CareQuality Commission

Requires improvement 🟠

West London Mental Health NHS 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)
Hammersmith and Fulham mental health unit and community services	RKL79	Hammersmith and Fulham crisis assessment and treatment Hammersmith and Fulham health-based place of safety	W6 8NF
Lakeside mental health unit and Hounslow community services	RKL14	Lakeside crisis assessment and treatment team Lakeside health-based place of safety	TW7 6AF
St Bernard's and Ealing community services	RKL53	Ealing crisis assessment and treatment team	UB1 3EU

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement	🟠
Are services safe?	**Requires improvement**	🟠
Are services effective?	**Good**	🟢
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:

- Since the last inspection the team configurations had changed and in July 2016 the new crisis assessment and treatment teams had been launched. This meant that while changes from the last inspection had been started, they had not all been robustly completed and embedded. At the previous inspection in June 2015, we found that the trust had not implemented governance systems to ensure compliance and address areas where improvements had to be made. At this inspection we found that whilst some systems were in place, local auditing procedures were variable, there was insufficient oversight of safeguarding referrals in one team, and inconsistent completion and storage of risk assessments. There were also not clear systems to collect feedback from patients to identify further areas for improvement.
- The trust figures for compliance with target times from referral to assessment across the crisis assessment and treatment teams, indicated that they were not always met, and there had been some significant breaches. Team managers were not aware of this data, and therefore unable to take any action to improve the situation.
- Where there were delays in the assessment of people admitted to the places of safety, staff were not recording the reason for this delay. In addition, staff were not always recording that they had informed patients admitted to the places of safety of their legal rights.
- Further work was needed on staff engagement with significant numbers of staff saying they did not feel senior managers communicated with them sufficiently about ongoing changes.
- Whilst it was recognised that the crisis assessment and treatment teams were fairly new, the staff appraisal rates needed to improve. Also staff would benefit from some more training on topics relevant to their roles, for example, working with people at risk of suicide, or people with eating disorders.

- Staff from the crisis assessment and treatment teams were mostly supporting patients in their own homes and some were not following the lone working protocols.
- Patients supported by the crisis assessment and treatment teams fed back that they would like to see the same staff more often and have more consistency of care.

However:

- Improvements had been made to the physical environment of the health-based places of safety following the inspection in June 2015. Following an external review a number of immediate changes were made. A new health based place of safety was opening in January 2017 at Lakeside which will accommodate two people at any one time.There were still a few other minor changes needed to reflect the Mental Health Act Code of Practice.
- Patients were positive about the support provided, including some innovative support from particular staff members.
- Staff treated patients with respect and compassion, and provided flexible support according to their needs.
- At the June 2015 inspection we found that staff were not receiving sufficiently regular supervision. However, at the current inspection it was clear that improvements had been made and staff were receiving regular supervision sessions.
- Monitoring of incidents and complaints was taking place, with action plans developed as learning points from these.
- Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served.
- There was an improvement in support for patient's physical health, being rolled out from the Ealing team across the crisis assessment and treatment teams.

Summary of findings

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

Are services safe?

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

- In the crisis assessment and treatment teams, whilst improvements had been made in the completion of risk assessments, this was not yet done to a consistently high standard. Risk assessments were not stored consistently which could make them hard to locate.
- There was insufficient oversight of safeguarding alerts made by staff at the Hammersmith and Fulham crisis, assessment and treatment team to ensure that all abuse was reported.
- Medicines at the Hammersmith and Fulham crisis assessment and treatment team were not stored at an appropriate temperature.
- In the crisis assessment and treatment teams, whilst a lone working working protocol was in place and staff had been issued with lone working devices, the new protocol was not yet fully embedded.

However:

- There were improvements in incident reporting and learning from incidents across the teams, and a new system was in place to monitor incidents, although it was too new to evaluate.
- Whilst staffing levels were a challenge across the crisis, assessment and treatment teams, especially in the Ealing team, this was being addressed by the trust through a recruitment campaign.
- The environment at each place of safety was clean and well maintained.
- The staff assessed and managed risks relating to the environment and to patients in the health-based places of safety appropriately.
- There were sufficient numbers of appropriately trained staff to work in each of the health-based places of safety services and to ensure that people were safe.

Requires improvement ●

Are services effective?

We rated effective as **good** because:

- Staff received appropriate levels of support and supervision in both the crisis, assessment and treatment teams and health-based places of safety.

Good ●

Summary of findings

- Staff worked well as a team, with effective handovers and sharing of information. There were good links with other services provided by the trust and external statutory and voluntary organisations.
- Staff assessed people's needs upon arrival at the places of safety appropriately and then assessed patients' needs in detail once they were admitted.
- Staff appropriately managed the needs of young people below the age of 18 admitted to the health-based places of safety.
- Staff monitored and addressed patients' physical health needs in the health-based places of safety appropriately.
- Staff in the health-based places of safety worked effectively with external agencies, including the police, to meet peoples' needs.

However:

- Although we found some improvements, the records kept across the teams were not consistent and accurate and work on this needs to continue.
- Not all staff had received training on topics relevant to their roles, for example, working with people at risk of suicide, or people with eating disorders.
- Appraisal rates were low across the teams.
- For some patients admitted to the places of safety, there was no record to confirm that they had been informed of their legal rights.

Are services caring?   Good ●

We rated caring as **good** because:

- Patients were involved in their care and treatment.
- Staff demonstrated good knowledge and understanding of patients needs.
- Feedback we received from patients was generally positive. Teams were supportive and patients said that they were treated with respect. Patients described having good relationships with staff. Staff listened to and supported patients with their care and with other aspects, including medication and education opportunities.
- Staff demonstrated a caring and compassionate attitude to those admitted to the health-based places of safety.
- Patients had access to independent advocacy to support them to raise issues regarding their care and treatment.

However:

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- Some patients found it difficult to see a large number of different staff from the crisis, assessment and treatment teams. They said that they would prefer to see the same staff for continuity.
- There were not always effective ways for collecting feedback from patients and other people involved in their care.

Are services responsive to people's needs?

Requires improvement ●

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

- There was no bed or mattress for patients at the Ealing place of safety. This was not in accordance with the Mental Health Act codes of practice.
- Where the time taken to assess people admitted to the places of safety exceeded the four hour maximum cited in the provider's policy staff did not record the reason for this. Staff were therefore not able to monitor the reasons for delays in order to help reduce them.
- The trust data for the time taken for patients to be seen following emergency, urgent and routine referrals indicated that the crisis, assessment and treatment teams were on occasion, failing to meet their targets by a considerable margin, indicating that patients were waiting too long to be seen.

However:

- The crisis assessment and treatment teams were generally meeting the target of assessing 95% of admissions to inpatient beds.
- Across the crisis, assessment and treatment teams, staff tried to offer patients flexible appointments to reflect their individual circumstances.
- Staff in all teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served.
- Staff provided information to patients regarding external services that were available to support them.
- Each place of safety had access for those with limited mobility.

Are services well-led?

