful and kind in their approach.
- People who used the service told us that they received high quality care from the teams and that they felt that staff empowered them to reach recovery in their own way. We also spoke with carers, who reported high quality care.
- Staff in the health based places of safety were very aware of the need to support patients in a manner that maintained their dignity.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The home treatment teams were able to respond to the needs of people who called in to request further support that day and people who used the service were assessed within 24 hours of referral.
- The trust could meet the needs of patients who needed to access the health based place of safety although they may need to be transported between boroughs.
- The staff were also very aware of following up people who missed their appointment.
- Staff we spoke to displayed an understanding of how to manage complaints.

However the environments at the Lambeth and Maudsley health based places of safety did not promote the privacy, dignity and recovery of patients using these facilities. These issues included the location of the nurses office in relation to the room people who used the service would be in, and a lack of soundproofing. The place of safety at Maudsley hospital had a large observation window that did not allow the privacy and dignity of the person using the unit. People who used the health based place of safety at Lambeth hospital did not have access to showering facilities. There was no 24 hours crisis line in place for patients or carers/relatives to access help on a 24 hour basis although this was being developed.

Are services well-led?

Good

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

Summary of findings

- Overall there was good morale within the home treatment teams. Staff were aware of the organisations values and reflected these in their work.
- Both services used a range of data to monitor their performance.
- The trust had made a proposal to commissioners to change the model of provision for the health based places of safety as they were aware that improvements were needed.

Summary of findings

Information about the service

South London and Maudsley NHS Foundation Trust provide crisis mental health services across Croydon, Lambeth, Lewisham, and Southwark.

The home treatment teams which are based in each of the four boroughs, operate between the hours of 8am and 10pm every day (apart from the Lewisham home treatment team which operates between 8am and 9pm), with out of hour access to crisis services being 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, triage wards acute inpatient admissions wards and from psychiatric liaison on a 24 hour basis.

The trust had four health based places of safety. These were provided at the Bethlem Hospital, the Maudsley Hospital, Lambeth Hospital and Lewisham Hospital. The health based places of safety provide facilities for the support and assessment of people found by the police in a public place and thought to be in immediate need of care in a safe environment.

Three of the health based places of safety which were managed under the Psychosis clinical academic group were Southwark (Maudsley Hospital), Lewisham (Ladywell Unit), and Lambeth (Lambeth Hospital). The Croydon health based place of safety was delivered and managed under the Psychological Medicines clinical academic group and was located at the Bethlem Hospital.

The home treatment teams had not been inspected before. The health based place of safety at Lewisham Hospital had been inspected as part of larger inspection and improvements to the physical environment were needed. Progress with this is covered in this report.

Our inspection team

The team who inspected mental health crisis services and health based places of safety consisted of nine people, two inspectors, two mental health nurses, a social worker, a Mental Health Act reviewer, a psychologist, a psychiatrist 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?

Summary of findings

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

During the inspection visit the inspection team:

- visited all four of the home treatment teams at their bases and looked at the quality of the environment in which they saw people who used the service
- spoke with 17 people who were using the home treatment team service and 2 carers of people who were using the service
- spoke with the team leaders for each of the home treatment teams
- spoke with 38 other staff members; including nurses, psychiatrists (consultants, associate specialist doctors, staff grade), support workers, support time recovery workers, student nurses, an occupational therapist and social workers
- interviewed the service director and the clinical director for the psychological medicines clinical academic group (CAG) who had responsibility for these services
- attended and observed four hand-over meetings, one multi-disciplinary meeting and 12 clinical appointments with people who used the service.
- looked at 29 treatment records of patients and 37 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 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 who used the service said that they would feel comfortable raising any complaints they had, and that staff listened to them.

Good practice

- Physical health monitoring was taking place and embedded in the delivery of care in Lewisham and Croydon home treatment teams demonstrating a good level of evidence based practice.
- A collaborative research project between a local university and the Lambeth home treatment team was being conducted exploring the experiences of people who use home treatment teams.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the current environments used as health based places of safety are made safe and have adequate levels of observation.
- The trust must ensure that the alarm system at the Lambeth home treatment team at Orchard House is regularly checked to ensure it is working order.
- The trust must ensure that risk assessments used by the home treatment teams are stored consistently and are accessible to care professionals who need this information.

Action the provider SHOULD take to improve

- The trust should ensure that the current environments used as health based places of safety promote people's privacy and dignity.

Summary of findings

- The trust should ensure home treatment teams support patients to receive and know how to use their crisis plans.
- The trust should ensure home treatment teams and staff working in the health based places of safety are able to use and record mental capacity assessments.
- The trust should ensure that home treatment teams complete medication administration records so they include all the necessary information such as records of allergies.
- The trust should ensure that home treatment teams support staff to complete their mandatory training.
- The trust should ensure that home treatment teams communicate with inpatient wards to ensure there is clarity about which patients are on section 17 leave.
- The trust should ensure that staff in the Southwark home treatment team have access to regular supervision.
- The trust should ensure that crisis care plans and crisis contingency planning is personalised, has good service user involvement and is documented clearly in care records

South London and Maudsley NHS Foundation 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
Lambeth Home Treatment Team Lambeth Health Based Place of Safety	Lambeth Hospital
Lewisham Home Treatment Team Lewisham Health Based Place of Safety	Ladywell Unit
Croydon Home Treatment Team Croydon Health Based Place of Safety	The Bethlem Royal Hospital
Southwark Home Treatment Team Southwark Health based place of Safety	The 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.

