Requires improvement

Oxleas 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)
RPGAD	Green Parks House, Princess Royal University Hospital	Bromley home treatment team, day treatment team and health-based place of safety	BR6 8NY
RPGAE	Oxleas House, Queen Elizabeth Hospital	Greenwich home treatment team, day treatment team and health-based place of safety	SE18 4QH
RPGAH	Woodlands Unit, Queen Marys Hospital	Bexley home treatment team	DA14 6LT
RPGAG	Park Crescent Day Centre, Erith and District Hospital	Bexley day treatment team	DA8 3EE

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Oxleas 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 Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas 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	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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.

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Overall summary

We rated mental health crisis services and health-based places of safety as **requires improvement** because:

- The environment of the health-based places of safety and day treatment teams had several ligature anchor points, which posed a high risk to patients. The Bromley and Bexley day treatment team facilities had not completed environmental risk assessments including a ligature assessment in areas where patients would be unsupervised. The service was not aware of the risks, which meant that the risks were not adequately mitigated.
- The risk assessments completed by the home treatment and day treatment teams demonstrated inconsistencies in how staff documented and managed risks. Care records lacked evidence that patients had person-centred, detailed crisis plans. There was a lack of evidence that physical healthcare monitoring was regularly taking place. The home treatment teams did not always demonstrate that staff carried out an initial physical health screening or full assessment.
- Staff did not routinely carrying out checks of personal panic alarms, clinical equipment and infection control. One team did not have access to emergency life support equipment including emergency drugs, which meant that staff was unable to attend to patients in an emergency.
- Bromley HTT and Greenwich day treatment teams had not ensured that all staff had completed all mandatory training courses. Twenty-five percent of staff in Bromley HTT had not completed basic life support training. Thirty-three percent of staff had not all completed breakaway training and 50% of staff had not completed food safety training in the Greenwich day treatment team.
- Staffing levels varied across the three boroughs. Staff in some teams found it difficult to manage the increasing acuity of the caseload. Staff told us that on occasions joint visits were unable to take place, as there had not been enough staff. Patients were provided with transport in order for them to attend the team base to be seen.
- Bexley day treatment team had minimal psychology input and was unable to provide specialist psychology support to their patients. After the inspection, the trust advised us that an additional two days per week of psychology input would be provided to the day treatment team starting from October 2016.
- Trust systems and processes were insufficient in ensuring that the health-based places of safety-protected patient's safety, privacy and dignity.The entrance doors to the Greenwich place of safety were clear glass and meant passers-by were able see in to the place of safety.One of the places of safety did not provide a comfortable environment for patients, as there was no bed or shower facility available.
- The trust did not provide staff with specific Mental Health Act (MHA) training in accordance with the new MHA code of practice. Staff lacked knowledge in the application of the MHA and were unable to support patients that remained under the MHA in the community
- Patients did not have access to information, which related to their rights as a patient and independent mental health advocacy. The information was not clearly displayed in waiting areas and in the health-based places of safety.
- There was an inconsistent approach in the use of outcome measures. Home treatment teams were using specific measures and the day treatment teams were not. This did not ensure that teams were able to review their clinical effectiveness. However, the trust planned to roll out a new tool that was being piloted by the Bromley HTT.
- The teams were not ensuring that the systems and procedures that were in place were working effectively. The processes in place to ensure that patients were receiving safe care and treatment, which also protected their privacy and dignity, needed to improve.

However:

- The trust had plans to review and refurbish the health-based places of safety, although there were

no set dates for completion. The trust had responded to and rectified the privacy and dignity issue at the place of safety in Greenwich after the inspection.

- Staff within the home treatment teams, day treatment teams and health-based places of safety demonstrated good practice in responding to people in crises. Staff were professional, caring and supportive. Teams routinely reflected on incidents and looked at how practice could be improved and lessons learnt.
- The health-based places of safety were adequately staffed.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** for mental health crisis services and health-based places of safety because:

- The building that the Bexley day treatment team was located in had many exposed ligature anchor points. An environmental and ligature risk assessment had not been completed in order to minimise the risks as much as possible. The lounge area at the Bromley day treatment team had exposed ligature points, which were not being adequately mitigated by the service. The health-based places of safety had several exposed ligature risks and a mirror that had been broken. These posed a high risk to patients and the environments were not safe.
- Staffing levels varied across the three boroughs. Staffing levels had not been reviewed in a long time and staff in the Bexley and Greenwich HTT did not feel they had enough staff to cope with the increasing acuity of the caseload.Staff told us that on occasions joint visits were unable to take place, as there had not been enough staff. Patients were provided with transport in order for them to attend the team base to be seen.
- Staff were not documenting risk in the identified place in the record system which made it difficult to locate the most up-to-date risk assessment. The records did not always demonstrate how staff managed identified risks, including the environmental risks. There was a lack of evidence to demonstrate that crisis planning was taking place. The plans that were available were not of good quality and lacked person-centred detail.
- Staff were not routinely carrying out checks of staff personal panic alarms, clinical equipment and infection control. This equipment was not being maintained regularly and could put patients and staff safety at risk.
- The Bexley day treatment team did not have access to emergency life support equipment and emergency medicines. The trust advised us that staff were expected to begin life support (CPR) whilst awaiting ambulance services. However, the service did not have access to oxygen and could not administer this alongside CPR.

However:

- The trust had plans to refurbish the places of safety to address the risks to patients and to promote their comfort and recovery.
- Staff demonstrated a good understanding of reporting incidents and could identify changes in practice because of this reporting. The day treatment and home treatment teams

Summary of findings

worked closely with inpatient wards and began engaging with patients early in their admission. The health-based places of safety had emergency alarms systems in place and the person in charge was clearly identified.

Are services effective?

Requires improvement

We rated effective as **requires improvement** mental health crisis services and health-based places of safety because:

- There was a lack of evidence that staff regularly monitored patients' physical healthcare needs. Care records did not always demonstrate that a patient received an initial screening or physical health assessment when transferred to a team.
- Fifteen out of 18 care records reviewed across the teams, demonstrated a lack of comprehensive crisis planning. One crisis plan had been created in July 2015 but had not been updated. Two were detailed and personalised.
- The trust did not provide staff with specific MHA training in accordance with the new code of practice. Staff lacked knowledge in the application of the MHA and were unable to support patients due to the lack of adequate training.
- Across all of the teams, there was lack of consistency in the use of outcome measures. Some teams were using specific measures and others were using the patient feedback questionnaire as their only measure. However, the trust planned to roll out a new tool that was being piloted by the Bromley HTT.
- There was a lack of psychology input into the Bexley day treatment team. This was due to commissioning arrangements. However, after the inspection, the trust advised us that an additional two days per week of psychology input would be provided to the day treatment team starting from October 2016.
- Twenty-five percent of staff in the Bromley HTT had not all completed basic life support training. Thirty-three percent of staff had not all completed breakaway training and 50% of staff had not completed food safety training in the Greenwich day treatment team.

However:

- There was evidence of good interagency work between the police, staff and approved mental health professionals (AMHPs). The health-based places of safety were mostly always open unless there were maintenance issues and were always staffed appropriately. Staff explained patients' rights to them and this was documented. Staff always told patients what to expect while at the place of safety.

Summary of findings

- Staff had access to specialist training which included suicide prevention (STORM) training and nurse prescribing.

Are services caring?

Good

We rated caring as **good** for mental health crisis services and health-based places of safety because:

- Staff in the home treatment and day treatment teams treated patients with dignity and respect and were kind in their manner. Staff treated patients with respect and dignity when using the health-based place of safety.
- Most people we spoke with told us that they felt that they received a good standard of care and their individual needs were met. Most patients told us that their families and carers were involved in their care and the team involved them. Staff told us that carer's assessments were available. However, we did not see evidence to demonstrate assessments were routinely taking place.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** for mental health crisis services and health-based places of safety because:

- The current health-based places of safety did not provide a comfortable environment, which promoted privacy and dignity.
- Data showed that staff did not always notify the approved mental health practitioners (AMHPs) of an admission immediately; meaning patients were not always assessed within the three-hour trust target.
- Patients felt the waiting areas at the hospitals were too open and unfriendly. The waiting areas were close to the main entrance and were very busy.
- Leaflets that were provided by teams did not meet the needs of people that lived in the local communities.