Requires improvement ●

We rated well led as **requires improvement** because:

- At the previous inspection in June 2015, the trust did not have governance systems that ensured the teams worked consistently and safely to meet patient's needs. Although there

Summary of findings

had been some improvement since the last inspection, managers were still not using accurate data to monitor important aspects of the teams' performance. These included safeguarding practice, waiting times and patient experience.'

- A significant number of staff across the crisis assessment and treatment teams reported low morale.

However:

- Staff we spoke with across services reflected the values of the trust. They were committed and caring about the people they worked with to deliver care.
- Staff in the health-based places of safety received appropriate training and supervision.
- The morale of the health-based places of safety teams was good and staff said they felt supported. Staff demonstrated clear job satisfaction.
- Staff felt able to raise issues or concerns with their managers.

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Information about the service

The trust has three crisis assessment and treatment teams (CATTs). The teams are based in Ealing, Hammersmith & Fulham and Hounslow. The CATTs are multi-disciplinary community based services providing initial assesments to adults 24 hours a day. These include urgent and emergency mental health assessments when needed. Following assessment patients may be directed to clinical and social support services in primary care, specialist secondary care or the independent sector.

Access to the teams is via the trust's single point of access. Patients are also offered short-term support for a period of up to 12 weeks, known as brief intervention, and home based intensive treatment as an alternative to in-patient care for mental health crisis.

The trust has three health based places of safety. These are provided at Ealing, Hammersmith and Fulham and Hounslow. Each of the three facilities forms part of the mental health services based at these locations.

At the previous inspection three requirement notices were given relating to unsuitable health based places of safety, insufficient governance systems and insufficiently regular staff supervision.

Our inspection team

The team that inspected the mental health crisis services and health based places of safety consisted of two inspectors, a pharmacist inspector, two specialist advisors (one nurse, and one psychiatrist with experience of running similar services) and a Mental Health Act reviewer.

Why we carried out this inspection

We undertook this inspection to find out whether West London Mental Health Trust had made improvements to their mental health crisis services and health-based places of safety since our last comprehensive inspection which took place from 8 – 12 June 2015.

When we last inspected this service, we rated mental health crisis services and health-based places of safety as **requires improvement** overall; we rated the core service as requires improvement for safe and effective, good for caring and responsive and requires improvement for well-led.

After the inspection, we told the trust that it must take the following actions to improve mental health crisis services and health-based places of safety.

- The trust must ensure that the physical environment and the clinical practice relating to 136 detentions at Lakeside is in line with the Mental Health Act code of practice.
- The trust must ensure that accurate, detailed and consistent records are kept in respect of people's care including updating risk assessments.
- The trust must ensure that staff in the home treatment teams receive regular supervision.
- The trust must ensure that governance systems are implemented to ensure the home treatment teams are working consistenty and safely to meet the needs of people using the service.

These related to the following regulations under the Health and Social Care Act (Regulated

Activities) Regulations 2014:

Regulation 15 Premises and equipment

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Regulation 17 Good governance

Regulation 18 Staffing

We have followed up these areas for improvement at this inspection.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three health-based places of safety run by the trust located at Ealing, Hammersmith & Fulham and Hounslow

- interviewed three unit coordinators, three nurses and one clinician at the health-based places of safety
- observed one patient admission to the place of safety

- looked at the records of 10 patients and the admission register for each place of safety for the past month
- looked at a range of policies, procedures and other documents relating to the running of the services

- visited all three crisis, assessment and treatment teams in Ealing, Hammersmith and Fulham & Hounslow and shadowed staff members whilst they were visiting people
- spoke with nine patients and two carers
- spoke with the managers for each of the teams
- spoke with 18 other staff members; including doctors, nurses, social workers, pharmacists and support workers

- attended and observed handover meetings at each team, and a case review meeting
- looked at 24 care records of patients in the crisis assessment and treatment teams
- carried out a check of the medicines management at each of the teams
- looked at other relevant records such as records of checks of resuscitation equipment and policies

What people who use the provider's services say

Feedback we received from patients was generally positive. They found the crisis, assessment and treatment teams to be supportive and said that staff treated them with respect. Patients described having good relationships with staff. They described feeling listened to and well supported by staff with their care and appreciated the flexibility of the service.

A significant proportion of patients said they saw a number of different staff and would prefer to see the same staff for continuity. A small number of patients waid that they would like more time with staff on visits. Patients were aware of how to make a complaint if they wished to do so.

Good practice

- At the Hounslow crisis assessment and treatment team a staff member was working to improve patients' self esteem and fitness. He provided a role model for young men, encouraging regular gym attendance, and supporting people to remain drug free. He had supported one patient to start college.

- The Ealing crisis assessment and treatment team arranged a 'crafternoon' in every month, during which they would make items to sell and donate profits to MIND. This team also had a support worker who had taken on the role of physical health champion, and

Summary of findings

was also leading on smoking cessation therapy and mindfulness. He wrote to patients' GPs to inform them of progress, and had designed a new form for communicating findings effectively.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure all patients supported by the crisis assessment and treatment teams have thorough risk assessments, that are updated when needed and are easily accessible for staff.

- The trust must ensure that further improvements to governance systems are implemented to ensure the crisis assessment and treatment teams are working consistently and safely to meet the needs of patients and enable improvements to the service.

- The trust must ensure that there are systems in place to monitor the referral to assessment times for patients using the crisis assessment and treatment teams. Managers must have access to this information to ensure they are meeting the targets.

Action the provider SHOULD take to improve

- The trust should ensure that staff inform all patients admitted to the places of safety of their legal rights and record that they have done this.

- The trust should ensure, where there is delay in the assessment of people admitted to the places of safety that exceeds the limit set by the policy of the trust, that staff record the reason for this delay.

- The trust should ensure that staff working in the crisis assessment and treatment teams follow the trusts lone working protocols.

- The trust should review storage arrangements for medicines at the Hammersmith and Fulham crisis assessment and treatment team to ensure that medicines are stored safely at an appropriate temperature and this is monitored.

- The trust should ensure that all staff in the crisis assessment and treatment teams receive relevant training for example, working with people at risk of suicide, or with substance misuse issues or eating disorders.

- The trust should review the caseloads of each crisis assessment and treatment team to ensure that this can be managed safely.

- The trust should monitor any missed appointments by the crisis assessment and treatment teams, or by patients, so that appropriate action can be taken for patients' safety.

- The trust should ensure that all staff have annual appraisals of their performance in working in the crisis assessment and treatment teams.

- The trust should ensure the crisis, assessment and treatment teams have formal ways to collect regular feedback from patients to improve service provision.

- The trust should try and improve the consistency of staff supporting patients using the crisis assessment and treatment team.

- The trust should look at ways of improving staff morale.

CareQuality Commission

West London Mental Health NHS Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
• Hammersmith and Fulham crisis assessment and treatment team • Hammersmith and Fulham health-based place of safety	Hammersmith and Fulham mental health unit and community services
• Lakeside crisis assessment and treatment team • Lakeside health-based place of safety	Lakeside mental health unit and Hounslow community services
• Ealing crisis assessment and treatment team • Ealing health-based place of safety	St Bernard's and Ealing community services

Mental Health Act responsibilities

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

Staff had received mandatory training on the Mental Health Act. Overall staff appeared to understand the requirements of the Act.