The trust were working towards ensuring that at least 85% of staff working in the home treatment teams and health based places of safety had received mandatory training in the Mental Health Act. In the home treatment teams the completion rates varied and in Lambeth was only 35%.

Staff reported that they could seek advice on the Mental Health Act (MHA) from a nominated lead within the trust, and could seek advice from approved mental health practitioners employed by the local councils.

The home treatment teams informed people who use the service of their rights under the Mental Health Act when on section 17 leave in addition to the discharging ward. People who are detained in the health based places had their

rights under the Mental Health Act explained and information and guidance were available but this was not consistently displayed in all of the health based places of safety.

At one home treatment team, we were unable to find authorisation of leave or written confirmation of discharge for three patients who were receiving treatment at home after a period of detention in hospital.The staff when asked were very unclear about their status. We also found patients who were having extended section 17 leave authorised without due consideration to a community treatment order.

Patients being supported by the home treatment teams did not have a record of using independent mental health act advocates. Staff said that this was arranged by the wards and that they had not been involved in speaking with any independent mental health advocates.

Mental Capacity Act and Deprivation of Liberty Safeguards

The staff working in the home treatment teams were not fully up to date with Mental Capacity Act training. Only 59 % of staff in the Lambeth and Lewisham teams and 64 % in the Croydon team had current training.

Some staff demonstrated an understanding of the assessment of mental capacity. Non-medical staff told us that they felt it was the duty of medical staff to assess mental capacity. A person's capacity to make decisions was discussed within the home treatment team meetings and staff could seek advice from leads within the trust.

While staff described how they assessed capacity in the home treatment teams, patient records showed few records of capacity assessments being conducted and where they were there was an inconsistency in how this was documented.

Assessment and documentation of capacity was also poor in the health based places of safety. In the 11 electronic care records which were reviewed, two showed issues around the prescribing of rapid tranquilisation medication. There was no documentation of discussion with the service user around the prescribing decision or the assessment of the person's mental capacity to consent in this situation. The staff we spoke with about these incidents informed us that rapid tranquilisation medication was often prescribed by doctors routinely, in case nurses needed to administer these medications. The staff we spoke with reported that capacity assessments were completed by nurses when medication was administered , not when it was prescribed. This reflected poor prescribing practice and poor assessment of capacity in prescribing medications in the health based places of safety.

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

Home Treatment Teams

Safe and clean environment

- Most of the treatment rooms and clinic rooms in the bases we visited had adequate alarm systems in place. The treatment and clinic room used by the Lambeth home treatment team base at Orchard House had a local alarm system that sounded within the building. The alarms were hard for staff to reach as they were located behind where the patient would sit. Staff told us that the rooms felt unsafe and that there was no guarantee that there would be other clinical staff readily available to respond to alarms being raised. There were alternative ways of requesting assistance including the use of personal alarms and a device for signalling an alarm to the rest of the hospital site. Reception staff in the building said they would call the police should an alarm be raised and no-one clinically trained was available to respond. Staff were unable to produce records that any of the alarms in the building were routinely checked, and said that this checking systems were not in place.
- We also found that the building in which the Southwark home treatment team was based was unsuitable for appointments with people who used the service. Staff used rooms at the Maudsley hospital site for appointments, which were only available 9am-5pm Monday-Friday. This meant that patients who had appointments outside these hours would have to meet staff in more public areas off the site which staff said could compromise their dignity and confidentiality.
- Most of the clinic rooms we inspected were well equipped with the necessary equipment to carry out physical examinations. However the clinic room at Orchard House, used by the Lambeth Home Treatment team had a defibrillator that staff were unsure when it was routinely tested and by whom. The pouch in which the defibrillator was held stated that it should have been returned to the drug store in 2013, and staff were unsure what this meant.
- 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 being undertaken and signs reminding staff about hand washing were routinely displayed. Staff carried alcohol hand gel when working in community environments and home settings.
- Equipment in the clinic rooms had up to date portable appliance testing checks demonstrated by stickers, and were calibrated.

Safe staffing

- Staffing levels differed across the teams we inspected dependent on the commissioning arrangements in each of the four boroughs. The investment had recently increased in the Lambeth and Lewisham teams due to the implementation of the new adult mental health model. In Croydon there were 27 substantive members of staff (with a vacancy rate of 31% and a sickness rate of 10%), in Lambeth there were 32 members of staff (with a vacancy rate of 10% and a sickness rate of 7%), in Lewisham there were 25 members of staff (with a vacancy rate of 18% and a sickness rate of 9%) and in Southwark there were 21 members of staff (with a vacancy rate of 23% and a sickness rate of 10%). All teams included registered nurses, psychiatrists, support workers or support time recovery workers and social workers. Croydon had an occupational therapist. None of the teams had a psychologist, apart from the Croydon team who had 0.5 whole time equivalent.
- Staff reported that the number of staff on a shift varied across the teams, with the established staffing levels being 7 (4 qualified and 3 unqualified) in Lambeth, and 6 (4-5 qualified and 1-2 unqualified) in Lewisham. In Lambeth there was a pattern of lower than agreed staffing levels on the late shift but this was in partly mitigated with higher levels of staffing in the early shift.
- There was no maximum caseload identified by the trust for the home treatment teams however they operated on a caseload of 35-40 people dependent on their acuity levels. For example caseloads were 36 in Lambeth home treatment team and 34 in Lewisham home treatment team.