However,

- There was a comprehensive physical health initial screening by healthcare professionals when patients first arrived into the health-based place of safety.
- There was good communication between the duty senior nurse (DSN) and the mental health liaison team when a patient initially presented to A&E. The health-based places of safety had clear protocols of where patients go when they are in crisis and required a place of safety.
- The home treatment teams had low waiting times for patients that required assessment and treatment.

Summary of findings

- Staff were experienced and skilled at working with patients in a time of crisis.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** for mental health crisis services and health-based places of safety because:

- The service's governance systems and process that were in place were not robust enough in order to ensure that patients were receiving safe care and treatment and an environment that protected their privacy and dignity.
- Not all teams demonstrated their clinical effectiveness with the use of outcome measures. and the health-based places of safety did not routinely collect data to evaluate their performance. However, the Bromley HTT was piloting a new tool which the trust planned to roll out across all teams in order to demonstrate clinical effectiveness.

However:

- Staff enjoyed working for the trust and the overall morale was good within the home treatment and day treatment teams.
- The trust had created a staff support network in order to ensure that a range of staff groups were adequately supported and had an opportunity to meet others.
- Staff clearly understood procedures to report safeguarding's and incidents. The trust gave staff an opportunity to discuss and learn from incidents at embedded learning events. Teams had made effective changes because of lessons learnt from incidents.
- The Greenwich and Bromley home treatment teams were accredited by the Royal College of Psychiatrists home treatment accreditation scheme (HTAS).

Summary of findings

Information about the service

Oxleas NHS Foundation Trust provides crisis mental health services to the London boroughs of Bromley, Bexley and Greenwich.

Home treatment teams were based in each borough. The home treatment teams offered assessment and interventions to any person aged 18 to 65 who were in a crisis and experiencing mental health problems and may require admission to an inpatient ward for intensive support and treatment. The teams operated between 8am and 10pm, seven days a week. The Greenwich home treatment team offered a 24-hour response time to assessments between Monday and Saturday. The accident and emergency departments provided the out of hour's support when the home treatment teams were closed. The teams accepted referrals from community mental health teams, the acute inpatient wards, mental health liaison, primary care plus and the trusts 24 hour crisis phone line. Primary care plus was a service created for GPs to refer patients directly for an urgent assessment.

Day treatment teams were based in each borough and operated between 9am and 5pm, Monday to Friday. The aim of the day treatment teams was to work with people to prevent admission to hospital and to support people who have been discharged early from hospital. The teams provided intervention groups and psycho-education.

The trust had two health-based places of safety based at Queen Elizabeth Hospital and Princess University Royal Hospital. The health-based places of safety provided facilities to support and assess people detained by the police in a public place and thought to be in immediate need of care in a safe environment. The health-based places of safety at both hospital sites were managed and staffed by the acute inpatient wards located on that site.

The home treatment, day treatment teams and the health-based places of safety had not been previously been inspected by the Care Quality Commission.

Our inspection team

The comprehensive inspection was led by:

Chair: Joe Rafferty, Chief Executive, Mersey Care NHS Trust

Head of Inspection: Pauline Carpenter, Care Quality Commission

Inspection managers: Peter Johnson and Shaun Marten Care Quality Commission

The team that inspected Oxleas NHS Foundation Trust's mental health crisis services and health-based places of safety comprised of two CQC inspectors, one mental health act reviewer and three specialist advisors including a nurse, a psychiatrist and an approved mental health professional.

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?

Summary of findings

- 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 by using comment cards.

During the inspection visit, the inspection team:

- visited three home treatment teams and three day treatment teams across four hospital sites and looked at the quality of the environment and observed how staff were caring for patients
- visited two health-based places of safety at two hospital sites
- met with 16 patients who were using the service
- interviewed the managers or acting managers for each of the home treatment teams, day treatment teams and health-based places of safety
- met with 14 other staff members; including doctors, nurses, social workers and an approved mental health professional
- interviewed the director with responsibility for the home treatment and day treatment teams
- attended and observed one handover meeting and two multidisciplinary meetings
- collected feedback from patients using comment cards
- Reviewed in detail 31 care and treatment records of patients
- carried out a specific check of medicines management for all six teams
- 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

Most people we spoke with told us that they had a positive experience and received good quality care from the home treatment and day treatment teams.

Patients told us that staff were caring, polite and kind. Patients gave mixed feedback in relation to the delay of a care coordinators allocated to them when the services were reconfigured in 2015.

Patients told us that the urgent advice line was not always helpful, for example, at times patients were given inappropriate advice or to attend accident and emergency. However, others praised the service and told us that the phone line had helped them greatly.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the current environments used for the Bromley day treatment team and the Bexley day treatment team are safe.
- The trust must ensure that the current environments for the health-based places of safety are made safe and to fully promote people's privacy and dignity.
- The trust must ensure that risk assessments and crisis plans are comprehensive and are accessible to the care professionals that need them. The assessments must clearly outline identified risks and how the risks are being managed.
- The trust must ensure that each individual patient has their needs assessed and care planned accordingly. This includes the care plan being holistic, personalised and jointly carried out with the patient.
- The trust must ensure that patients have access to an initial comprehensive physical health assessment and subsequent physical health monitoring. This includes the assessments being documented in patient records.
- The trust must ensure that staff notify the approved mental health professionals within the set trust target time when a MHA assessment is required. This includes any delays documented accordingly in the patient's record.

Summary of findings

- The trust must ensure that there adequate systems and processes in place to monitor whether patient documentation is detailed and up to date, and that patient dignity and respect is maintained at all times.

Action the provider SHOULD take to improve

- The trust should ensure that staff regularly check the personal alarm system and clinical equipment to ensure they are in working order.
- The trust should ensure that all staff complete mandatory training and are regularly updated.
- The trust should ensure that the Bexley day treatment team has access to emergency equipment including oxygen.
- The trust should ensure that teams are consistently measuring their clinical effectiveness and using the results to improve performance.
- The trust should ensure that all staff have access to MHA training which is in accordance with the new code of practice.
- The trust should ensure that patients have access to a range of leaflets that meet the needs of the local communities.
- The trust should ensure that staff are gaining informed consent from patients when starting treatment and this is to be documented accordingly.
- The trust should ensure that the call handlers managing the urgent advice line for the trust are suitably trained and qualified in order to carry out their role effectively.
- The trust should ensure that routine checks are carried out across all teams in order to ensure that the environment is clean and adhering to infection control protocols.

Oxleas 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
Bromley home treatment, day treatment team and health based place of safety	Green Parks House, Princess Royal University Hospital
Greenwich home treatment, day treatment team and health based place of safety	Oxleas House, Queen Elizabeth Hospital
Bexley home treatment team	Woodlands Unit, Queen Marys Hospital
Bexley day treatment team	Park Crescent Day Centre, Erith and District Hospital

Mental Health Act responsibilities

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

The trust did not provide staff with training on the MHA and the new code of practice. Staff had a limited understanding of the MHA and the new code of practice. Staff were unable to apply it when working with patients in the community. Staff had told us that they would seek advice and support from the inpatient wards, the trust's MHA office or from the approved mental health practitioners (AMHP) employed by the local councils.

The trust carried out audits in order to assess the number of patients that required admission under the MHA. However, the trust collected trust wide data and was unable to provide specific data that related to HTT. The trust audited whether patients were given the correct information when detained under the MHA.

Independent mental health advocacy and patient rights leaflets were available in some teams. Some patients we spoke with were not aware of independent advocacy services available to them and others were aware and declined to make contact.

Detailed findings

People detained in the health-based places of safety had their rights explained to them under the MHA and information and guidance were available in leaflet form. However, this information was not displayed in the health-based places of safety.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff completed training on the Mental Capacity Act (MCA) and the overall training compliance rate was 98.5%.

Staff demonstrated a clear understanding of the principles of assessing mental capacity. While staff we spoke with felt it was their responsibility to assess mental capacity and gain consent from patients, the records demonstrated an inconsistency in how staff documented consent and capacity.

Staff who managed the health-based places of safety had a basic understanding of the MCA. Staff were aware of assessing mental capacity taking into consideration when patients were intoxicated. As medicines were generally not prescribed in the places of safety, consent to treatment was not documented in the care notes.