The documentation in respect of the Mental Health Act was generally good.

Improvements had been made to the health-based places of safety since the previous inspection.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Only 38% of staff had received training on the Mental Capacity Act (MCA) within the crisis, assessment and treatment teams. The trust was aware that this was an area for improvement.

Staff we spoke with demonstrated knowledge of the principles of the MCA.

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

Crisis assessment and treatment teams
Safe and clean environment

- Since merging into new crisis, assessment and treatment teams (CATTs) in July 2016, each team had access to rooms for meeting with patients although most appointments were in patients homes.
- Meeting rooms were appropriately furnished, with safety alarms and closed circuit television monitoring in place, although there was poor heating regulation at some sites.
- An appropriate standard of cleanliness and infection control procedures were provided at each site, including hand washing posters to prompt staff.
- At Hammersmith and Fulham CATT there was not sufficient room available to accommodate all members of the staff team, and staff were split across two sites.
- There were arrangements to respond to foreseeable medical emergencies across the teams with regular checks of equipment in place.
- Clinical areas were generally well equipped except at Hammersmith and Fulham where medicines were stored in a small office used by staff.

Safe staffing

- Staff managed to see patients on the team caseloads regularly, but it was recognised that teams were very stretched at times. Staff recruitment was taking place. Each team had a minimum staffing level for each shift including at least one night staff member which was achieved. Staff we spoke with told us they felt that caseloads were generally manageable, although they did have concerns sometimes about being short staffed. There were some vacancies across all teams and regular use of agency staff, in addition to staff undertaking extra shifts or regular bank staff covering shifts. Sickness rates and staff turnover across the teams were low. It was recognised that more medical input was needed and additional recruitment was taking place.
- In Ealing, there were pressures on staff due to staff shortages. At the time of the inspection there were vacancies for three band 6 nurses and one support worker (11% nurse vacancies). These shifts were covered by bank and agency staff. There had been a recent recruitment drive to fill the posts. Within the last year there was a turnover of six staff (five of which were promotions). The team crisis caseload was 80-90, but we were told that it should be a maximum of 50, and there were 20 patients receiving brief intervention support. Approximately six assessments were undertaken each day. Staff advised that the team caseload had increased as a result of the local recovery ward closing two months before the inspection. Staff said they struggled to meet deadlines for seeing new patients, and described difficulties prioritising work, and discharging patients.
- The Ealing CATT team consisted of 39 whole time equivalent staff including five newly recruited nurses. There was a team manager, five band 7 posts (one vacant covered by 0.7 agency), 23 band 6 posts (20 filled and 3.6 covered by bank and agency staff), and six band 3 posts (one vacant). Six shifts had been unfilled between April to June 2016. There were plans to improve medical cover for the team which staff said was not sufficient, to four consultants and eight staff grade doctors to meet the team needs.
- In the Hammersmith and Fulham CATT team there was a caseload of approximately 30 - 40 crisis patients and 15 brief intervention patients. Establishment levels were 18 band 6 nurses (with seven vacancies covered by four locum staff), five band 7 positions (with two vacancies). Overall there were 32% nurse vacancies. There were also two band 3 support workers (no vacancies). There was a turnover of one staff member in the last year. The team manager noted that one area of difficulty in recruitment to the team was the geographical area covered. On the day of the inspection there was a shortfall of two nurse band 6 positions, and staff indicated that they worked below the team numbers needed approximately once a week placing pressure on the team. Three shifts had been unfilled between April to June 2016. There were plans to increase the medical team by recruiting another specialist registrar doctor to cover the team.
- In the Hounslow team the crisis caseload was 30-40 patients, and there were 30 brief intervention patients. Staff advised that the caseload had increased as fewer inpatient beds were available for patients, but they were

Are services safe?

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managing to keep shifts filled. There were four band 7 posts, (one covered by an acting post, and one maternity post not covered). There were eleven band 6 nurses in post, out of an establishment of 15 band 6 posts, (covered by two agency and one by bank staff or staff working additional shifts). They also had a band 5 post (occupational therapy health assistant) providing outreach support with physical health and fitness. Although there was a band 3 (support worker) vacancy, the team manager advised that they were looking to leave this unfilled, and provide another car for the team (only three cars available). There had been a turnover of two staff members in the last year. Sixteen shifts had been unfilled between April to June 2016. There were 40% nurse vacancies (trust average was 26%) and 50% support worker vacancies.

- There was 85% mandatory training compliance across the services.

Assessing and managing risk to patients and staff

- All of the teams had daily staff handovers between shifts where each patient on the team's caseload was discussed. At these meetings the individual risks for each patient were discussed and plans put in place to address these risks.

- Staff were trained in safeguarding and policies and procedures were available. Training compliance was 98% for level 1 safeguarding adults and 100% for safeguarding children. There were safeguarding leads in teams and a trust lead on safeguarding that staff could access for advice and support. In Ealing a safeguarding lead visited the team at least every week, to monitor referrals and in Houslow, a spreadsheet was maintained of all safeguarding referrals. However in Hammersmith and Fulham, the team did not have a clear oversight on the number of referrals made for safeguarding alerts and the team manager acknowledged that it was a blind spot. She said that she had requested extra training for staff in this area. A staff member expressed concerns that insufficient safeguarding alerts had been made for the team, and that staff were not sufficiently clear about the thresholds for making alerts. We observed one example of a patient whose care records indicated serious neglect and a safeguarding alert had not been made or considered. At the Hammersmith and Fulham team there had been no safeguarding referals since the CATT team was operational in July 2016.

- At the last inspection we found a variation in the quality of recorded risk assessments and found that these were not always being updated as needed. At the current visit, we found that whilst work had taken place to improve the quality of formal recorded risk assessments including training in record keeping, the quality varied across and within the CATT teams. Audits were undertaken of risk assessments every three months and showed improvements but there was more to do. Initial risk assessments were undertaken at the initial assessment, and were updated when patients' needs changed. However, the content of risk assessments was at times limited, with more details provided in the patients' progress notes. We observed that staff regularly used progress notes to update changes in patient's care, rather than updating risk assessments and care plans. Staff in all teams confirmed that this was the case. This meant that new staff looking at risk assessments may not have all the required information, without going through progress notes, which placed patients and staff at risk. We did see appropriate support in place for positive risk taking, and crisis plans put in place for the majority of patients. All patients were given the 24 hour helpline number in the event of an emergency out of hours.

- All teams were aware of the risks and had systems in place to manage the risks associated with lone working. Although all teams had been issued with lone working devices, we found that the use of these varied. Many staff indicated that they did not find them useful. At the Ealing team, a strong secondary system of texting after each appointment was working well. However, although the system had been introduced, this had not yet been embedded in the other two teams. The lone working systems were included on the risk registers for these teams.

- Only the Ealing team was using a red, amber and green rating system, to help prioritise patients' home visits, and action to be taken if they were unable to contact a patient. The other two teams were using whiteboards to record information about each patient. They had no easy system for prioritising patients, without reading through the full caseload, so there was a risk that high risk patients may not be prioritised appropriately.

- Pharmacy staff visited each team every weekday to screen prescription charts, order medicines, and top-up stock medicines. The use of a new green sticker system

Are services safe?

