

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)
RKL79	Hammersmith and Fulham mental health unit and community services	<ul style="list-style-type: none"> Hammersmith and Fulham home treatment team Hammersmith and Fulham health-based place of safety 	W6 8NF
RKL14	Lakeside mental health unit and Hounslow community services	<ul style="list-style-type: none"> Lakeside home treatment team Lakeside health-based place of safety	TW7 6AF
RKL53	St Bernard's and Ealing community services	<ul style="list-style-type: none"> Ealing home treatment team Ealing health-based place of safety 	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?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



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.

Summary of findings

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Summary of findings

Overall summary

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

- The health based place of safety at the Lakeside mental health unit was not suitable for purpose. At Lakeside mental health unit the place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their privacy and dignity. Females could not be admitted to the place of safety on the male ward. Women who had been detained under section 136 were taken through a separate entrance onto Grosvenor ward where they would be initially assessed in an interview room. The trust had plans to relocate the place of safety within 12 months as it was not considered fit for purpose.
- The records across the teams were not consistent and accurate especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met.
- The number of staff being supported by receiving regular supervision was very low.
- Governance processes across the home treatment teams were not working well. Audits were not always

taking place. There were variations for example in the quality of record keeping, the regular supervision of staff, supporting patients with their physical health and staff understanding and use of the Mental Capacity Act. These could all potentially present a risk to the safety of patients.

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. Monitoring of incidents and complaints took 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.

The trust had been working with the police, local authority and other agencies and to develop effective policies and protocols for the use of the places of safety to ensure the principles of the crisis care concordat work were firmly implemented. For over a year no patient under a section 136 had been held in a police cell. The trust was working with local commissioners to improve access to crisis care.

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:

- The health based place of safety at the Lakeside mental health unit was not suitable for purpose. At Lakeside mental health unit the place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their privacy and dignity. Females could not be admitted to the place of safety on the male ward. Women who had been detained under section 136 were taken through a separate entrance onto Grosvenor ward where they would be initially assessed in an interview room. The trust had plans to relocate the place of safety within 12 months as it was not considered fit for purpose.

Some improvements were also needed around the medicine management system, improved understanding of the duty of candour regulation and arrangements for lone working.

Incident reporting and learning from incidents was apparent across teams. There was a culture of openness and transparency. Staff had been trained and knew how to make safeguarding alerts.

Whilst staffing levels were a challenge across the home treatment teams, this was being addressed.

Requires improvement



Are services effective?

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

- The records across the teams were not consistent and accurate especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met.
- The number of staff receiving regular supervision was very low.

However 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 had completed mandatory training and were working towards their appraisal. Staff had received training on the Mental Capacity Act but some needed to learn more about how to apply this in practice.

Requires improvement



Are services caring?

We rated caring as **good** because:

Good



Summary of findings

- Staff demonstrated a good knowledge and understanding of patients using the service.
- Feedback we received from patients using the service was generally positive. Teams were supportive and that they treated them with respect. People described having good relationships with staff. Staff listened to and supported people with their care and with other aspects, including medication and employment opportunities.

However a number of patients said they saw a number of different staff from the home treatment teams and would prefer to see the same staff for continuity. Some people fed back that they would like more time with staff on visits. The method for collecting feedback from patients and other people involved in their care and the response rates varied between teams.

Are services responsive to people's needs?

We rated responsive as **good** because:

- The home treatment teams were meeting the target for gatekeeping admissions to inpatient beds.
- Across the home treatment teams, staff tried to offer patients flexible appointments to reflect their individual circumstances.
- For over a year no patient under a section 136 had been held in a police cell.
- Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served.

The trust has agreed timeframes with North West London commissioners for urgent referrals. Some patients were having to wait longer than they should. Also at night if a patient needed to see a healthcare professional the only option was to go to A&E as the home treatment teams could only offer advice by phone. People using the services needed more information about how to make a complaint.

Good



Are services well-led?

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

- Governance processes across the home treatment teams were not working well. Audits were not always taking place. There were variations for example in the quality of record keeping, the

Requires improvement



Summary of findings

regular supervision of staff, supporting patients with their physical health and staff understanding and use of the Mental Capacity Act. These could all potentially present a risk to the safety of patients.

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. The trust was working with local commissioners to improve access to crisis care.