Requires improvement

Are services safe?

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

- The home treatment teams did not have a key worker system in place. Patients were seen by the staff who were allocated for that shift. Allocations of appointments were made twice daily and caseloads were discussed in weekly support meetings as well as in team meetings.
- Staff told us that bank shifts were used to cover sickness and annual leave, as well as gaps in the rota due to vacancy rates. Staff told us that these bank staff were either familiar with the service or had received an induction to the team. Lewisham and Lambeth had received additional funding to develop in-reach work.
- Differences in staffing levels across the home treatment teams meant that there were inconsistencies in the ability to provide inreach workers to acute inpatient wards. This would have allowed all the teams to identify and work with patients who may be in a position to be supported by home treatment teams rather than as inpatients.
- People who used the service had access to a psychiatrist rapidly within office hours (9-5pm) and had access to psychiatric liaison teams and out of hours psychiatrists outside of these hours.
- Mandatory training completion rates varied across the teams, as well as between different subjects of training. Training rates ranged from 100% in Lambeth for safeguarding children and 35% in Lambeth for Mental Health Act training. Training rates were also low across the teams for promoting safe therapeutic services training, which was 78% in Lambeth, clinical supervision 69% in Lambeth, 33% in Lewisham, Mental Health Act training 63% in Lewisham, Mental Capacity Act training 59% in Lambeth and in Lewisham, infection control 59% in Lambeth and clinical risk 68% in Lewisham, 48% in Lambeth. Staff highlighted that some of the low completion rates were due to training being added to the trusts central reporting system in the previous 3 months. In some cases a shortage of places for training was the reason for not being able to keep up to date with training.

Assessing and managing risk to patients and staff

- Risk assessments were often incorporated into the general assessment when people who used the service first accessed the team. The designated sections for risk assessment in the electronic care records were not completed regularly and risk assessment were being updated in progress notes in the care records.
- There were regular discussions taking place in team meetings in about changes in risk and risk assessment. A 'zoning' system to assess risk was being used and this would help to determine the frequency that the person who used the service would be visited. 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 twice daily handovers, although this discussion was not consistently recorded in the care records of the people using the service.
- In the care records there were plans for patients to call the team if they felt they needed more support or to contact the team in a crisis. However we found little evidence of in depth, and person centred crisis plans. Two patients we spoke to fedback that they were not aware of a crisis plan for them to use if needed.
- Staff we interviewed told us it was rare for people who used the service to have advanced decisions in place.
- Although mandatory training rates differed across the teams, staff we spoke with were aware of safeguarding procedure and were knowledgeable about different signs of abuse. We also observed the tracking of which people required child safeguarding assessments on the team allocation board.
- There was a good implementation of lone working policy across the home treatment teams Staff had regular access to trust mobile phones to communicate when working in the community. 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 was used as an alternative to lone working.
- Medication was stored securely appropriately and in accordance with best practice. We found that there was limited direct access in teams to a pharmacist. For example in the Croydon team there were weekly visits from a pharmacist. However there were arrangements

in place to enable the Croydon team to have access to the medicines information line, the on-call pharmacist and a pharmacist in the Bethlem pharmacy at times when the pharmacist was not present at the team. When we reviewed the medicine administration charts, we found on some of the charts key information such as allergies and gender were not always completed.

Track record on safety

- During the period April 2014-August 2015 there were four serious incidents involving the death of service users whilst receiving care from the home treatment teams. Within the same period there were 9 reported incidents of violence.
- We saw evidence of learning from an incident following an investigation conducted by a coroner where it became policy for the shift co-ordinator to be a qualified member of staff, rather than a member of staff without a professional qualification.

Reporting incidents and learning from when things go wrong

- Staff were aware of the process for reporting incidents. Staff reported incidents in first place to the shift co-ordinator who reported it to the team leader. Staff also completed electronic forms using the trust incident reporting system. This system alerted local managers as well as consultants. Serious incidents were escalated to senior management within the clinical academic group.
- Staff also fed back that they discussed incidents in monthly team meetings, as well as within daily handovers between shifts.
- Learning from incidents was fed back to staff via blue (for immediate attention) and purple (outcomes and actions following trustwide audits) bulletins, as well as learning points being sent to team leaders to distribute to other members of staff.
- Staff reported they felt they were debriefed appropriately following serious incidents and had access to a routine weekly support group.
- The psychological medicines CAG was compiling a learning lessons report which shared a number of incidents and the findings from incidents. This was shared in the home treatment teams on a regular basis and helped with sharing and learning from serious incidents.