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was used to alert staff to high prescribed doses of medicines. These medicines were taken by staff to patients who were being supported with their medicines in the community.

- Clinical rooms were clean with hand washing facilities available. Medicines were stored securely in locked cupboards. In Ealing and Hounslow, staff recorded the ambient room temperature of the room where medicines were stored. There were some gaps in recording and some temperatures were above the range required to maintain integrity. This meant that there was no assurance that medicines were stored at the correct temperatures to remain effective. The storage temperature of medicines in the Hammersmith and Fulham office was not monitored. There were no medicines fridges as staff did not need to store medicines requiring refrigeration.

- Staff had adequate medicines disposal facilities, including access to sharps bins which were dated appropriately. Staff had access to tamper proof bags for transporting medicines in the community but these were not always used.

- Medicines administration records were accurate. The prescription charts had patient identifiable data, and allergy status completed for all patients. Stickers were used to track whether medicines were dispensed by a GP or the team; whether patients were self-administering or not; and whether the medicines were in the office or in the patient's home.

- Staff had access to an emergency drug cupboard and an on call pharmacist out of hours.The pharmacists were well integrated into the team despite not always being able to attend ward rounds. The pharmacists had implemented an excel spreadsheet to keep track of which medicines were dispensed, when they were dispensed, and number of days supply provided. This was a valued resource for the teams.

Track record on safety

- Between April 2015 and March 2016, there were three serious patient incidents in Ealing home treatment team, and three in the assessment team. There were two serious incidents in the home treatment team in Hounslow, and one in Hammersmith and Fulham.

Reporting incidents and learning from when things go wrong

- A new incident reporting system had been put in place for the trust a month before the inspection. However, not all staff had received training in its use, and there were still some difficulties in using the system, and accessing data from before the change. The new system was designed to allow staff to follow the progress of any reports they had made, and easily access learning from incidents.

- All staff were expected to take responsibility for reporting incidents. Staff told us that they reported incidents on the trust's electronic reporting system and these were signed off by their manager. They advised that reporting of incidents had increased within each team. In each team staff were able to give examples of learning from incidents with patients. For example, a dual diagnosis lead had been put in place following an incident involving drug use by a patient, and staff had improved planning for pregnant patients to ensure they had appropriate support.

- All serious incidents were investigated and discussed in a range of forums, such as in team meetings, business meetings, clinical improvement groups, and senior management meetings. The trust also had annual learning lessons conferences.

Duty of candour

- Staff had an understanding of duty of candour and were clear that they needed to be open with patients and families if something went wrong with their care delivery. The duty of candour policy for the trust linked in with the incident reporting policy.

Health based places of safety
Safe and clean environment

- The environment within each of the three health-based places of safety (HBPoS) was good and appropriate to meet the needs of patients. Each place of safety was a self-contained unit on the ground floor within a hospital, separate from other wards and had a separate entrance to allow patients to be escorted into the unit away from people using other services. This supported the privacy and dignity of patients using each of the HBPoS.

- During our last inspection of the trust in June 2015 we found that the facilities at the Lakeside place of safety in Hounslow were not fit for purpose. This was because the place of safety was only accessible by going through another ward, which compromised the privacy and dignity of patients using the facility. Also, because the

Are services safe?

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ward in question was a male ward, the place of safety was not accessible at all for female patients, who, as an alternative, had to use an interview room on a different female ward. As a result of this breach of regulation the trust took steps to address the problems at the Lakeside place of safety. When we visited on this current inspection we found that the provider had made alterations to the facility so that patients could access it via a separate entrance and did not have to enter through a different ward. The facility was for male patients only. Female patients who needed a place of safety were now taken to the HBPoS at Ealing Hospital, which was for females only. In addition to these changes the trust was building a new HBPoS at Lakeside opening in January 2017.

- At each location staff had conducted an environmental risk assessment to identify and manage risks and was taking appropriate steps to manage these risks. The facilities were free of ligature points. These measures included ligature-free door handles and curtain rails. Two places of safety, in Hammersmith and Fulham and Lakeside, had mattresses, which were also anti-ligature.

- Each place of safety was secure, with no blind spots and mirrors where appropriate to permit staff to see into all parts of each facility. At each location there was a staff room next the room set aside for the patient. Each facility had capacity for one patient. Each of the patient's rooms had an en-suite toilet, with washing facilities. Staff usually monitored the safety of patients through close observation, which involved a staff member being in the same room as the patient, or observing them from the adjacent staff room, with the door open. One staff member was always on duty for observations for each room. Access to shower facilities at each place of safety was located on adjacent wards. Staff accompanied patients wishing to use shower facilities to support their safety and dignity.

- Each place of safety was equipped with an emergency alarm system so that staff were able to immediately request assistance when required from their colleagues in an adjacent ward. Staff also carried personal alarms.

- All emergency equipment and drugs in each place of safety was located in an adjacent clinic room. At Lakeside and Hammersmith and Fulham this clinic room was on an adjacent ward and at Ealing this was in a clinic room accessed by other wards. All clinic rooms were appropriately close by for staff to be able to

promptly access emergency drugs and equipment. Staff regularly checked the resources in each of the rooms to ensure that equipment was working and that drugs were up to date and appropriately stored. Where medicines were kept refrigerated staff monitored the fridges daily to ensure they were at the correct temperature. Ligature cutters were in the clinic rooms and all staff working at the three sites knew where these were. Staff used these clinic rooms for conducting any physical examinations of patients.

Safe staffing

- The staffing level at each place of safety comprised, where required, a unit coordinator, a registered nurse and a healthcare assistant. Whenever a patient was admitted to one of the place of safety there were always two members of staff working there, one of whom was a registered nurse. Staff members for the places of safety were taken from other mental health wards. There was an agreement between the trust and local police that once police had had escorted someone to one of the locations they would remain there for an hour to help ensure that the patient and staff were safe. We interviewed seven members of staff across the three units who all said there was sufficient staffing available to ensure the facilities were safe and met patients' needs.

- The trust did not use bank or agency staff in the place of safety.

- All staff working in the places of safety had to complete an induction before working there. This included learning the procedures, protocols and policies.

Assessing and managing risk to patients and staff

- Staff working in the place of safety received appropriate training in preventing and managing aggression and in de-escalation techniques.

- Whenever staff needed to physically restrain a patient they recorded this as an incident. We looked at the records regarding three patient restraints. The records showed that staff had undertaken restraints in accordance with policy and procedure. Staff said that they used restraint only as a final option and used verbal de-escalation techniques to resolve a situation. The three records we looked at supported this.

- At all three places of safety staff explained that where a patient became so unwell that a situation could

Are services safe?

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

become potentially unsafe they transferred them to a seclusion room in the mental health unit. The seclusion rooms were on wards and this allowed more staff to be potentially available to support the needs of the patient.

- Staff rarely administered rapid tranquilisation to patients. Staff explained that it was common for those arriving at the place of safety to be heavily intoxicated and therefore they did not perform this procedure in those circumstances as it was not safe. The records showed that where staff undertook this procedure they did so according to trust policy and procedure.