Summary of findings

Information about the service

The trust had three home treatment teams. The teams were Ealing, Hammersmith & Fulham and Hounslow. Out of hours there was one staff member in each of the home treatment teams available to answer calls. Advice, support and signposting were offered to people who contacted the service at these times. The trust also had a 24 hour service user support line. In the event of a mental health emergency people would be expected to attend A & E to access the liaison psychiatry team.

The trust had three health based places of safety. These were provided at Ealing, Hammersmith and Fulham and Hounslow.

The home treatment teams have not been directly inspected previously. There were no outstanding compliance actions relating to them.

Our inspection team

The team that inspected the mental health crisis services and health based places of safety consisted of an approved mental health professional, two inspectors, two Mental Health Act reviewers and three nurses.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Visited all three home treatment teams in Ealing, Hammersmith and Fulham & Hounslow and shadowed staff members whilst they were visiting people.
- Spoke with 14 people and received comment cards from 17 people who were using the service.
- Spoke with senior staff members for the 24 hour patient and carer line.
- Spoke with the managers for each of the teams.
- Spoke with 23 other staff members; including doctors, nurses, social workers, pharmacists and support workers.
- Attended and observed handover meetings at two of the home treatment teams, one case review meeting and one business team meeting.
- Looked at 28 care records of patients.
- Carried out a specific check of the medication management at each of the home treatment teams.

Summary of findings

- 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 people using the service was generally positive. They found the home treatment teams to be supportive and that they treated them with respect. People described having good relationships with staff. They described feeling listened to and well supported by staff with their care and with other aspects of their care, including medication and employment opportunities.

However, the majority of the patients we spoke with feedback that they were unsure of how to go about making a complaint if required or how to contact advocacy services if needed. A number of people said they saw a number of different staff and would prefer to see the same staff for continuity. Some people fed back that they would like more time with staff on visits.

Good practice

- The trust had been working with the police, local authority and other agencies and to develop effective policies and protocols for the use of the places of safety to ensure the principles of the crisis care concordat work were firmly implemented.
- The Hammersmith and Fulham team was involved in a piece of research with UCL on the use of peer-support workers as a longer term intervention for people discharged from crisis care. Following discharge from the team, staff identified people to complete 10 sessions with a peer-support worker.

Areas for improvement

Action the provider **MUST** take to improve

- 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 consistently and safely to meet the needs of people using the service.

Action the provider **SHOULD** take to improve

- The trust should ensure safe medicine management systems in the home treatment teams are in place and adhered to.

- The trust should ensure that all teams understand the duty of candour regulation. The duty of candour was introduced for providers to ensure they are open and honest with people when something goes wrong with their care and treatment.
- The trust should review the arrangements for lone working to ensure that all home treatment teams have clear systems in place.
- The trust should ensure home treatment teams complete relevant local audits to identify and improve the quality of the service they provide.
- The trust should ensure there is a clear policy which is implemented on how physical health is managed across the home treatment teams.
- The trust should ensure that staff's understanding and application of the Mental Capacity Act becomes embedded.

Summary of findings

- The trust should ensure the home treatment teams and health based places of safety consider ways to collect regular feedback from people who have used their services to improve service provision.
- The trust should ensure that staff are appropriately engaged about changes that affect them during the ongoing changes.
- The trust should continue to work with commissioners to ensure that the 24/7 home treatment function to support people outside of working hours is more responsive to the needs of the local population accessing the service. The current provision outside of hours was limited although a business case for a 24/7 single point of access had been agreed.

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)

- Hammersmith and Fulham home treatment team
- Hammersmith and Fulham health-based place of safety

- Lakeside home treatment team
- Lakeside health-based place of safety

- Ealing home treatment team
- Ealing health-based place of safety

Name of CQC registered location

Hammersmith and Fulham mental health unit and community services

Lakeside mental health unit and Hounslow community services

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 in the trust 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. People were being supported by home treatment teams whilst on section 17 leave.

The environment within the health based places of safety at the Lakeside mental health unit was not fit for purpose.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training on the Mental Capacity Act (MCA) which was incorporated within the mental health law training in the trust.

It was acknowledged within the trust that the understanding and application of the MCA had not been

embedded amongst all staff. Some staff we spoke with demonstrated knowledge of the principles of the MCA but did not always feel confident in how to apply the law to their practice.

In Hammersmith & Fulham more focussed sessions on the MCA within the health based places of safety had been carried out with regards to decision making in the suite.