Health based places of safety

Safe and clean environment

- In the four places of safety we inspected, we found variations in the quality of the physical environment. All four places had appropriate management of ligature anchor point risks. The health places of safety at the Maudsley, Bethlem and Lewisham Hospital had appropriate management of ligature anchor point risks and had environments which were ligature free. At Lambeth Hospital there were numerous ligature points and the room was included in the ligature audit. The trust mitigated the ligature risk by ensuring that people who used the service were observed by staff whilst occupying the place of safety. However the number of ligature points which were present and the layout of the environment meant that the place of safety at Lambeth Hospital did not meet the needs of people who might be in crisis and was not safe.
- There were other environmental concerns in the place of safety at Lambeth Hospital. The door to the room was not suitable and did not have a suitable locking mechanism for situations where it might be used as a seclusion room. The viewing window into the room was marked, scratched and dirty. This resulted in poor visibility and an inability to observe service users and maintain their safety in the room.
- The room at Lewisham Hospital did not allow for safe observation of the people who used the service whilst they were assessed in the room. There were blind spots in the room when looking through the viewing window and the viewing angle of the CCTV camera also had areas it did not cover, meaning that patients could not be observed and their safety could not always be ensured. Since the last inspection a mattress had been provided so that patients could rest which was a requirement at the last inspection.
- Overall the places of safety were clean and well maintained. However it was observed that the place of safety at Lambeth hospital was dirty and had marks and holes on the ceiling.

Requires improvement

Are services safe?

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

- In the longer term, the trust has plans to build a purpose built health based place of safety. The trust aimed for a completion date for the building and the new service starting in March 2016. There were on-going discussions with local authorities at the time of inspection around the provision of AMHP service for the purpose built unit and final agreements on provision of AMHP services had not been met. In the meantime the safety of patients using the existing facilities needed to be assured.

Safe Staffing

- The places of safety that were part of the psychosis clinical academic group (Lambeth, Lewisham & Southwark) were staffed by staff from the psychiatric intensive care (PICU) wards. The staffing levels within these wards directly affected the levels of staffing in the health based places of safety.
- At Croydon, the health based places of safety was staffed by staff from the triage ward. As with the other places of safety, the staffing levels within this ward affected the levels of staffing in this place of safety. The trust had established a virtual section 136 team which floated between the health based places of safety and supported staffing where needed.
- For Mental Health Act assessments to take place approved mental health professionals (AMHPs) and Section12 doctors were accessed. There could be delays in accessing AMHPs out of hours due to the number of AMHPS available, but generally response times were good.

Assessing and Managing risk to patients and staff

- Staff working in the health based places of safety had received mandatory training in managing conflict and aggression and felt confident in using de-escalation techniques.
- The staff we spoke to said that restraint was often used in the health based places of safety, however this was recorded through the PICU or triage ward incident reporting system and this information was not available on the the health based places of safety.
- All staff were expected to take responsibility for reporting incidents. Staff told us that they reported incidents on the trust's electronic reporting system.
- Staff reported that rapid tranquilisation was often used when people are being assessed in the section 136 assessment rooms. When rapid tranquilisation was administered to people who used the service, staff followed trust protocols and ensured that there was regular observations and monitoring of the persons health and wellbeing.
- All health based places of safety were equipped with an alarm system which was linked to the hospital wards. Staff we spoke with were aware of how the alarm systems worked and reported that these were effective.

Track Record on Safety

- There had been a recent incident of violence towards staff at Lambeth place of safety which had led to a change in the staffing arrangements for responding to incidents within the unit. A rapid response team was allocated to each shift to respond to incidents of violence or aggression on the unit following this incident.

Reporting Incidents and learning when things go wrong

- Incidents were reported through the trust's incident reporting system. Staff we spoke with were aware of the need to report incidents. These were reviewed by the manager responsible for the service.
- There were opportunities to discuss and debrief following incidents in the health based places of safety.

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

Home treatment teams

Assessment and planning of care

- We found that care records contained care plans that were up to date and holistic, as well as being orientated towards the person's recovery.
- Initial crisis plans were completed at intial assessment with the home treatment team. This included information on how to access help out of hours via an accident and emergency department and how to contact and leave a message with the home treatment team on an answer messaging service overnight or out of working hours..
- The service users we spoke to said that they were given a welcome pack with a leaflet which had a crisis plan which included telephone numbers and who to contact in an emergency.
- We did not find personalised, detailed crisis contingency planning in the care plans we reviewed. Furthemore there was no evidence of patient involvement in their crisis care planning in the electronic care records which were reviewed.
- Assessment and care planning of service users social needs was taking place in the home treatment teams and there was a holistic approach to providing care.