- Upon the admission of a person to each of the places of safety an initial assessment of their needs and risks to them was undertaken either by a duty doctor, or the unit coordinator. The unit coordinator at each site was a registered nurse. This assessment was usually done in the emergency vehicle that had brought the person to the place of safety. Where staff assessed that an admission to the place of safety was appropriate they then requested a psychiatric assessment to be undertaken by an approved mental health professional (AMHP) and a doctor, in accordance with the Mental Health Act. The purpose of this assessment was to determine whether someone required admission to the mental health unit attached to the place of safety.

- Where required staff at all three locations raised safeguarding alerts concerning patients to the local authority so that they could investigate them. For example, staff raised safeguarding alerts with the local authority if they had concerns regarding the circumstances which had led police to bring someone to a place of safety. This included where staff were concerned that someone had been the victim of abuse.

Reporting incidents and learning from when things go wrong

- We spoke to six staff members about their understanding of how to report incidents and they all showed that they understood how to do this. There was also evidence of staff learning from incidents and changing their practice as a result. For example, following an incident at the Ealing HBPoS where a patient had self-harmed while using the toilet where the viewing screen of the toilet door had been closed, staff decided to only allow patients to use the toilet with the screen closed after first assessing that they were safe to do so.

Are services effective?

Good ●

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

Our findings

Crisis assessment and treatment teams
Assessment of needs and planning of care

- Assessments were completed following a referral. CATT teams worked with the inpatient wards attending meetings with patients to discuss their suitability for being discharged to the care of the team. Staff undertook joint assessments with the early intervention teams where there were indications of a first episode of psychosis.
- In the Hammersmith and Fulham team the assessment team remained separated from the rest of the CATT team, and based at a different location. In the other two teams staff worked across both the crisis and assessment teams.
- At the previous inspection in June 2015, we found that the standard of patients' records was not good enough to ensure their safety. We found an improvement in records kept on this occasion. Staff had received training on record keeping and records were looked at during supervision. However, there was still a variable standard of record keeping across the teams. Most updated details were recorded in progress notes, rather than care plans and assessments. This made it difficult for staff to find up to date information and be clear about the current care plan to address the patient's assessed needs. At each service we found at least two patients' records out of eight that were not up to date, holistic, or recovery orientated.
- Records of patients' physical health were not consistent, with some patients receiving more input than others. Teams acknowledged that better communication was needed with GPs. In the Ealing team a new initiative to support people with physical health needs was proving effective. Two staff members ran physical health clinics on site or at people's homes. However, they were reliant on other members of the team to refer patients to this service, so not all eligible patients were receiving this support. Similar systems were in the process of being set up in the other two CATTs.

Best practice in treatment and care

- The new model for the CATTs was based on another trust's model, and team managers had been involved in consultation about this strength based model.

- NICE guidance was considered when medicines were prescribed, and staff could access local prescribing guidelines via the trust intranet.
- The teams followed NICE guidance on the management of patients in crisis. None of the teams had psychology input but could access an inpatient psychologist if needed. There was a waiting list for attention deficit hyperactivity disorder assessments, currently booking for May 2017.
- Hounslow undertook a range of clinical and non-clinical audits relevant to the team's practice, and there were a small number in Ealing. At Hammersmith and Fulham we did not see evidence of local audits being undertaken. Quality monitoring systems differed between the teams. There were not always sufficient systems in place for the teams to identify inconsistencies and thereby effectively improve the quality of their service.
- We looked at the proportion of admissions to acute wards assessed by the crisis assessment and treatment teams (data to June 2016) with 94.6% as the lowest point the trust reached during January to March 2016. This was the only time the trust failed to achieve the national target of 95%. In the most recent quarter, the trust figure rose above the target again.
- The teams were involved in some trials including looking at the effects of oral versus intramuscular antipsychotic medicines.
- They completed health of the nation outcome scores for each patient.
- Each team had plans to improve groups provided to patients and links with local support groups in the community. At the Hounslow team there were links with the recovery college, and plans for benefits clinics. A band 5 staff member was working to improve patients' self esteem and fitness. He provided a role model for young men, encouraging regular gym attendance, and supporting people to remain drug free. He had supported one patient to start college. Other staff told us of their plans to undertake training as a nurse medical prescriber and to incorporate mindfulness training in their sessions with patients.
- Ealing carried out a 'crafternoon' in every month, during which they would make items to sell and donate profits to MIND. At Ealing a support worker had taken on the role of physical health champion, and was also leading

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on smoking cessation therapy and mindfulness. He wrote to patients' GPs to inform them of progress, and had designed a new form for communicating findings effectively.

Skilled staff to deliver care

- At the previous inspection in June 2015, we found that the trust was not providing sufficiently frequent supervision to staff members. At the current inspection we found there had been an improvement in the frequency of supervision rates in the two months prior to the inspection. Before this supervision had been more sporadic. Supervision rates for staff were 84% in September and 88% in October.

- Staff appraisal rates were low, at 37% for Hounslow, 47% for Ealing, and 56% for Hammersmith and Fulham.

- There were lead roles for staff members within each team including a lead for physical health, for incidents and clinical governance, for inpatients, training, safeguarding, voluntary sector, health and safety, diversity, police liaison, and dual diagnosis.

- A psychotherapist provided reflective practice sessions for staff fortnightly.

- Most staff told us there were good opportunities for staff development. For example, support workers were supported to undertake nurse training.

- Staff training was not provided in working with complex issues such as suicide, long term mental health issues and anorexia although they worked with patients with these conditions. Some staff told us that they had requested dialectical behavioural therapy and emotional regulation training.

Multi-disciplinary and inter-agency team work

- Staff working across the teams were from a range of professional backgrounds including, nursing, medical, social work, administrative, occupational therapy, support workers and psychology. Each team had at least daily multi-disciplinary handover meetings where patient risk was discussed and care planned. Discussions took place around involving others, for example the police, carers and plans for patient engagement.

- Teams were proactive in working with other community teams around the triage of new referrals. For example, teams worked closely with referring teams to support their understanding of why patients had been referred.

- Managers held liaison meetings with the single point of access, primary health, site liaison managers, accident and emergency manager and improving access to psychological therapies liaison meetings.

- There were working relationships in place with external agencies across all teams including social services, GPs, the police, and housing and voluntary organisations.

Adherence to the MHA and the MHA Code of Practice

- Staff had received mandatory training in the trust on the Mental Health Act. Compliance with this training was 88% across the teams. Hounslow CATT was the only team that failed to achieve the trust target, with only 76% compliance. Overall, staff appeared to understand the requirements of the Act.

- Referrals were made to approved mental health professional's (AMHPs) or section 12 doctors to undertake Mental Health Act assessments where required.

- Teams could access mental health advocacy services if needed.

Good practice in applying the Mental Capacity Act

- Staff received training on the Mental Capacity Act (MCA). Until May 2016, this was incorporated within the mandatory mental health law training in the trust and also bespoke training. The trust had recently introduced a mandatory on-line MCA training course and across the teams compliance rates were 38% although most staff had received the previously provided training and this was not included in this figure.

- Staff we spoke with demonstrated knowledge of the principles of the MCA and we observed that MCA assessments were being undertaken when needed, although these varied in the level of detail recorded.