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

Summary of findings

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

- The health based place of safety at the Lakeside mental health unit was not suitable for purpose. At Lakeside mental health unit the place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their privacy and dignity. Females could not be admitted to the place of safety on the male ward. Women who had been detained under section 136 were taken through a separate entrance onto Grosvenor ward where they would be initially assessed in an interview room. The trust had plans to relocate the place of safety within 12 months as it was not considered fit for purpose.

Some improvements were also needed around the medicine management system, improved understanding of the duty of candour regulation and arrangements for lone working.

Incident reporting and learning from incidents was apparent across teams. There was a culture of openness and transparency. Staff had been trained and knew how to make safeguarding alerts.

Whilst staffing levels were a challenge across the home treatment teams, this was being addressed.

136 suite would be accessed if no other rooms were available. We were told there were plans in place for meeting rooms to be developed in the future off site. Staff visited most patients in their homes.

- There were arrangements to respond to foreseeable medical emergencies across the teams. In Hammersmith and Fulham the emergency checklist did not include that the defibrillator should be checked. We were told that action would be taken to tighten up the processes for checking the equipment.

Safe staffing

- Staff were managing to see patients, but it was recognised that the teams were very stretched and staffing levels were being reviewed or staff recruitment was taking place. Each team had a minimum staffing level for each shift. 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. In most of the teams there was limited usage of agency staff, with staff undertaking extra shifts or regular bank staff covering shifts. Sickness rates across all of the teams were low.
- In Ealing, there were pressures on staff due to staff shortages. Staff we spoke with expressed concerns about workload in the team which was split into two teams – red and blue. The blue team had a higher caseload and the manager was concerned this team had a higher caseload than they could support with the current establishment. Both teams were absorbing the overall caseload. It had been identified that with the current vacancies additional staff were required to cover the demand for the service. The staffing levels had been identified as a high risk on the team's local risk register. At the time of the inspection there were seven vacancies and two further staff were due to leave the team. Two agency staff on three month block contracts had been approved for the team to help fill the short fall in the interim. Vacancies were being advertised. Although there were pressures staff said they did not cancel visits. The manager of the Ealing team also managed the assessment team.

Our findings

Home treatment teams

Safe and clean environment

- Most teams had access to rooms for meeting with patients. However the Hammersmith and Fulham team did not have their own dedicated space for meeting with patients. Staff could access the child visiting room and tribunal room if these were available. On occasion the

Are services safe?

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- In the Hounslow team it was just as busy during the week as it was on the weekend. The manager said the staffing levels at the weekend were to be reviewed. Temporary staff were identified to fill posts in the interim to ensure that services continued to be delivered effectively.

Assessing and managing risk to patients and staff

- All of the teams had daily staff handovers between shifts where each person on the teams caseload was discussed. At these meetings the individual risks for a person were discussed and plans put in place to address these risks.
- Staff were trained in safeguarding and policies and procedures were available. There were safeguarding leads in teams and a trust lead on safeguarding that staff could access for advice and support. Safeguarding incidents were communicated at handover meetings or earlier. If the alert was around children, staff informed us they would contact children and family services. In several of the teams staff acknowledged that they could do better at understanding the threshold for raising a safeguarding alert. In Hammersmith and Fulham a safeguarding issue had been discussed at handover. Although it had been acknowledged that this should be raised as a safeguarding alert, the reliance had been placed on a staff member outside of the organisation to raise this instead. At Hounslow we were told that the safeguarding lead had worked with staff to improve understanding around safeguarding.
- The quality of formal recorded risk assessments varied across the teams. Initial risk assessments were undertaken at the initial assessment, at discharge and when people's needs changed. However, the content of risk assessments was at times limited. In one team a staff member said there can be a delay in updating risk assessments if staff are overworked. Staff we spoke with told us they regularly used progress notes to update changes in people's care.
- All teams were aware of the risks and had systems in place to manage the risks associated with lone working. Despite this there was a variation in how the panic alarm and lone working system was operating across teams. For example staff were not always logging when they had completed a home visit through their lone working device.