Best practice in treatment and care

- Staff demonstrated a knowledge of NICE guidelines and prescribing. Staff also had access to an internal medications guide. We reviewed 37 prescription charts which showed that prescribing was in accordance with best practice and NICE guidelines.
- Referals for psychological therapies were made to services outside of the home treatment teams. The home treatment teams were not providing psychological therapies routinely across all four of the home treatment teams. Croydon home treatment team had psychologist input into the team. Lambeth home treatment team were in the process of recruiting a psychologist to work within the team though Southwark and Lewisham home treatment team did not have psychologist input. Some staff received training in dialectical behaviour therapy techniques and were using these skills and approach to support people in crisis. Staff had also received training in brief solution focussed therapy at Croydon and Southwark home treatment teams.
- Staff told us that they offered signposting to other services as well as support themselves to help meet the employment, housing and benefit needs of the people who used the service.
- The physical health needs of patients were discussed at multi-disciplinary team meetings and there were records of physical health checks having been undertaken in the care records. There was a named member of staff in the Southwark home treatment team who helped to organise activities for people who used the service such as football matches and rambling groups to help meet the physical and social needs of people who used the service. Croydon home treatment team had established a weekly physical health clinic which patients were encouraged to attend. Both nurse and doctors ran this clinic and provided routine physical health checks and investigations. In addition the team were able to offer physical health screening and checks for patients prior to commencing antipsychotics and medications that can cause physical health side effects. This was a good example of delivering evidence based practice.
- Staff used the health of the nation outcome scales as a clinical outcome measure.
- Staff input information weekly for clinical audits, and there were peer audits of care plans conducted by staff.
- Southwark Home Treatment Team had embedded a culture of recovery based practice and routinely used feedback from patients to guide the teams' approach to care. This was a innovative and collaborative approach to service delivery.

Skilled staff to deliver care

- Each home treatment team had slightly different skill mix and different number of mental health professionals. Croydon home treatment team had a locum occupational therapist and were in the process of making this post a full time position .

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.

- Staff were experienced and qualified. A number of staff had been working within the teams for more than 10 years. All staff received an induction (including bank staff) which included writing reflective accounts of their understanding of different aspects of the role.
- In the majority, staff received the levels of clinical supervision identified in operational trust policy. The home treatment teams operated a process of ongoing peer and clinical supervision which occurred twice daily during handover between shifts, in weekly support groups and fortnightly reflective practice meetings. However in Southwark home treatment team one senior staff member was responsible for supervising 22 members of staff which meant that some staff members received managerial supervision every two months.
- All staff had received appraisals within the previous year. Staff in Lambeth, Southwark and Croydon home treatment teams had received training in areas that were not mandatory, such as in brief solution focused therapy, drug and alcohol work training, coaching, and mentorship. In one team the trust had supported a member of staff to undertake a masters degree.
- There were appropriate measures in place to manage poor staff performance, but in the majority of teams staff told us this was not a current issue. Where this was an issue, it was being addressed appropriately.

Multidisciplinary and inter-agency team work

- Overall there were good examples of multi disciplinary and interagency working, though this varied in application across the home treatment teams. In the meetings we observed, we saw efficient multidisciplinary working with care being discussed and planned with input from different professions.
- There were sometimes difficulties in referring people onto other mental health teams and discharging service users to other mental health services. Lambeth home treatment team had designated link workers that engaged and carried out inreach work to the community health recovery services and triage wards. Croydon home treatment team had a designated member of staff working as an in reach worker to the acute wards on a daily basis to identify and work with service users to facilitate early discharge for patients from acute wards. This was helping with the access to the service and facilitating people who used the service moving through the care pathway. This was not happening at Southwark home treatment team due to staff capacity.
- Staff from the home treatment teams often attended the ward round of people who were approaching discharge from a mental health ward to assess whether they would be suitable for support from a home treatment team.

Adherence to the MHA and the MHA code of practice

- The trust were working towards ensuring that at least 85% of staff working in the home treatment teams and health based places of safety had received mandatory training in the Mental Health Act. In the home treatment teams the completion rates varied and in Lambeth was only 35%.
- Staff reported that they could seek advice on the Mental Health Act (MHA) from a nominated lead within the trust, and could seek advice from approved mental health practitioners employed by the local councils.
- The home treatment teams informed people who use the service of their rights under the Mental Health Act when on section 17 leave in addition to the discharging ward.
- At one home treatment team, we were unable to find authorisation of leave or written confirmation of discharge for three patients who were receiving treatment at home after a period of detention in hospital. The staff when asked were very unclear about their status. We also found patients who were having extended section 17 leave authorised without due consideration to a community treatment order.
- Patients being supported by the home treatment teams did not have a record of using independent mental health act advocates. Staff said that this was arranged by the wards and that they had not been involved in speaking with any independent mental health advocates.

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.

Good practice in applying the MCA

- The staff working in the home treatment teams were not fully up to date with Mental Capacity Act training. Only 59 % of staff in the Lambeth and Lewisham teams and 64 % in the Croydon team had current training.
- Some staff demonstrated an understanding of the assessment of mental capacity. Non-medical staff told us that they felt it was the duty of medical staff to assess mental capacity. A person's capacity to make decisions was discussed within the home treatment team meetings and staff could seek advice from leads within the trust.
- While staff described how they assessed capacity in the home treatment teams, patient records showed few records of capacity assessments being conducted and where they were there was an inconsistency in how this was documented.

Health based places of safety

Assessment of needs and planning of care

- Initial assessments were completed in a timely manner. A clear process for commencing mental health assessment and physical health checks was in place and used when people were brought to the places of safety under Section 136 of the Mental Health Act.

Best practice in treatment and care

- Staff at Lewisham place of safety reported that they had recently completed an audit of care plans and explanation of patient's rights under the Mental Health Act.

Skilled staff to deliver care

- The places of safety were staffed by staff from identified wards at the locations they situated in. Each place of safety had a unit coordinator who was responsible for ensuring the place of safety was staffed appropriately on a 24/7 basis. There was also overall co-ordination of the section 136 assessment suites by the leader of the section 136 management team.
- At Croydon place of safety staff were receiving regular 1:1 supervision and reflective practice groups were held to discuss clinical issues and practice.