Health based places of safety
Assessment of needs and planning of care

- Staff assessed the physical health needs of patients before they admitted them to the place of safety. This was usually done in the vehicle that brought someone to the place of safety. The purpose of the assessment included identifying whether they required immediate, emergency treatment. Where this was necessary staff

Are services effective?

Good ●

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directed those who had brought the person to the place of safety to first take them to an accident an emergency department. Each place of safety was located near such a department. Where someone had physical health needs but did not require emergency care staff supported them to access the place of safety and then monitored and attended to their physical health care needs at the location.

- Where staff admitted minors into the place of safety they completed a serious incident report and immediately informed the local child and adolescent mental health service in order to assess the needs of the minor, in accordance with trust policy.

Best practice in treatment and care

- Once patients were admitted to one of the places of safety a duty doctor reviewed their physical and mental health needs. Staff regularly monitored patients' physical healthcare and recorded observations using national early warning scores standards. This identified if a patients physical health was deteriorating and they needed to be urgently referred to a doctor.

Skilled staff to deliver care

- Staff working at the places of safety were taken from mental health wards in the units where they were located. Each place of safety was managed by a unit coordinator. This staff member was always clinical team leader (CTL) who worked on one of the other mental health wards. The CTL was responsible for ensuring that the place of safety was appropriately staffed and correctly run according to the procedures and protocols of the trust. The training that staff received as part of their work on mental health wards was appropriate to support their work in the HBPoS. This included training in conducting close observations, communication skills and verbal de-escalation techniques.

- Staff across all three units received monthly clinical and managerial supervision. Additional supervision was also available for staff if it was required. The staff we spoke with said that they felt well supported.

- Staff responsible for managing each of HBPoS met every month to discuss their work. This meeting was attended by the CTLs, ward managers and the modern matron from wards that provided staff for the places of safety.

We looked at minutes from these meetings at each HBPoS and saw that staff discussed issues including the number of admissions to the units, incidents and staffing requirements.

Multi-disciplinary and inter-agency team work

- In accordance with new practice guidance on the work of the HBPoS developed by the trust senior managers reviewed the operation of each location on a daily basis. The purpose of these meetings was to monitor the needs of patients, including those who required transfer to an acute ward and whether there were any delays to this process. The managers also reviewed incidents to ensure that staff and responded to them appropriately.

- Because people are usually brought to places of safety by police officers, where they believe someone is in need of care from mental health services, HBPoS staff liaised every month with local police forces to exchange information and discuss collaborative working. Such partnership agreements are also in accordance with recommendations in the Mental Health Act codes of practice regarding collaborative working between services and police. This work was supported by a police liaison officer who worked with the trust. The collaborative working between the trust and the police had helped to develop the trust's policies and procedures regarding the HBPoS. This included an agreement that, having supported someone to access a place of safety, the police would remain there for one hour to help ensure the safety of that person and the staff. At the Ealing HBPoS a pilot scheme had also been running for several months where police were based on the grounds of the hospital to additionally support safety.

- Staff at each of the units said that they valued the collaborative work with the police and that this was supporting them to do their work more effectively. For example, staff explained that their collaborative working had led to the police more frequently calling ahead when they believed that they may need to support someone to attend a HBPoS. This allowed staff to discuss that person's needs with police and, through obtaining their personal details, find out whether they had used services before. This helped staff identify their potential needs. We observed staff at the Ealing place of

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safety liaising with police in such a situation and saw that they was an effective exchange of information that allowed staff to plan for someone's admission, before they arrived with police officers.

- Records showed that staff liaised with police and other agencies when discussing the circumstances and needs of someone possibly requiring admission. Staff also had a checklist of questions they asked police when assessing peoples' needs, including their level of intoxication and whether they had self-harmed.
- The trust had worked with the police, local authority and other agencies to develop effective policies and protocols for the use of the places of safety and ensure the principles of the crisis care concordat were implemented.

Adherence to the MHA and the MHA Code of Practice

- We examined 10 patient records across the three places of safety and saw that staff had correctly completed all the paperwork in relation to patients' admissions.
- All staff working in the place of safety had completed mandatory training concerning the MHA.
- In seven of the 10 records we looked at we saw that staff appropriately informed patients of their rights under the MHA, both verbally and in writing, following their admission to the place of safety. However, in three of the records we examined at the Lakeside place of safety there was no record that staff had informed patients of their rights, in anyway. There was also no recorded reason why staff had not done this.

Good practice in applying the MCA

- Staff assessed the capacity of patients as part of the assessment process.
- Staff demonstrated an understanding of the main principles of the Act.

Are services caring?

Good 🟢

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

Our findings

Crisis assessment and treatment teams
Kindness, dignity, respect and support

- Staff demonstrated a good knowledge and understanding of patients. Staff showed a good understanding of each patient's individual needs. In multi-disciplinary team meetings we found that staff reflected the wishes and views of the patients they were discussing. On home visits, it was clear that staff had an understanding of patient's needs and treated them with respect.

- Overall patients were consistently positive about the care they received from staff. They described good relationships with staff, and could contact staff outside of a scheduled visit time, and receive a prompt response. They felt listened to and well supported by staff.

- Patients said that staff had sought their consent to share their information with other health care professionals. They described consistent support with medicines, and day to day tasks, as well as support to access education and employment opportunities, and to improve fitness and self esteem.

- Patients said that they were generally offered a copy of their care plan. Information was available to patients and their friends and relatives in the reception areas for each team. These included leaflets about support services, physical health, carers information, local charities, and benefits and housing.

- However, a consistent theme was that patients described seeing a large number of different staff and most said that they would prefer to see the same staff for continuity. A small number of patients said that they would like more time with staff on visits.

The involvement of people in the care they receive

- At all services, patients were given a leaflet with relevant contact numbers for the service.
- The method for collecting feedback from patients and carers varied between teams. Feedback forms were being used at all three services including forms for family and carers. However, only small numbers of completed surveys had been received.
- We saw evidence from care records there had been good family and carer involvement and this was confirmed by people we spoke with. Carers' assessments were offered to people when appropriate.
- Feedback from a group of 18 carers in Ealing was very positive about the service, describing staff as caring and effective. However, other feedback from a group of service users in Ealing and Hammersmith and Fulham, indicated concerns about long waits for therapies and insufficient discussion of diagnosis.

Health based places of safety
Kindness, dignity, respect and support

- We observed the admission of one patient to the Hammersmith & Fulham place of safety and saw that staff treated them with care and compassion and demonstrated sensitivity and concern for their particular needs. Staff interacted with them in a manner that was supportive and kind.

The involvement of people in the care they receive

- Records showed that as part of their assessment staff sought the views of patients.

- Patients were able to access an independent mental health advocacy service to give them advice and support about their rights. Staff displayed information at each of the three services informing people how they could access an advocate. Staff also had access to interpreting services, where required.

Are services responsive to people's needs?

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

Our findings

Crisis assessment and treatment teams
Access, discharge and transfer

- Ealing received the highest number of referrals of all three teams. Staff told us that they were meeting their targets, but this was not supported by the data from the trust. Each team had trust targets for referral to assessment times. None of these were met in the year ending June 2016. Targets were four hours for emergency referrals, 24 hours for urgent referrals, seven das for routine plus referrals, and 28 days for routine referrals.