Inadequate

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 and day treatment teams

Safe and clean environment

- Across services, interview rooms were fitted with panic alarms and staff had access to personal alarms but used them differently. For example, staff in the Bromley and Bexley home treatment team (HTT) and day treatment team did not wear personal alarms. Day treatment team staff told us that patients were always seen in areas that were fitted with alarms. Bromley HTT were due to be provided with a new personal alarm system called Sky guard. The new alarm provided staff with safer ways to communicate and escalate concerns. Staff at Greenwich HTT and DTT regularly checked alarms were working properly and documented this accordingly. The alarm panel showed where the alarm had been activated was located within the main reception. This meant staff had to go to the main reception in order to identify where the incident was, which could cause delay to a patient or staff member receiving help in an emergency. The concern was raised to a senior manager for the service and as a result, a member of staff from each team was provided with a two-way radio, which linked to the reception to improve communication. The senior manager told us that the location of another panel would be included in the planning of the redesign of the area where the community teams were based.
- The Bromley day treatment team provided patients with a lounge and kitchen facility. The room had exposed ligature points including fixed pipes and fixings to the windows. The manager told us that this had been escalated to senior staff over the past two months and had been escalated to the health and safety team. An environmental risk assessment had been carried out. The trust told us that they felt the risks were mitigated by the room being locked prior to groups starting at the beginning of the day and when the last group of the day finishes, the room being frequently checked by staff and by reviewing patient risk. We observed staff walking in and out of the room. Bexley day treatment team building had many exposed ligature points, which we raised to the service managers. The trust told us that the risks were mitigated by patients being risk assessed and through staff observation. However, the trust had not ensured that the environment had been appropriately risk assessed for ligatures in order to minimise risks where possible. The patient toilets had several ligature anchor points and these risks were not mitigated.
- Not all teams had access to a well-equipped clinical room. Bromley HTT and day treatment team did not have a dedicated clinical room with access to a fridge. Patients in Bromley were taken to clinical rooms on the inpatient wards if a physical health examination was required. Bexley day treatment team did not hold emergency equipment or medicines. Staff were trained in basic life support and the process was for staff to call emergency services. Staff were expected to perform life support (CPR) whilst awaiting ambulance services. However, the service did not have access to oxygen and could not administer this alongside CPR. Bexley HTT was moved to another building and they did not have equipment to carry out physical health checks or provide emergency life support. Patients did not visit the team base. However, at Greenwich HTT and day treatment team there was a well-equipped clinic room with the relevant equipment to carry out physical examinations. The teams had access to emergency equipment.
- Infection control and equipment checks were not always completed or recorded for areas that contained clinical equipment (blood pressure monitor, emergency equipment) and clinical tasks were carried out (administering medication). Bromley and Bexley HTT and day treatment tea were not carrying out regular checks to ensure that the medical devices were working effectively and that the environment was clean. The lack of infection control checks increased the risk of medication being dispensed and handled in an unhygienic environment. The rooms and facilities had signs reminding staff about the importance of hand washing.

Safe staffing

- Staffing levels/vacancies varied across the different teams we visited. Bromley HTT had the highest vacancy rate of 12.5% with one nursing post vacant. The team

had funding to recruit another nurse and there had been difficulties recruiting into one nursing post. Bexley HTT had the lowest nursing vacancy rate of 3%. Sickness rates varied between the teams. Bexley HTT had the highest sickness of 6%. This was due to short periods of sickness. Greenwich HTT had recently recruited two nursing assistants. The Bexley day treatment team had six substantive staff (no nursing vacancies and the sickness rate was 2%) and Bromley day treatment had 12 substantive staff.

- Staffing levels varied across the different teams with established staffing levels being seven qualified and two unqualified nurses in Bexley HTT, nine qualified and three unqualified in Bromley HTT and 13 qualified and three unqualified in Greenwich HTT. The Bexley team felt that they did not have enough staff to cope with caseload. The establishment for the Bromley day treatment team was two qualified and seven occupational therapists (OT), Greenwich was one qualified nurse, one unqualified and four OTs and Bexley had one qualified nurse and two OTs.
- Bexley day treatment employed one permanent bank nurse to fulfil a vacant support worker post. The bank nurse had worked with the team for a long period.
- Staff from the Greenwich HTT told us that on occasions joint visits were unable to take place, as there had not been enough staff. Patients were provided with transport in order for them to attend the team base to be seen.
- Not all services had a set caseload number per team and caseload numbers varied across the teams. For example, Greenwich HTT had a limit of 30 but it could increase significantly. The team managers told us that staffing levels would increase to reflect this by using bank/agency staff. Bromley HTT did not have an upper caseload limit. The team manager told us that the trust used to have a cap on numbers but felt that the team managed the caseload well. Staff we spoke with told us that they felt supported to carry out their role and were overall positive about the quality of work that was carried out. The Greenwich day treatment team had an increasing caseload from 24 to 30. The team manager told us that this would increase when the vacant posts had been filled. Bexley day treatment had 40 patients on their caseload, whereas Bromley had caseload limit of 18 and the caseloads had reached capacity.
- Home treatment teams across all three boroughs did not allocate key workers to patients. Allocation of key workers was not mandatory and the trust advised us after the inspection that this was not viable for the HTT model. Allocations of appointments and home visits were organised in the twice daily handover and zoning meetings. However, the day treatment team provides patients with allocated keyworkers.
- HTT did not use bank and agency staff regularly. Bank staff was used to cover staff sickness, absence or staff vacancies. The Bromley team manager told us that staff covered shifts using the internal bank system. Most of the day treatment teams did not use bank and agency staff due to the nature of the work carried out, staff needed to be experienced and able to facilitate groups.
- Across all HTT, staff were rotated on a weekly basis to carry out in-reach work on the acute inpatient wards. This allowed the teams to identify and support patients who may be in a position to move their care from wards into the HTT.
- We visited two hospital sites, which had a duty senior nurse (DSN) in place 24 hours a day, seven days a week. The DSN role was an extremely busy job and included responding to the trusts urgent advice line (UAL), manning and organising the health-based place of safety as well as supporting the inpatient wards. The DSN was required to coordinate admissions from the A&E department to the inpatient wards and the 136 suite. At the weekends, the DSN was also responsible for bed management. The DSN staff we spoke with said that the workload was manageable as they were well supported by their peers and senior staff.
- Patients who used the service had rapid access to a psychiatrist within office hours (9-5pm). Access to psychiatric liaison teams which were based at local acute hospitals and an on-call duty doctor was available outside of these hours.

Assessing and managing risk to patients and staff

- Risk assessments were completed on the electronic patient record system. However, risk assessments were not always updated when patients transferred into the HTT and day treatment teams from another team. Of 18 care records reviewed, eight risk assessments were not documented comprehensively and management plans had not always been formulated. Three records from the Bromley HTT demonstrated did not hold up to date risk assessments and risk was not formulated. Staff did not use the designated section in the electronic care records to complete risk assessments, they were adding this

information in daily progress notes. This made it difficult to locate and review patient risk. Three out of four records from the day treatment teams in Bromley demonstrated good practice in documentation of risk and associated risk management plans.