Multi-disciplinary and interagency team work

- The health based places fo safety were putting in place strategies to ensure that people who were experiencing mental health crisis were receiving help in a timely and effective way. Regular network meetings and strategies to work between police, social services and ambulance services were in place to ensure that the principles of the crisis care concordat were being worked towards and met.
- The staff we spoke with reported that the inter-agency working with the police had improved and there were better links and conversations prior to police bringing detained patients to the health based place of safety. This had been helped by the street triage system which allowed police to contact the trust prior to bringing someone to a place of safety for assessment. There were regular meetings between the local police service and the trust liaison committee that reviewed the use of section 136 assessments and how places of safety were accessed.
- Staff were able to refer and signpost people who used the service to relevant support agencies or services to provide follow up care plans if a person had been discharged from the place of safety.

Adherence to the MHA and MHA Code of Practice

- People who are detained in the health based places had their rights under the Mental Health Act explained and information and guidance were available but this was not consistently displayed in all of the health based places of safety.

Good practice in applying the MCA

- Assessment and documentation of capacity was also poor in the health based places of safety. In the 11 electronic care records which were reviewed, two showed issues around the prescribing of rapid tranquilisation medication. There was no documentation of discussion with the service user around the prescribing decision or the assessment of the person's mental capacity to consent in this situation. The staff we spoke with reported that capacity assessments were completed by nurses when medication was administered, not when it was prescribed. This reflected poor prescribing practice and poor assessment of capacity in prescribing medications.

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

- We observed 12 clinical appointments and home visits and saw staff treating patients with kindness, dignity and respect.
- The 17 patients were spoke with said staff were very caring and kind. They reported the team was very supportive and made an effort to instill hope and positivity. People who used the service felt the staff they met with empowered them and supported them to get better in their own way. Some service users we spoke with told us it was sometimes difficult for them to explain their concerns to a different member of staff and being able to see the same member of staff regularly would have been helpful. We also spoke with 2 carers of people who used the service who reported that the staff were kind and respectful.
- There were 3 compliment letters from people who used the service praising the staff for their support.
- Staff demonstrated an understanding of the needs of the person who used the service, which we also saw in the handover meetings we observed.
- 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

- The home treatment teams had started holding service user forums in the month prior to inspection, however the attendance was low (no attendees in Lambeth, one in Croydon and two in Lewisham). Staff planned to continue this forum and try to increase awareness of the event.
- People who had used the service were involved in the recruitment of new staff.
- Some of the people we spoke with that used the service were unaware of how to access advocacy services although these were available.
- There was a carer's support group locally that ran weekly sessions. The welcome pack also included information for carers.
- People who used the service were able to give feedback via the friends and family test as well as an internal trust feedback form which was routinely fedback to the team. The Southwark home treatment team had particularly good practice in this area.

Health based places of safety

Kindness, dignity, respect and support

- Staff we spoke with across the locations described how they would support people who used the service through the section 136 process in a considerate manner, and how they ensured that those people were treated in a way to uphold their privacy and dignity at all times. Staff at Lambeth hospital expressed a caring, positive attitude towards Section 136 Assessment as an important stage of providing care for people in crisis.

The involvement of people in the care they received

- Advocacy service and interpreters were available for patients to access from the places of safety and staff routinely accessed these if needed.
- Service users had been consulted about the plans for a single point of access crisis hub and centralised health based place of safety suite.

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

- During the hours when the teams were working new referrals were assessed within 24 hours of referral to the teams. If this was not possible, as well as informing the person that they could attend accident and emergency if they needed they were also sign posted to other organisations such as the Samaritans.
- When the patient was an inpatient a joint assessment with the home treatment team and any keyworker or care co ordinator would take place within 7 days of the team receiving a referral. This helped to begin initial discharge planning and facilitate joint working with other services.
- Staff would agree the frequency of appointments to meet the individual needs of the patient.
- People who used the service told us that cancellation of appointments was unusual and the appointments were quickly re-arranged. Staff reported letting people who used the service know when they would be delayed in attending their appointment or visit to their home.
- Across the home treatment teams, there was a good approach to working with people who were hard to engage. Missed appointments were discussed during handover meetings and there was a clear escalation process to manage the non engagement.
- Appointments for medical reviews were generally held at two times per day between 9am-5pm Monday-Friday. Staff reported they were sometimes able to accommodate appointments outside these hours.
- Delays in discharging patients from the home treatment teams were commonly caused by housing issues and challenges in arranging joint discharge meetings with other services.
- The trust did not have an out of hours crisis line service though plans were in place to develop and introduce this service. Some of the patients we spoke with reported that they sometimes had difficulty accessing help out of hours but when they made contact with the home treatment teams, they were very helpful and supportive. Some patients reported that they knew how to access help out of hours though this was not through the use of a crisis line but by presenting to Accident and Emergencey Services.

The facilities promote recovery, comfort, dignity and confidentiality

- There were rooms in which staff could meet with people who used the service. These interview rooms had adequate sound proofing to protect the confidentiality of the person using the service.
- There were leaflets on some local services in the waiting rooms as well as information on how to complain.