- The trust advised that data might be inaccurate due to changes in team configurations and the creation of the Single Point of Access team which started in April 2016.

- The trust indicated that data from July 2016 onwards was a more accurate representation of whether the teams were meeting the targets. However, data for Ealing from July 2016, indicated 4 day waits for emergency patients to be seen, and 3.5 days to see urgent patients in July 2016. They also reported 1.9 days for urgent patients to be seen in October 2016. For routine plus referrals patients waited over 7 days in July and August, and an average of 9.7 days in September 2016.

- Trust figures indicated that in Hammersmith and Fulham, patients waited 4.5 days for urgent referrals in July 2016, 14 days for routine plus appointments and 41 days for routine appointments in this month. In October 2016 they waited 13.5 days for routine plus appointments.

- Trust figures indicated that in Hounslow patients waited 46 days for routine plus appointments in August 2016.

- These figures did not reflect the performance reported by individual team managers during our inspection.

- Data was not monitored regarding any 'did not attend' visits by the crisis assessment and treatment teams, or patients missing appointments. Across the teams, we found that patients were given flexibility in when they could see staff and where. Most patients were seen away from the office. Staff were responsive to people's individual requests and needs and tried to work around these. Staff said that appointments were rarely

cancelled. If they had to cancel a visit or a person was not available during their scheduled visit, this would be discussed with the team and risk assessed and escalated if required.

- If referrals were not considered appropriate this would be discussed with the individual or team who had made the referral. There were no set acceptance criteria for a service. Teams would accept referrals based on an individual need. Patients were not excluded if they would benefit from treatment.

- The average length of stay with the teams varied from a few weeks to up to 12 weeks for brief interventions depending on the individual's need and complexity of support required.

- The trust operated a 24 hour 7 day a week advice and support line via the single point of access. Referrals could be made directly by patients, or carers, GPs or other agencies. The CATT teams each had one person working at night who could speak with patients or see patients for assessments via the local accident and emergency department. This system had been put in place to address patients' needs. For example, it was found that emergency admissions to hospital peaked between the hours of 7pm and 11pm.

- Ealing CATT worked to support people at a new recovery house in the area.

- The CATT teams were responsible for gatekeeping all admissions to inpatient beds. The teams were largely achieving 95% for this indictor that all referrals that may need admission to hospital were seen by the team. If staff were not able to find a bed locally, this was escalated and the next nearest bed would be sought with agreement within the NHS or independent sector if needed.

Meeting the needs of all people who use the service

- The teams used interpreters where needed and information was available in a range of languages from the trust on request. Some staff across teams spoke a range of different languages. For example a Farsi speaking staff member described positive work they had undertaken with a patient recently. A staff member trained in british sign language was also available to support patients.

- Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served.

Are services responsive to people's needs?

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

- Staff were aware of the need to support people in a manner that respected their preferences. For example, if someone requested a visit from staff of the same sex, the teams tried to facilitate this.
- Teams had developed links with local support groups such as Mind and drug and alcohol services, which they could signpost people to.
- Staff noted that they attempted to meet people in their preferred setting, for example in a café if needed. They were also in contact with the street homeless teams to discuss joint work for the future.

Listening to and learning from concerns and complaints

- Formal complaints were investigated in line with the trust's complaints procedure. Learning was identified from complaints and this was shared with the team. In the last 12 months (to June 2016), ten complaints were received relating to discharge and transfers. No complaints were referred to the ombudsman. Four complaints were fully or partially upheld. Complaints data since the CATT teams had been in place was not available.
- The category with the highest number of complaints was staff issues. For example patients unhappy at seeing many different staff, as well as patients unhappy at discharge from the service.
- People we spoke with were aware of how to raise a complaint. Staff were able to describe the informal process for managing concerns as well as how a person could raise a formal complaint.

- Staff tried to resolve issues raised locally where possible and examples were given of informal concerns that were raised and how they had been resolved. Examples of recent concerns raised included the lack of advanced notice of when staff would be coming for a home visit, lack of continuity with staff members and rushed visits. In each case staff took time to understand the issues and make arrangements to improve the service provided.
- The complaints procedure was available in an easy read format.

Health based places of safety
Access and discharge

- The trust operated a policy of accepting admissions, if there was space available, regardless of where someone

was from. If a place of safety was occupied when an admission was requested, staff searched for alternative services that had capacity, such as other places of safety, or an acute ward.
- The Mental Health Act provides for someone to be detained under the Act for the purposes of bringing them to a place of safety for a maximum of 72 hours. Staff across all three HBPoS always assessed patients within this period, to determine whether the patient required further assessment or treatment under the Mental Health Act.
- The MHA codes of practice of the Act (16.47) recommend that, where there are no clinical grounds for delay, it is good practice for a person admitted to a place of safety to be assessed by an approved mental health practitioner (AMHP) within three hours of their admission. The policy of the trust directed that this period should not exceed four hours. In seven of the 10 patient records we looked at showed that these limits had been exceeded. However, in none of these seven cases did staff record the reason for the delay. Staff told us that it was not uncommon for an AMHP to be delayed in attending to assess a patient, especially at night or the weekend. But, without any record stating the reasons for any delay in assessment, staff were not able to monitor the causes for them and therefore reduce any potential delays in providing patients with appropriate care and treatment.
- Where staff had assessed patients as requiring admission to a mental health ward for further assessment or treatment, a bed was not always immediately available for patients to transfer to. Staff said that in these circumstances patients had to wait in the place of safety for a bed to become free on a ward.
- The health based places of safety received admissions of young people under 18 year olds, if this was necessary. Where such admissions had occurred the records showed that staff notified appropriate mental health professionals with experience in working with under 18s to conduct their assessment.

The facilities promote recovery, comfort, dignity and confidentiality

- At the previous inspection in June 2015, we found that the health based place of safety at Hounslow was not fit for purpose due to its access through a ward. This had been rectified and each place of safety had direct access via a driveway, leading up to the entrance of each

Are services responsive to people's needs?

Requires improvement 🟠

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

facility, allowing emergency vehicles to back up to the entrance door of each location. The entrances to the HBPoS at the Ealing and Hammersmith and Fulham (H&F) sites supported the privacy and dignity of patients accessing the service. This was because once an emergency vehicle had parked beside the door of both of these locations it was clear that it would be difficult for other people nearby to see someone being escorted into the place of safety. Also, it was not possible to see into either unit from the outside. However, the entrance gate to the place of safety at Lakeside was on a public road, and was also visible from housing nearby. Although this gate could be opened to allow a vehicle to back up to the entrance of the place of safety staff said that this did not happen. A new place of safety was opening in January 2017 at Lakeside.