- The care records demonstrated that only three patients had crisis plans in place. However, the crisis plans lacked clear direction for the patient and were basic.
- Across all HTT teams there were regular meetings and discussions taking place regarding risk assessment and patient wellbeing. Teams had a 'zoning' system, which was used to assess the risk of the patient, and determined the frequency of home visits. 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 in the 'green' zone. The office white board reflected the risk through a colour coded system. Handover meetings took place twice daily and staff updated plans on the electronic care records. The day treatment teams also had daily zoning meetings and handed information over including patient risk, new referrals and plans for the day.
- The crisis teams did not provide assessments during the night and patients in a crisis would be directed to the mental health liaison department at the local hospital. Psychiatric liaison nurses would then assess the patient and coordinate an admission to hospital if required. If a patient were assessed as not requiring an admission, a referral would be made to a HTT team. The HTT was required to assess the patient within a 24-hour period. Staff told us that this was flexible depending on the risks identified at the initial assessment.
- Staff demonstrated a clear understanding for reporting a safeguarding concern and recognised different types of abuse. Staff identified the safeguarding vulnerable adults and child leads in the individual teams. The trust safeguarding protocol was visible in the different team offices. Staff we spoke with had completed safeguarding training and could identify the trust's identified safeguarding lead. Safeguarding protocols were clearly displayed on the walls.
- The trust had a lone working policy in place. Staff had access to trust mobile phones to communicate when working in the community and would document their whereabouts by signing in and out of a team diary. Staff in the HTT and day treatment teams in Greenwich and Bromley was aware of the location of panic alarms at the team base if they required assistance.
- The trust had an urgent advice line (UAL) for patients to use in a time of crisis, 24 hours a day, and seven days a week. The phone line provided initial contact and staff took brief details from the patient. Between 9am and 5pm, the most appropriate team would be required to call the patient back. Outside of this time the duty senior nurse for the individual hospital would cover the UAL and was required to respond within 20 minutes to a phone call. A separate call hander initially took the call details and the details were passed on. A senior manager for the service told us that the aim of the UAL was to signpost patients to the most appropriate service, which included the A&E department, or emergency services if appropriate. Staff told us that the UAL was a priority during the day and the phone system had been changed to improve the signal of the duty senior nurses phone so that calls were not missed. A senior manager told us that the call handlers had not had specific training for the role as it was felt it was not required. The manager told us that the call handlers followed a protocol and their main role was to signpost to mental health liaison and note brief details. The call handlers logged the calls on a call spreadsheet, which was monitored by the trust. The call logs demonstrated that Bexley had received the highest numbers of calls averaging at 73 calls per month. Bromley received on average 45 and Greenwich received 54 over a four-week period.
- We reviewed the medicines management across all HTT. At the Bromley HTT medicines were stored within a locked cupboard within the office. Only nurses had access to the medicines cupboard. Keys were kept safe in a coded safety box. The team held individual patients regular medicines and also provided 'crisis packs' to patients who required medicines urgently. Quantities of medicines given to patients were risk assessed against the patient's risk history. If a patient was unable to have a longer supply of medication due to being at risk of an overdose, staff ensured a prescription card was completed and single tablets could be dispensed from the inpatient wards. The team had appropriate medicine bottles available and pre-printed labels for when medicines were dispensed. Medicines were recorded in a log book and only nurses were able to undertake dispensing.

Track record on safety

Inadequate

Are services safe?

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

- There had been five serious incidents in the past 12 months that all involved a patient death whilst receiving care from the HTT. No serious incidents had taken place in the day treatment teams.

Reporting incidents and learning from when things go wrong

- Staff were aware of the process of reporting incidents via the trusts internal electronic reporting system. The system alerted the team managers. Managers told us that staff would also speak to them directly and raise any concerns. The trust produced a newsletter twice yearly which included incidents and outcomes from incident investigations.
- Staff told us that incidents were discussed at 'embedded learning' events, which the trust provided a few times a year. This gave staff an opportunity to reflect and learn lessons from incidents that had occurred from across the trust. Staff told us that local incidents were discussed in team meetings and incident summaries were shared with the team via email. Team meeting minutes in the Bexley team demonstrated that the recent serious incidents had been discussed.
- The trust held a meeting called the patient safety group which was for team managers to attend. The meeting included discussing lessons learnt from incidents. The Bromley HTT manager had implemented an incident board so that staff were able to view an incident and what changed as a result of it.
- Staff reported that they were debriefed after serious incidents, which they found helpful. Staff also had access to reflective practice sessions with a psychologist, which provided support and an opportunity for teams to discuss any difficult incidents.
- Staff were able to explain lessons learnt from serious incidents. For example, there had been a serious incident after information was not shared with a patient's GP. The HTT teams had introduced a 'sharing information' leaflet, which provided patients with clear guidance on information staff were required to share with external agencies.

Health-based places of safety

Safe and clean environment

- In the health-based place of safety at Oxleas House, we found a broken mirror above the patient's bed. Staff used this mirror to observe the blind spot in the bedroom. However, the mirror was in reaching distance and was a serious risk and safety concern. This was raised to a senior manager of the service who told us that maintenance were awaiting an opportunity for the room to not be in use so that it could be fixed. Staff said that the risk was being mitigated by staff not closing the bedroom door and by observing the patient in the room. The identified environmental risks of the health-based place of safety were not reflected in individual patient risk assessments. The health-based place of safety in Bromley had ligature anchor points in the toilet. Staff told us that this risk was mitigated by ad hoc assessments of patients before they accessed the toilet. Staff told us that they would be able to access the toilet if the patient was uncommunicative with them. However, this was not reflected in the individual risk assessments of patients using the bathroom facilities. Refurbishment was due to start on the site in July 2016 and in the meantime. After the inspection, the trust advised us that they mitigated the risk by having two members of staff present at all times when a patient was using the place of safety. Ligatures must not be in a health-based place of safety according to national guidance written by the Royal College of Psychiatrists.
- At Greenwich's health-based place of safety, there were alarm buttons in the main room, the bedroom and the toilet. Staff showed the panic alarms to the patient when they first arrive into the place of safety. In Bromley, staff had two-way radios, which they checked weekly. In Greenwich, the staff had personal alarms connected to a pinpoint system, which alerted them if the battery was low. At the Bromley health-based place of safety, there were alarm strips along two walls and a panic alarm in the toilet.
- In Bromley, there was basic life support equipment in the nearby staff office, including ligature scissors. Emergency drugs were sourced from the inpatient wards, which were in the same building. In Greenwich, basic life support equipment was in a medical storeroom located nearby. Emergency medication was also in nearby along with ligature scissors.
- Both health-based places of safety were clean and had up-to-date cleaning records. Staff had not completed an infection control audit as the trust deemed the room

not to be a clinical area. However, these were clinical environments. Interventions carried out in the health-based places of safety included administering medication and physical interventions.
- The trust had plans to refurbish the places of safety; the start date was July 2016. However, in the meantime the safety of patients using the existing facilities required a robust management plan.

Safe staffing

- The places of safety at the trust did not have dedicated staffing. Staff members were attached to the inpatient mental health wards.
- The Duty Senior Nurse (DSN) directly managed the health-based places of safety. The DSN had a number of other responsibilities, including managing the inpatient mental health wards and taking calls on the urgent advice line (UAL) during the working day. Between 5pm and 9am and on weekends, the DSN also had responsibility for bed management for the inpatient mental health wards. Staff told us that the health-based place of safety was a priority when police make contact to notify them they are bringing a patient in to hospital. The senior nurses told us that if an incident happened on an inpatient ward at the same time as a patient requiring the health-based place of safety, the staff would manage the incident on the inpatient ward first and attempt to delay the police until staff became available. This meant that the patient waiting to be transferred to the health-based place of safety was being monitored and supervised safely until staff were able to attend. Bank staff were used to support the health-based places of safety. The modern matron was responsible for managing the rota of who was allocated DSN on shift. The DSN worked alongside the duty doctor, who was usually a doctor that was approved to use the MHA. A senior nurse told us that staffing of the health-based places of safety was the priority of the DSN role. There were four staff members, one from each in patient ward, who were identified to be on call to support the DSN.
- Staff said that the DSN role was well supported. There was always a service manager on call after hours. The duty doctors support the DSN and there was a consultant on call at all times. The inpatient director was also available. The modern matron was also available during the day to assist. Staff said that the lines of communication were not hierarchical and that everyone was ready to help if there were issues with incidents or staffing levels.
- A review of the meeting minutes from the liaison meetings between crisis services in the three boroughs did not demonstrate there were issues with staffing the health-based places of safety.