Meeting the needs of all people who use the service

- Interview rooms were on the ground floor and there was disabled access. The Southwark office did not have disabled access but staff would see patients in other locations.
- Information leaflets on a variety of topics were present, however they were not routinely present in different languages. Leaflets in other languages could be printed off the trusts website.
- The team had access to a 24 hour phone line and could book a face to face intepreter with 24 hours' notice.

Listening to and learning from concerns and complaints

- Two of the teams had received complaints within the past 12 months which were upheld. Lambeth home treatment team had one complaint that was upheld, and Lewisham had two upheld complaints. None of the teams had complaints that had been referred to the parliamentary health ombudsman.
- People who used the service could use the patient advice and liaison service to raise complaints and were given information on how to make complaints during their assessment.
- People who used the service that we spoke with told us they were aware of how to make complaints, and would feel confident in doing so, however they had not needed to.

Are services responsive to people's needs?

Good

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

- Staff told us that complaints were discussed in daily and weekly meetings, as well as having formal feedback at team meetings.

Health based places of safety

Access and Discharge

- A triage system had been put in place where police contacted the section 136 management team when a section 136 had been placed on a person. This helped to identify a suitable place of safety and whether it was open before the person was brought to the place of safety. Staff reported this had helped to identify an open and available place of safety if there had been closures due to staffing shortages. The staff we spoke with reported that there were still occasions where the police had brought a person to a closed place of safety, though systems were in place to help mitigate this.
- The trust had fedback that the measures implemented to manage demands on health based places of safety has resulted in stopping the use of police custody suites as alternatives to places of safety. However, the closure of places of safety at times meant that patients may have been escorted by the police to an available place of safety in another area. This meant that people would not have received care in the area they live in and having to travel to another area could impact on the individual experience of the person using services in a time of crisis.
- In the event of person under the age of sixteen being brought to the place of safety there was clear guidance in the operational policy about setting up a joint review with CAMHS specialists. The staff we spoke with fedback that admitting a child or adolescent to a place of safety happened infrequently. When this had occurred, staff reported that the joint working was quick and effective to assess and source an appropriate place of care.
- An activity report completed between Jan – May 2015 showed that there were 312 admissions to a place of safety in this period. The average length of stay was 12hrs 25 minutes.
- During this period there were 162 occasions where a place of safety was closed. Closing a place of safety due to staff shortages accounted for 80% of all incidents of closures. Croydon experienced the highest number of closures (60) during the period followed by Southwark (42), Lambeth (24) then Lewisham (16). The average length of closure was 17 hours 15 minutes. The trust commented that this averaged figure is high as a number of PoS were closed for several days at a time because they were used for seclusion or were awaiting extensive repairs.
- Both February and April saw a sharp increase in length of closure in Lambeth and Lewisham respectively. In February Lambeth place of safety was closed five days whilst awaiting repairs to the floor and in April Lewisham place of safety was closed on two occasions (both for two days) due to high acuity of patients on the hosting ward and staffing shortages. There was an occasion where Southwark place of safety was closed for five days in May as it required repairs. The trust fedback that there had been no occasions where the trust had closed all four health based places of safety but were unable to comment whether there had been occasions where a place of safety had been unavailable for a person to be detained due to all of the open units already being used.
- This had an impact on the availability of people accessing health based places of safety and during the period. There were 24 occasions when there were no places of safety available to accept a patient. At the time of inspection the health based place of safety at Lewisham Hospital was closed due to staffing shortages.
- The place of safety locations received admissions for their respective boroughs and also received admission from London boroughs outside of the trust's area of coverage and people from areas outside of London. The admissions for people living outside of trust covered London boroughs (including people of no fixed abode) accounted for 22% of the total number admissions. This represents a high use of places of safety for non-residents of boroughs served by SLAM.
- A more recent activity report highlighted some of the reasons for the closure of the health based places of safety in June 2015. The health based places of safety were sometimes used as seclusion rooms and this accounted for 20% of the closures of the health based places of safety. Closure of the health based place of safety due to staff shortages accounted for 45% of the closures during this period which was a reduction from

Are services responsive to people's needs?

Good

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

previous months. A further 20% of recent closures did not have a stated reason for closures. The remaining reasons for closure include deep cleaning, repairs and high acuity on the ward.

- There were contributing factors leading to increasing the length of stay of people who used the place of safety, including; waiting for doctor assessment, waiting for AMHP assessment, intoxication from alcohol and transport waiting times. A lack of available beds for admission was the most frequent reason for increasing length of stay in places of safety. Staff reported that this was a real pressure on the length of stay in the places of safety and meant that service users often remained in an environment which was not suitable for their needs.
- The trust was conducting daily capacity meetings at a senior manager level to review the demand for inpatient beds and staffing levels across the trust and was in the process of putting in measures to address the demands for inpatient hospital beds.