- Two places of safety, in Hammersmith and Fulham and Lakeside, had mattresses for the patients to sleep on. There was no mattress at the Ealing place of safety. Staff at the Ealing service said this was because their aim was to move patients there to a ward as quickly as possible in order to provide them with a more therapeutic environment. In case someone needed to lie down staff pushed together wide anti-ligature seats to form a bed. However, the Mental Health Act codes of practice state that such facilities should include a bed and a mattress.
- Although each of the places of safety met the safety needs of patients none of them contained a clock that was visible to the patients held in them. This was a breach of the Mental Health Act codes of practice.
- There were no shower facilities located within in any of the places of safety, but patients were able to access these located on adjacent mental health wards. Where a patient needed to use a shower the staff escorted them

to an adjacent ward. Where necessary, to protect the dignity of the patients, staff first made sure that the corridors on other wards leading to the shower were clear of other people.

- There were facilities on each of the places of safety for staff to make drinks for patients.

Meeting the needs of all people who use the service

- Each of the places of safety provided access for those with limited mobility.
- Upon admission to the service staff verbally explained to people how the process of their admission worked and what their rights were. Staff also provided information about people's legal rights.
- A variety of information regarding external services was available for patients. This included local organisations such as drug and alcohol services, independent advocacy and a mental health support line. There was also information regarding patients' legal rights in a variety of languages as well in respect of mental health treatments and religious observance rules.
- Religious support services were available from a variety of faiths.
- Information was available regarding how patients could make a complaint.

Listening to and learning from concerns and complaints

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

Are services well-led?

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

Crisis assessment and treatment teams

Vision and values

- The mission statement for the CATT teams was to "aim to prevent distress, deterioration and promote recovery."
- Staff we spoke with reflected the values of the trust. They were committed and caring about the people they worked with.

Good governance

- At the previous inspection in June 2015, we found that the trust had not implemented governance systems to ensure that the teams worked consistently and safely to meet the needs of patients. We found some improvement during the current inspection, but some areas for improvement remained, so this was a continuing breach.
- Service managers at all three CATTs were not aware of their own performance figures for referral to assessment. Without this information they were not able to monitor the daily performance of their local services.
- Since the previous inspection the teams had been restructured to form the crisis, assessment and treatment teams working to provide mental health assessments for adults in crisis. The CATT teams came into place in July 2016 and were still embedding their new functions.
- We saw minutes from each team's monthly clinical improvement group (CIG) meetings and the tri-borough CIG meetings. Topics discussed included the dating of care plans, booking extra staff to free staff time for report writing, running a report of progress every few days, and checking these at handovers.
- The only key performance indicator for the teams was around gate-keeping to ensure that all referrals that may need admission to hospital were seen by the team. Managers indicated that they were awaiting further performance indicators to be developed for their teams.
- Monitoring of incidents and complaints took place, with action plans developed to address learning from these.
- The teams conducted different local audits. A significant number of local audits were completed in Hounslow, including audits of safeguarding, care plans, risk assessments, and medicines. In Ealing audits were

undertaken on risk assessments and care plans, and a safeguarding lead monitored safeguarding for the team. However, in Hammersmith and Fulham these were not undertaken. This had led to the lack of safeguarding referrals from this team going unnoticed and unaddressed.

- Since the previous inspection a new incident recording system had been implemented, to enable staff to follow the progress of all incidents reported. However it was too early to evaluate the system which had been operational for less than a month. Incidents were discussed at local and tri-borough clinical improvement groups, and clinical governance meetings.
- Since the previous inspection, we found an improvement in the staff's understanding and implementation of the Mental Capacity Act, although further training was needed. We also found some improvements in record keeping, although there remained variations in quality and in addressing patient's physical health needs.
- This meant that teams did not all have effective quality monitoring systems in place to identify where gaps in practice and record-keeping were and therefore take action to promote consistency amongst staff. For example, there were no clear systems for monitoring the number of missed appointments to patients.
- Although we found varying practices, there was no formal way of collecting and assessing feedback from patients in order to improve service provision. At the Hammersmith and Fulham office staff had displayed 'you said, we did' feedback regarding the continuity of care, indicating that they would attempt to have more consistency of staffing, and have a review of the access to psychological therapy.
- Managers acknowledged that inreach work with staff and patients on wards had slipped in recent months, but were planning staff awareness training on the wards.
- In Hounslow, the layout of the building meant that the crisis and assessment teams were located on different floors, and in Hammersmith and Fulham they were spread across two offices, making it difficult to fully integrate the teams.

Leadership, morale and staff engagement

- There had been a lot of changes across the services and morale amongst the teams was variable. Staff described feeling bypassed by senior management, and not part

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.

of the communication loop. At recent team meetings, staff members had reported not feeling safe, and a lack of clear team direction. Staff from a variety of disciplines indicated that senior managers from the trust rarely visited their service.

- At a local level most staff reported feeling happy within the teams where they worked. However, some staff expressed concerns about the impact of staff vacancies especially in Hammersmith and Fulham.
- In Ealing the opening of the recovery house was seen as a success, and other teams were keen to emulate this. Having had a number of managers in recent times, the staff in this team appreciated the stability of having a consistent manager in place.
- Staff across teams continued to receive general updates from the trust. Examples included email updates, the trust's intranet and discussions at staff meetings.
- Staff were aware of the whistleblowing process if they needed to use it. They also reported a change in the culture of the services, as one staff member described it, "less of a culture of blame now."
- The allocation of each team member as a champion for a particular area of responsibility was undertaken as a way of making each team member feel valued as part of the team. This also provided support for the new team managers.
- Team managers described weekly support from their line managers by phone and monthly managerial supervision provided to support them.

Commitment to quality improvement and innovation

- Ealing had opened a recovery house, and its implementation had been successful at providing an alternative to inpatient admissions where appropriate. Staff from the CATT team provided in reach support by referring patients into the service and visiting patients while they were there.

- Each team spoke of plans to implement a crisis café service for patients. They also described plans to start sports groups for patients linked in with the physical health clinics and were also looking to start care planning clinics with patients. Hounslow CATT said that ideally they would like to set up a crisis bus service if that were possible.

Health based places of safety
Vision and values

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

Good governance

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

Leadership, morale and staff engagement

- Most staff said that they felt very well supported, not only in terms of supervision but also in respect of their own personal development. For example, one nurse said that their manager had agreed to their request to undertake additional training in psycho-social interventions.
- Morale among the teams working in the places of safety was good. However, two members of staff said that they felt that senior management in the trust did not communicate appropriately with staff to inform them changes and developments within the service. Both commented that because many colleagues regarded their futures where they worked as potentially uncertain, clearer communication from senior managers about the plans of the trust would help to reassure staff.
- Staff said that if they had any concerns or complaints they would feel confident to raise these with senior managers. One staff member gave an example of how they had raised an issue with their manager, and this was resolved promptly in an appropriate and professional way.
- Job satisfaction was evident among all the staff we spoke with. Staff felt mutually supported and that the work they did made a difference to people's lives who used the service.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. The crisis assessment and treatment teams did not always complete patient risk assessments robustly, keep them update and ensured they were stored consistently. **This was a breach of Regulation 12(1)(2)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not have governance systems and processes which were operated effectively in the crisis assessment and treatment teams to ensure compliance and address areas where improvements needed to take place to mitigate risks to the health,safety and welfare of patients. Team managers were not aware of their teams' performance data regarding time taken to see emergency, urgent, and routine referrals to ensure that these were met. **This was a breach of Regulation 17 (1)(2)(a)(b)(c)**