Assessing and managing risk to patients and staff

- Police searched patients before bringing a patient into the health-based place of safety. This would minimise the risk of the patients harming themselves whilst accessing the room.
- Staff at the Bromley health-based place of safety told us that after a risk assessment had been completed with a patient, staffing levels were determined based on the patient's need. If a patient presented as a low risk then health care assistants (HCAs) supported the patient and if the risk were higher, a qualified nurse and HCAs would support the patient.
- We reviewed 15 care records for patients that had used the health-based places of safety and one record demonstrated staff had not completed a risk assessment, as the patient was familiar to the health-based place of safety. This was not a robust approach to risk assessing and managing new risk behaviours. Staff had not completed risk assessments in the identified area on the electronic care record, but documented these in the overall care notes section. However, the risk assessment was updated regularly and staff told us they knew where to locate the latest risk assessment
- Care records demonstrated that staff completed medical assessments when patients arrived to the health-based places of safety. Staff told us that if the police were concerned about a patient's physical health they were taken directly to a general hospital to be medically cleared before being brought to a place of safety. If they were deemed by the DSN as too unwell or too intoxicated to be safely managed at the place of safety, the patient would be transferred to A&E located on-site. If a patient became unwell whilst in the place of safety, the duty doctor would assess and liaise with the A&E for further advice and a second opinion.
- There had only been one incident of rapid tranquilisation used in the health-based places of safety for the previous year. This had been prescribed and administered appropriately.

Inadequate

Are services safe?

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

Track record on safety

- There had been no serious incidents recorded for the places of safety in the past 12 months. There had been two incidents of prone restraint reported between October 2015 and March 2016. Prone restraint means a person would be placed facedown and prevented from moving. The restraints were documented appropriately.

Reporting incidents and learning from 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. The manager responsible for the service reviewed these.
- Staff told us that there was always a debriefing session after a difficult situation and staff felt very well supported by their managers and other staff. The debriefing sessions provided staff with an opportunity to reflect on good practice and to support one another.

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 and day treatment teams

Assessment of needs and planning of care

- Care plans did not always demonstrate the care provided was personalised, holistic or involved the patient in the planning process. The care plans did not include risks that staff had identified in the risk assessment. The care plans were generic and did not reflect some of the patient's needs identified in their initial assessment. For example, a patient that was prescribed an anti-psychotic medication called Clozapine did not have a specific care plan for this. A care plan for this should have been clearly available. However, staff documented separately that the patient was closely monitored. This did not ensure that the patient was receiving sufficient care that was measurable and the record did not demonstrate if the patient had been given a copy of their care plan.
- Out of the 18 care records reviewed across the teams, three crisis plans had been completed. One crisis plan had been created in July 2015 but had not been updated. Two were detailed and personalised. The trust carried had out a care plan audit in the past six months, which found the same areas for improvement. Following this, staff made an action plan and target times were set for the problems areas to be addressed.
- The Bexley and Greenwich HTT were using a spreadsheet system to ensure that the team caseload was reviewed and risk was routinely rated. This was developed alongside the team's daily planner. Staff updated the spreadsheet with interventions and was used as part of the patient's discharge summary which was sent to the local GP. All members of the team had access to the spreadsheet. The tool was not being used in the Bromley HTT.
- Patient records were held on an electronic patient record system. Staff required access to the system by using an individual password. The system allowed other teams to review the patient record as they transitioned from one team to another. Staff in the Greenwich HTT told us there was a system called Connect Care, which linked the trust, the local acute trust and GPs together so that they were able to review patient's notes collectively.

Best practice in treatment and care

- Medicines were prescribed in accordance with national institute of clinical excellence (NICE) guidelines. Thirteen records were reviewed and demonstrated good practice. Medicines given to patients in a crisis were balance checked daily. Greenwich HTT designed a side effects monitoring form in collaboration with patients. For example, the form included "I experience the following side effects" and "I understand my side effects will be managed by". The teams had an identified pharmacist, which visited the teams on a regular basis to monitor stock and review medicines administration charts.
- The HTT and day treatment teams provided national institute of clinical excellence (NICE) recommended psychological therapies. The Bromley HTT and day treatment team shared a psychologist and the Greenwich and Bexley HTT had a psychologist within the team. However, this was not on a full-time basis. Psychology input into the Bexley day treatment team was minimal. The team had psychology support for a few hours per week. Bromley and Greenwich HTT and day treatment shared psychology support. The psychology input for these teams was not sufficient and patients would need to wait for specialist psychology support. The patients at the Bexley day treatment team received minimal one to one support from a psychologist. After the inspection, the trust advised us that an additional two days per week of psychology input would be provided to the day treatment team starting from October 2016.
- All of the home treatment teams had employed social workers who provided patients with advice and support for housing, employment and benefits. The trust had a recovery college which staff could signpost patients to for further support.
- The HTT and day treatment teams were not consistently meeting patients' physical health needs. Out of 16 records reviewed across all three HTT, four records did not demonstrate that patients had received an initial physical health screening when transferred to the team. One record lacked clear documentation as to whether an assessment had been carried out. Bexley HTT were providing minimal physical healthcare monitoring to their patients as the team base was temporary and was not an appropriate clinical environment. Staff told us that they found it difficult to transport physical

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healthcare equipment to visits and at times it was not appropriate, for example, when testing urine. Staff ensured that patients visited their local GP, which mitigated this to a degree. A senior manager told us that well-being clinics were being organised for physical healthcare checks at another location in Bexley. However, this had not been set up and there were no dates in place for the clinics to start. Patient records in the Bexley DTT showed that patients received ongoing physical health care monitoring. Staff from the Greenwich HTT told us that they had a well-being clinic in place and the team requested physical health information from patients GPs when they were initially transferred into the team. Staff were aware of the side effect rating scales and the need for monitoring patient bloods regularly if patients are prescribed anti-psychotic medications.

- Three of 16 records showed that a patient was comprehensively assessed at every visit; physical health was monitored routinely including a heart monitoring check (ECG).
- Care records demonstrated that there had been good communication with external teams. For example, the local safeguarding team and the patient's care plan had been updated accordingly. The third record demonstrated that appropriate action had been taken when the patient was not contactable.
- The Bromley HTT team were involved within a project, which looked at clinical outcome measures. The trust planned to refine the tool and roll it out to the other HTT teams. The other teams were using the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) and a self-reporting questionnaire (CORE) and other teams were not. All of the teams were using the trust patient survey questionnaire, which provided data before and after treatment. The patient experience team collated the data and a report was provided to the teams. Bexley day treatment team were not using any other outcome measures.
- Staff did not actively participate in clinical audits. The trust carried out trust wide audits, which included a comprehensive review of care records.
- The trust provided staff with regular mandatory training. The average compliance rate across all teams was 94%. Training records demonstrated that 25% of staff in Bromley HTT had not completed basic life support (BLS) training. Three members of staff were required to complete an update. Thirty-three percent (two) of staff in the Greenwich day treatment team had not completed breakaway training and 50% (three) of staff had not completed food safety level 2. The Bexley day treatment team had overall 100% compliance.

Skilled staff to deliver care

- Staff were experienced and qualified. Some staff had been working the trust for more than 10 years. Staff received inductions and were given time to ensure they understood their role and shadow other disciplines.
- The day treatment teams focused on providing psychosocial interventions and carried out therapy groups. Staff at the Bexley day treatment team recognised that the team lacked resources and were not able to offer as much therapeutic support to patients as the other two boroughs. This was largely due to the commissioning arrangements.
- Staff had received training that was not mandatory such as suicide prevention training (STORM), mindfulness and motivational interviewing. The trust had agreed to provide funding to nurses who wanted to be qualified in prescribing medicines.
- The trust had developed a leadership programme. Some staff told us that they were keen to develop their leadership skills and progress onto a managerial role

Multidisciplinary and inter-agency team work

- Most teams had fortnightly team meetings, which provided an opportunity for staff to discuss safety, incidents, training and workload. In the meetings, we observed we saw effective multidisciplinary working with patients care and treatment discussed and planned.
- Across all of the HTT and day treatment teams, there were designated in-reach workers who spent time on the inpatient wards to engage and identify patients that could be transferred from the ward to the teams to continue their recovery. Staff from HTT attended ward rounds and meetings on the inpatient wards to carry out assessments for patients that had been identified for early discharge. The in-reach work was helping with access to the service and ensuring people who used the service moved easier through the care pathway. Staff engaged with patients on the ward and attended ward rounds in order to identify patients that would be suitable for the team.

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.

- Across the HTT and day treatment teams, there was similar skill mix. The HTT included nurses, doctors, social workers, support workers and psychologists. The day treatment teams included occupational therapists, support workers and nurses.
- The teams had links with social services and the local safeguarding teams.