The facilities promote recovery, comfort, dignity and confidentiality

- The rooms across three of the health based places of safety offered environments which maintained the dignity and confidentiality of people using the service though there was variation in the standards of the facilities.
- The layout of Maudsley and Lambeth place of safety meant that the nursing station was in very close proximity to the assessment room. This meant that sound, conversations and discussion between staff could have impacted upon the privacy of the people using the service and led to noise causing a disturbance.
- The room at Lambeth Hospital was poorly lit, dirty in areas, unsafe and did not provide an adequate environment for a person in a crisis. The ensuite toilet area had a door which closed to maintain privacy of the people using the room but there was no shower facility in the en-suite area. This place of safety was not welcoming and was dirty. Staff fedback that because of this, they did not like bringing patients or visitors into the room.
- The room at Maudsley Hospital had a large viewing window which was oppressive and invasive and did not maintain dignity and privacy of the service user. There was an en-suite washing facility and toilet connected to the assessment room that maintained privacy and dignity of service users.
- The room at Lewisham Hospital did not have an en-suite toilet/shower area connected to the inside of the assessment room though people using the service were able to access toilet area which was adjacent to the assessment room.
- This meant that out of the four health based places of safety, only Croydon place of safety provided an environment which was comfortable, welcoming and promoted recovery. The environment was newly built and was clean and provided a good amount of space for people using the service.
- All of the health based places of safety were equipped with soft furnishings. All of the health based places of safety provided food, linen and clothing where needed from the ward they were situated in. People who were using the service were able to access food from the wards and obtain hot drinks outside of meal times

Meeting the needs of people who use the service

- The health based places of safety provided a service for adolescents and young people who may require assessment for detention using Section 136 of the Mental Health Act. The services catered for the needs of young people and adolescents and the Trust had an operational policy in place to ensure joined up and comprehensive assessment between adult mental health and childa and adolescent mental health services took place if a young person was admitted to the health based place of safety.
- Patient advice and liaison service information leaflets were available for service users using the service and were displayed in the units.
- There were information leaflets available in languages spoken by people who use services and staff were aware of how access these resources. Staff also reported that access to interpretation services was good and readily available.

Listening to and learning from concerns and complaints

- Staff were aware of how to handle complaints and staff tried to resolve issued raised locally where possible.

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 we spoke with were aware of the organisation's values and said they felt the values fitted with their current teams practice.
- Staff knew the names of senior members of the board and had received visits from the trust director of nursing. There were monthly meetings that team leaders could attend to meet with more senior management in the trust.

Good governance

- Teams had access to information about staff training and data from the patient record systems.
- The home treatment teams used key performance indicators to measure the progress of the teams for example numbers of referrals and other activity data. Regular audits had taken place looking at aspects of patient records although some of the improvements that were needed had not yet taken place such as ensuring risk assessments were written in the correct location.

Leadership, morale and staff engagement

- Overall, the teams were well managed and morale and teamwork across the four home treatment teams was good. Staff felt empowered to do their jobs.
- We found differing sickness rates across the teams, ranging from 7%-10% but staff we spoke with did not identify sickness as a particular issue within their teams.
- Staff reported no current bullying or harassment cases within the team, although in one of the teams staff told us that it had been an issue in the past, until a new manager had been put in post.
- Staff we spoke with were aware of how to whistle blow and felt comfortable doing this without fear of victimisation.
- Team leaders were given the chance to bring feedback on their service to regional meetings.

Commitment to quality improvement and innovation

- Peer reviews of services by other team leaders took place to help highlight what the teams thought was working well and less well.
- The Croydon home treatment team were accredited with a recognised quality improvement scheme the Royal College of Psychiatrists home treatment accreditation scheme. Other teams were not accredited under this scheme at the time of inspection.
- Staff in Lambeth home treatment team were involved in conducting research with an anthropologist at a local university into what the experience of using home treatment services was like for people who used the service.

Health based places of safety

Visions and Values

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

Good governance

- Data was collated that supported the monitoring of the performance of the health based places of safety.

Leadership, Morale and Staff Engagement

- There was strong leadership at a local and service level across the health based places of safety. The trust had good oversight of the health based places of safety and had plans in place to facilitate improvements in this area.
- It was acknowledged by some staff members that working in health based places of safety is challenging, though rewarding. Specifically there was low morale and feeling of being unsupported amongst the staff at Lambeth Hospital. Staff reported that the measures that had been put in place following a recent incident of violence were not sufficient and staff sometimes felt unsafe working in the health based place of safety.

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.

- Staff we spoke to across all the places of safety were positive and looking forward to the proposed central place of safety. Having a dedicated health based place of safety team was deemed to be a positive step as it would mean that staff from the wards were not being pulled from these areas to staff the section 136 assessment suites.

Commitment to Quality Improvement and Innovation

- The trust had plans to redesign the S136 assessment and health based places of safety and to build a new health based place of safety assessment centre which will be located at the Maudsley Hospital site. This would serve as a central place of safety providing Section 136 assessment for the four boroughs of Lambeth, Lewisham, Croydon and Southwark.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. This was because in the health based places of safety: The facilities at the Lambeth place of safety were not safe due to the risks from ligature anchor points and the environment was not fit for purpose. Lewisham health based place of safety had blind spots in both the observation window and the CCTV camera angle that meant that patient safety could not be guaranteed. In the home treatment teams: Personal and emergency alarm systems at Lambeth home treatment team at Orchard House were not regularly checked to ensure that they were working in the event that staff needed to request assistance. There were inconsistencies in where risk assessments completed by home treatment teams were held in electronic care records, which meant that it is was possible for staff (especially in other teams) to miss updates in risk information. This was in breach of regulation 12 (1)(a)(b)(d)