Adherence to the MHA and the MHA Code of Practice

- The trust did not provide staff with training on the MHA or the new code of practice. Staff had a limited understanding of using the MHA and was unable to apply it when working with patients in the community. Staff told us that they would seek advice and support from the inpatient wards, the trust's MHA office or from the approved mental health practitioners (AMHP) employed by the local councils.
- The trust carried out audits in order to assess the number of patients that required admission under the MHA. However, the trust collected trust wide data and was unable to provide specific data that related to HTT. The trust audited whether patients were given the correct information when detained under the MHA (section 132 information).
- Independent mental health advocacy leaflets were available in some teams. Some patients we spoke were not aware of the advocacy service and others were aware and declined to make contact. Patient rights leaflets were available in the waiting areas at the home and day treatment team bases.

Good practice in applying the MCA

- Staff were provided with training on the MCA. However, the training was not mandatory for staff across the trust. The training compliance rate was 98.5%.
- Staff demonstrated a clear understanding of the principles of assessing mental capacity. All of the staff we spoke with felt it was their responsibility to gain consent and this was discussed routinely within the team. However, three out of 16 patient records lacked documentation that staff had gained consent from patients when they were initially accepted into the HTT or day treatment service. Four other care records demonstrated a lack of quality in how consent and capacity was documented. Staff had not documented how consent had been gained from the patient and it was unclear whether consent had been given.

Health-based places of safety

Assessment of needs and planning of care

- Fifteen care records were reviewed which showed that staff planned personalised and holistic care for people using health-based places of safety. Staff told us that in the majority of cases, the police phoned ahead of time and gave brief details about the patient. This allowed time for staff to read the care record and prepare before the patient arrived.

Best practice in treatment and care

- Medication was rarely administered to patients in the health-based place of safety. In the past 12 months there had been one occasion where staff administered medication to a patient. Staff followed best practice and the legal framework in ensuring that an approved mental health professional (AMHP) and a section 12 doctor assessed the patient prior to medication being given.

Skilled staff to deliver care

- Staff that attended and managed the health-based places of safety were trained and supervised by the inpatient wards.

Multi-disciplinary and inter-agency team work

- The trust had regular meetings called 'the tri-borough joint working group' which focused on partnership working. Attendees included head of mental health legislation and safeguarding, director of nursing, heads of social care from the three boroughs of Bexley, Bromley and Greenwich, the responsible modern matron, representatives from the metropolitan police service, London Ambulance Service and the mental health liaison team. The group met quarterly and discussed ongoing issues as well as national trends in crisis care and areas of good practice. There were also frequent liaison meetings at borough level involving similar attendees. The minutes from these meetings showed projects and solutions to recurring issues being proposed, monitored and completed. Minutes of the meetings showed staff reflected on incidents and difficult situations in relation to the use of health-based places of safety and the use of the section 136 under the MHA. There was also evidence that demonstrated good feedback and communication between agencies

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 teams liaised and worked well with the police, AMHPs, community mental health professionals, psychiatrists and staff. We observed continuous communication and problem solving between professionals, which focused on best outcomes for the patient.
- Staff told us that if they encountered a problem in communication with police or other professionals, or a process that was not working correctly, they would raise it at the next liaison meeting. In these meetings, issues were discussed and recorded and senior staff decided the resolution or agreement reached. Staff gave examples of issues that had been resolved at the liaison meetings. Staff told us that the proximity of the A&E departments to both places of safety facilitated close working and any issues that arose was discussed and raised with the DSN.
- The trust had a specific policy for the health-based place of safety called 'Section 136 – Police Power to Remove to Place of Safety'. The policy stated that the police will remain to ensure that there is no risk to the patient or staff when bringing a patient into the place of safety. In practice staff said the police stayed for 30 minutes to complete handover and were able to stay longer if required. We saw good communication between staff and the police. There was a rapid escalation protocol in place, which outlined how disputes between trust staff and the police should be escalated, and ensuring the patient remains the focus of their work.

Adherence to the MHA and the MHA Code of Practice

- People who were detained in the health-based places of safety had their rights under the Mental Health Act explained and information was available in leaflet form. Patient rights were documented within the electronic care records. However, information explaining patients' rights was not displayed in the places of safety.

Good practice in applying the MCA

- Staff that managed the health-based places of safety had a basic understanding of the MCA. Staff were aware of assessing capacity taking into consideration when patients were intoxicated. As medication was not routinely prescribed in the places of safety, consent to treatment was not discussed in the care notes.

Good

Are services caring?

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

Our findings

Home treatment and day treatment teams

Kindness, dignity, respect and support

- We observed staff treating patients with kindness, dignity and respect during one to one phone calls and meetings.
- We spoke with 15 patients who provided mostly positive feedback in relation to how staff treated them. Patients told us that staff were caring, polite and kind. Staff were supportive and always concerned about patient wellbeing and recovery. Patients provided mixed feedback in relation to the allocation of care coordinators during the team's reconfiguration and the urgent advice line (UAL). Patients told us that there was a delay of being allocated a care coordinator but it had improved since reconfiguration. The UAL was not always helpful and staff would mostly advise that someone would return their call. Some patients did not feel that it was helpful during a crisis and others were thankful of how the service helped them in a crisis.
- Patients felt that staff understood their individual needs and goals. Staff we spoke with demonstrated their knowledge and understanding of what patients needed. Staff reviewed patients routinely during the daily zoning and team handover meetings. Staff maintained confidentiality by using a secure electronic notes system, visiting patients at home discreetly and meetings with patients taking place in a private room at the team base.

The involvement of people in the care they receive

- Overall, patients we spoke with told us that they had been involved in their care. However, care plan records demonstrated an inconsistency in patients being directly involved in the planning of care as staff had not documented how they had jointly worked with a patient to plan their care and treatment.
- The trust provided opportunities for patients to get involved in decisions about the running of the service such as recruiting new staff. Patients were provided with training in communication in order to be part of an interview panel. However, patients we spoke with mostly told us that they were either not aware of the opportunities available to them or had not been told how to get involved. Opportunities for families and carers to get involved were available. Staff told us that carers were involved in assessments and teams were able to support carers to access carers support. A carer's assessment was also available to carers. However, we did not see evidence of this taking place. Most patients we spoke with told us that the teams involved their carers and asked for consent to contact them.
- Some of the patients we spoke with were not aware of the advocacy service and others were aware and declined to make contact. An independent advocate was independent of the trust that supported a patient to defend or promote their rights, raise any issues they may have, access information about a service and explore choices and options about care available to them provided independent advocacy services.
- People who used the service were able to give feedback to the trust via an online friend and family test as well as an internal patient experience form. The patient experience team gathered the results and shared the feedback with the individual teams.

Health-based places of safety

Kindness, dignity, respect and support

- During the inspection, we observed a patient accessing the health-based place of safety. We observed the duty doctor treat the patient with kindness and respect. The doctor explained the patient's status under the MHA and gave the patient an opportunity to voice their opinion. The patient had a significant number of belongings with them and these were taken care of. Staff stored their belongings and gave the patient a property list. The doctor took a holistic approach to needs of the patient.
- Staff said that they viewed their role as engaging with and reassuring patients. If patients were unhappy, staff would do their best to make them feel better. Staff said they made patients aware of what was going to happen once they had arrived at the health-based place of safety. They also ensured they had their rights under the MHA read and if there were any delays, gave the patient a reason for the delays. If patients wanted to complain, staff gave details of the patient advice and liaison service (PALs).
- Staff said that they offered patients food and drink once in the place of safety. There were many occasions documented where patients were sleeping and their assessment would be delayed until they woke up.

Good

Are services caring?

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

The involvement of people in the care they receive

- Patients were included in the decisions made about them. We observed staff discussing options with a patient and allowing them to decide. Staff told us that patients rarely ask to have an advocate or a solicitor whilst in the places of safety, but if they did, they would discuss the solicitor options with them. However, there was no information on the walls informing patients of support that was available to them.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Home treatment and day treatment teams

Access and discharge

- During HTT, working hour's referrals were assessed within 24 hours. However, teams endeavoured to complete the assessment within the same working day of when the referral was received. The DTT responded within three days. However, it was acknowledged by the managers that if the patient was unavailable then the assessment was delayed. The HTTs did not provide assessments during the night. Patients would be encouraged to contact the UAL in a crisis and would be signposted to mental health liaison or appropriate organisations.
- During the inspection, the trust data stated that across the three boroughs of Bexley, Bromley and Greenwich the average waiting time from referral to initial assessment for the HTT was two days in the past 12 months. The trust told us that it was assumed that a patient would be provided with an initial assessment at the first appointment. Historically the trust did not have a target for this and had agreed a target time with the service commissioners in the past 12 months. However, data was not yet available against the target time as the teams had only started collecting data for referrals made by GPs. The average waiting time from the first appointment/assessment to treatment was two days. The teams commenced treatment from the first appointment by beginning the engagement process and exploring patient need. After the inspection, the trust advised us that assessments were carried out on the same working day and patients that are accepted are offered a next day appointment. The trust advised us that the data that had been provided was currently unreliable and they were working to ensure HTT that waiting times are reported accurately.
- The four main pathways into crisis services were; the UAL, mental health liaison, CMHTs and from a service called primary care plus (PCP) which was created for patients that were unknown to the teams. PCP made it easier for GPs to refer into which included the HTT. Referrals made from PCP were fast-tracked and responded to as a priority. Access to day treatment teams would be mainly from the inpatient wards and HTT. Mental health liaison teams referred patients that required an admission to the DSN. The DSN was made aware of the referral and a bed would be sourced. A senior manager told us that at times beds were unavailable and a patient would be made comfortable on another inpatient ward until a bed became available. Responsibility was then passed on to the inpatient wards to manage the admission.
- Patients told us that they had been provided with contact details of services they could contact 24 hours a day, 7 days week. They told us that appointments and groups were rarely cancelled and if they were, an alternative was arranged as soon as possible.
- The Greenwich HTT had two purposes. One group of staff operated Monday to Saturday managed the PCP referrals and 24-hour assessments. Another group managed routine appointments and home visits. The team did not technically provide assessments 24 hours a day. The team endeavoured to carry out assessments during the core working hours and on the same day if an admission was urgent. If a referral was received after this time, the team would carry this out within 24 hours.
- The trust recognised that there was a high pressure to manage admissions. In order to manage the pressure, in-reach workers from the HTT provided direct support to the inpatient wards and identified patients who were suitable for an early discharge. Link occupational therapists from the day treatment teams worked on the wards and also carried out a similar role in identifying and engaging patients early in their admission. This helped to move patients through the pathway into the next phase of treatment and support.
- Experienced senior nurses in the HTT carried out assessments with patients. Support workers carried out administrative tasks and took on a support role.
- Across the day treatment teams and HTT there was a good approach to managing people that were un-contactable and did not attend appointments (DNA). Managers for the DTT told us that they discussed non-engagement and followed this up. The team gave people three opportunities to attend before discharging. HTT discussed risk and engagement during the regular zoning and handover meetings.

The facilities promote recovery, comfort, dignity and confidentiality

- A range of meeting and clinical rooms was available to support care and treatment and was adequately sound

Are services responsive to people's needs?

Requires improvement

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

proofed. However, teams based at Green Parks house had limited interview rooms or space to meet with patients on a one to one basis. The Bexley HTT was in a temporary office and staff were not able to meet patients at the team base. The new office was scheduled for completion in September 2016. Patients told us that they did not like the setup of the reception at Green Parks house or Oxleas house as it was too busy, unfriendly and the alarms were too loud. Patients felt that it was too open as the waiting area was also used as a corridor.

- A range of leaflets were available in the waiting areas which covered a range of subjects including local services, patient rights and helplines.

Meeting the needs of all people who use the service

- Teams were located on the ground floor of buildings and provided access to those with a disability.
- The services did not provide leaflets that met the needs of people in local communities.
- The teams had access to the trust-wide interpreting services. If the service was unable to provide an interpreter at short notice, they were able to provide telephone interpreting as an alternative. Across the teams, staff were able to speak a range of languages, which helped with language barriers.

Listening to and learning from concerns and complaints

- Across all teams there had been five complaints raised within the past 12 months. Four complaints were partially upheld and one complaint was under investigation. As a result of a complaint and an incident the teams introduced a guide to disclosing information for patients. The guide included the information that would need to be shared with relevant parties i.e. the patients GP. Informal feedback was collected by the patient experience team and included patients asking for more 1 to 1 time in the day treatment teams. The manager in the Greenwich day treatment team told us that the group timetable was routinely reviewed and the manager discussed the patients' feedback directly with them.
- Most patients we spoke with were aware of how to make a formal complaint and had received the information for PALs which staff gave them at their first appointment. Patients told us that they felt comfortable to raise their concerns to the trust if required.
- Staff that we spoke with understood the complaints process and felt comfortable in raising concerns that they had. Staff told us that the service director regularly visited teams and discussed arising issues with them. Feedback from investigations was discussed in team meetings and in embedded learning events provided by the trust during the year.

Health-based places of safety

Access and discharge

- The police made contact with the trust in order to request using the health-based places of safety. The initial screening included information on the patient's name, resident borough, medical injuries, intoxication and level of violence or risk. Staff told us that this process mostly happened and that it gives time to arrange enough staff to greet the patient when they arrive.
- The trust's health-based places of safety were always open, unless there were maintenance issues. This was reflected in the data of patients accessing the places of safety.
- The Section 136 police power to remove people to a health-based place of safety trust policy stated that the DSN should notify the AMHP within 60 minutes of a patient arriving to the health-based place of safety. Between the months of December 2015 and February 2016, data demonstrated that 107 people used the trust's health based places of safety. Records stated that the AMHP was not notified within 60 minutes on 23 separate occasions. The trust was supposed to log the people who had used the health-based place of safety, including the time they had arrived, the time the AMHP was notified and the time of the AMHP assessment. During the three month period the log was incomplete on 13 separate occasions. This was not in accordance with the trust policy and meant that the trust was unable to monitor and keep oversight of delays.
- The trust policy stated that the AMHP should interview a patient within three hours of admission to the health-based place of safety. The interview may be delayed because of intoxication, violent behaviour, or because

Are services responsive to people's needs?

Requires improvement

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

the individual is asleep. In the December 2015 data, the records demonstrated that on eight occasions, the AMHP did not assess the patient within three hours, and on four separate occasions, no reason was documented. In the January 2016 data, records demonstrated that on 11 occasions the AMHP did not assess the patient within the three-hour target, and in seven of those cases, the reason was not documented. Although the availability of the AMHP was not directly under the control of the trust, it was the responsibility of the trust to ensure timely assessments. In the tri-borough meeting in January 2016, the delay of assessment was raised. However, there was no action plan to address this.

- There had been one occasion in the past 12 months where a young person under the age of 18 was brought into a place of safety and there was a 13-hour delay in finding a bed for the young person. The trust had an ongoing pressure to find appropriate beds for young people aged under 18 to be admitted into.

The facilities promote recovery, comfort, dignity and confidentiality

- The physical environment at the Greenwich health-based place of safety did not promote dignity and privacy. The place of safety entrance door had clear panes of glass, which could be seen through from the outside. There were no blinds or curtains to protect patient privacy and dignity. The trust rectified the risk to people's privacy at the place of safety by glazing the windows soon after the inspection. However, there were clocks on the walls of the observation room and the bedroom and there was a shower available.
- The physical environment at Bromley's health-based place of safety did not promote dignity and privacy. The back entrance to the place of safety was visible to the car park and a patient's window overlooked the entrance. Although the place of safety had glazed windows, members of the public and patients at Green Parks house could observe patients going in and out of the health-based place of safety. There was no shower facility no clocks on the walls, no information on the walls explaining people's rights under the MHA and nowhere for a patient to lie on and rest. This was not in accordance with the Royal College of Psychiatrist's guidance for commissioners for the health-based places of safety. The borough's health-based place of safety meeting minutes noted that the heath base place of safety was not sound proof. The trust had plans in place to refurbish the places of safety to address the risks to patients and to promote their comfort and recovery. There was no set completion dates for the works.
- At the Greenwich health-based place of safety, the AMHP had a desk in the room next to the place of safety. The proximity made it possible for the AMHP to be notified quickly about a person coming to the place of safety. However, the proximity was only an advantage for patients coming in from the local borough. If the patient was a resident of another borough, then the DSN would be required to contact the AMHP from the patient's borough.

Meeting the needs of all people who use the service

- Records demonstrated that there had been occasions when an assessment was delayed due to an interpreter not being available.
- The health-based places of safety accepted young people under the age of 18. Staff told us that the patient's family would be contacted in order for them to visit. Staff said they had access to the child and adolescent mental health services (CAMHS) who would be able to provide support to the health-based place of safety. There were protocols in place to transfer young people under the age of 18 to a separate facility at a neighbouring London mental health trust. Liaison meeting minutes for the trust noted that Oxleas as a trust had the highest level of people aged under 18 accessing the health-based places of safety.
- Staff said that if a patient had a learning disability then a pathway would be created so that they were transferred to the most appropriate ward in the trust as soon as possible. Patients who were intoxicated were allowed into the health-based places of safety 'as long as they could bear their own body weight' and have a coherent conversation. The AMHP told us that they would not assess people who were visibly drunk. The AMHPs would wait until the patient had been medically cleared to before an assessment, which was in accordance with the section 136 best practice procedure.

Listening to and learning from concerns and complaints

- Staff were aware of how to handle complaints and tried to resolve issues raised locally where possible. The complaints process was managed by the inpatient wards when the patient was transferred.

Are services well-led?

Requires improvement

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 and day treatment teams

Vision and values

- Staff we spoke with demonstrated they shared the organisations values. Staff demonstrated their commitment to the job and how they wanted to ensure they made a difference to people's lives.
- Staff knew the name of the service director who regularly visited the teams. Staff told us that they felt comfortable to speak with senior staff. Most staff had not met any other members of the senior management team including the chief executive.

Good governance

- The teams had systems and processes in place to that provided an oversight of mandatory training, staff supervision, incident reporting and complaints. The systems needed improvement to ensure that there were not inconsistencies between teams. For example, the monitoring of care records and the use of outcome measures to demonstrate clinical effectiveness. Some teams were using the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) and a self-reporting questionnaire (CORE) and other teams were not. All of the teams were using the trust patient survey questionnaire, which provided data before and after treatment.
- The commissioners for Bromley HTT had set commissioning for quality and innovation network (CQUIN) targets for the year, which the service commissioners monitored monthly. Commissioners for Bexley and Greenwich teams did not set CQUIN targets for the service. However, the trust monitored performance data for all six teams as well as referrals from mental health liaison. The teams collected information over the past 12 months, which included referrals that had been accepted, rejected and discharged as well as monitoring caseload ethnicity and patients who had cancelled their appointment. There was not a national standard for the day treatment teams to benchmark their performance against. However, the Bromley manager was planning to involve an external organisation who carried out pieces of work with current and ex- patients to assess their experience. The data would then be analysed and a performance report created.
- There was a difference in service provision for the Bexley day treatment and HTT. This was due to different commissioning arrangements. The day treatment team was under resourced in terms of psychology input. After the inspection, the trust advised us that an additional two days per week of psychology input would be provided to the day treatment team starting from October 2016.
- Staff received regular supervision from a more senior clinician on a four to six week basis. Supervision records demonstrated that most staff had up-to-date supervision including a written record of their conversation. However, supervision notes in the Greenwich and Bromley HTT did not have a set agenda and the notes did not provide a clear, detailed plan that was specific to the staff member's needs. The Bexley HTT and DTT had a clear supervision agenda, which included safeguarding, training, staff performance and wellbeing.
- On average 92% of non-medical staff had received an annual appraisal in the past 12 months.

Leadership, morale and staff engagement

- Most staff we spoke with understood the whistleblowing procedure and all staff felt confident to raise concerns without feeling victimised. Staff provided examples of when they had raised their concerns formally.
- Staff we spoke with were very positive and committed to their role. Staff were able to tell us that they felt they were making a difference to people's lives. Staff acknowledged the challenges that the trust faced but felt supported by the teams in their day to day work. The morale of teams was mostly good. However, some staff did tell us that the recent reconfiguration of services had affected them and it was difficult to get a balance between work and personal life.
- Senior staff encouraged teams to provide feedback about their service, which was discussed in team meetings. Staff told us that this happened regularly. Some teams had away days which helped the teams to reflect on their work. Some staff did not give regular feedback and felt that they would not be listened to by senior management.

Are services well-led?

Requires improvement

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.

- The trust had created a staff support initiative called Staff Network. The network groups included black and minority ethnic (BME), lesbian, gay, bisexual and transgender (LGBT), a disability network and a lived experienced network (LEN). The LEN was for members of staff who had experienced mental illness. The meetings provided staff with an opportunity to meet and gain support.
- The teams had sufficient administrative support. The administrative staff were heavily involved in the day to day running of the teams.
- Staff were unable to submit items directly to the trust risk register. However, there were systems in place for staff to report identified risks. Managers were able to escalate concerns and add items if required. For example, the ligature points in the Bromley day treatment lounge were added to the risk register as this was escalated to health and safety within the organisation.
- Staff were aware of the term duty of candour and were able to explain that this meant being open and honest with patients if something with their care has gone wrong. Staff gave an example of information being sent to the wrong person, breaching confidentiality. The team apologised to the patient for this and rectified the issue.

Commitment to quality improvement and innovation

- The Greenwich and Bromley home treatment teams were accredited by the Royal College of Psychiatrists home treatment accreditation scheme (HTAS). The Bexley team was not accredited under this scheme at the time of inspection and did not have plans to apply.

Health-based places of safety

Vision and values

- Staff were aware of the organisation's values and said they felt the values fit with their current teams practice.
- The trust had good policies and protocols for the use of health-based places of safety. The minutes of the meetings demonstrated a level of motivation to keep improving. Staff were confident in raising concerns at the borough meetings and felt they received appropriate feedback.

Good governance

- Staff were supposed to be completing the health-based place of safety log with the relevant data required. There was a lack of oversight that this was being completed routinely. Staff were not notifying the AMHP service within the 60 minute trust target and there could be long delays of an AMHP carrying out an assessment. There was no action plans in place from the borough meetings to demonstrate that the issue was being addressed. The health-based places of safety did not routinely collect data to evaluate their performance. However, the trust was a part of the NHS Benchmarking Network audit on restraint, which included quarterly medicines audits. The trust carried out ligature and crisis plans audits.

Leadership, morale and staff engagement

- Staff were extremely positive about the management and delivery of the service at the places of safety. They felt well supported and motivated. Staff were proud of the fact that management was non-hierarchical and that they could ask anyone for advice or support, regardless of their seniority.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Safe care and treatment:** Care and treatment was not always provided in a safe way. This was because: • Both places of safety were not fit for purpose and had several ligature anchor points exposed. • The environment of the day treatment teams did not ensure that ligature risks were minimised and mitigated as reasonably practicable. The Bexley day treatment team had not carried out a ligature risk assessment of the environment. • There were inconsistencies in where risk assessments were completed by home treatment teams in the electronic care records, which meant that it was possible for staff (especially in other teams) to miss updates in risk information. • The quality and documentation of risk assessments was inconsistent and risk management plans did not clearly demonstrate how risk was being managed. There was a lack of evidence to demonstrate that all patients received a crisis plan. • There was a lack of physical health monitoring. Records did not always demonstrate that patients had received an initial screening or assessment when transferred to the team. This was in breach of regulation 12 (1) (2) (a)(b)(d)(e)(h).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Person centred care:** The trust had not provided care and treatment that was appropriate and met the needs of patients. • Staff were not ensuring that the approved mental health professionals were notified in a timely manner which meant there were delays in Mental Health Act assessments taking place. Staff were not documenting the reasons for the delay in the patient records. • Care plans did not always demonstrate the plans were holistic, personalised and person-centred. The care plans were always completed jointly with the patient. This was a breach of Regulation 9 (1)(3)(a)(f)(g).
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Dignity and respect:** People were not being protected against the risks associated with unsuitable premises. • The environments at the Greenwich and Bromley health-based places of safety did not promote the privacy, dignity and recovery of patients using these facilities. The Bromley health-based place of safety did not have a bed, clock or shower facilities. The Greenwich health-based place of safety had a glass entrance doors, which meant the privacy, and dignity of the person using the unit was not protected. This was in breach of regulation 10 (1)(2)(b).