Medicine management system

- There were some variable medicines management practices around the storage and administration of medication. Pharmacy staff visited each team regularly to screen prescription charts, order medicines, and top-up stock medicines. These medicines were taken by crisis team staff to people who were being supported with their medicines in the community.
- Medicines stocks were stored securely, but were not well-controlled in two of the three crisis team offices. We found that the medicines refrigerator in the Ealing office was not locked, the temperature of the medicines refrigerator was not monitored every day, and contained insulin pens which we saw had expired.
- A stock record book that was in use at Hammersmith and Fulham, and staff were supposed to make a record in this book whenever they removed any stock. However there were discrepancies noted in stock levels for most of the stock medicines, which had not been investigated.
- We found single tablets which had been removed from their original container in the medicines cupboard in the Ealing office, so we could not tell what the batch numbers and expiry dates were for these medicines. This indicated that single tablets were being taken out on visits, without being administered from the original container.
- We shadowed home visits in Ealing where people were self-medicating. We found that the medication chart was completed by staff to demonstrate that the person had taken their medicines. However the actual medication box was not being checked as having been taken. We raised this with the manager in Ealing and were informed that this should be checked rather than only asking the person if they had taken this, this was also described as the correct process in accordance with the trust medication policy on self-medication.
- The trust wrote to us following the inspection and outlined action they taken in relation to the safe management of medication. Meetings had been held with the teams across the trust and a trust wide task and finish group had been established to focus on medicines management in the home treatment teams.

Track record on safety

Are services safe?

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

- All of the teams had daily handovers where each person on the caseload was discussed.

Reporting incidents and learning from when things go wrong

- All staff were expected to take responsibility for reporting incidents. Staff told us that they reported incidents on the trust's electronic reporting system. These were signed off by the relevant manager in the team.
- In Hammersmith and Fulham in the progress notes for one person there was an omission of medication in June 2015. This had not been raised as an incident.
- During 2014 there had been no serious untoward incidents specifically associated with the home treatment teams.
- All serious untoward incidents were investigated and discussed in a range of forums, such as in team, business, clinical improvement groups, and senior management meetings. The trust also had annual learning lessons conferences. Vignettes were used across teams to discuss learning from incidents.
- Two of the three teams were not consistently able to describe what was meant by having a duty of candour. However, staff demonstrated working within a culture of openness and transparency and discussed why it was important to be open with families and people if something went wrong with their care delivery. Staff in the Ealing team had a good understanding of the duty of candour and discussed specific incidents in relation to this

Health based places of safety

Safe environment

- All three places of safety we visited had appropriate management of ligature anchor point risks. They had an ensuite with a door therefore supporting people's privacy. Staff could manage risks through observation. The Ealing place of safety contained a viewing room from which people could be observed.
- At Lakeside mental health unit the place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their

privacy and dignity. Females could not be admitted to the place of safety on the male ward. Female section 136 admissions were taken through a separate entrance onto Grosvenor ward where they would be taken to an interview room as an alternative setting to the place of safety. The trust had plans to relocate the place of safety within 12 months as it was not considered fit for purpose. Concerns around the Lakeside 136 facilities had been identified from a trust review in May 2015 because there was no designated female 136 suite and the 136 suite was on a male inpatient ward.

- A number of patients when they arrived under 136 at the trust were assessed as needing to be placed directly into seclusion. This seclusion practice was under review at the time of the inspection.
- The other places of safety had their own entrances and privacy could be maintained within the suites.

Safe staffing

- The places of safety were staffed by staff from the other inpatient wards at the locations they were based. Each place of safety had a unit coordinator who was responsible for ensuring the place of safety was staffed appropriately on a 24/7 basis.
- For Mental Health Act assessments to take place, approved mental health professionals (AMHPs) and section 12 doctors were accessed. There could be delays in accessing AMHPs due to the number of emergencies occurring at nights.

Assessing and managing risk to patients

- All staff were expected to take responsibility for reporting incidents. Staff told us that they reported incidents on the trust's electronic reporting system. These were signed off by the relevant manager in the team.
- A clear system was in place for requesting assessments by an AMHP. In the records we reviewed we saw appropriate physical and mental health assessments had been undertaken.
- Individual risk assessments were in place and we saw an example in Ealing of where these had led to the decision

Are services safe?

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

to use the seclusion unit in Ealing to contain a person's aggressive behaviours. The police usually stayed for the admission of a person for the agreed hour with the trust if needed.

- The use of rapid tranquilisation and physical restraint was recorded. However this was not being collated overall to monitor the number of times this had been used.

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.

- There had been a recent incident which had led to a change in the numbers of staff working in the places of safety. There were now two staff working. The incident was escalated within the trust and learning from the incident was shared with peers from the other place of safety locations and across other services.

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.

Summary of findings

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

- The records across the teams were not consistent and accurate especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met.
- The number of staff receiving regular supervision was very low.

However 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 had completed mandatory training and were working towards their appraisal. Staff had received training on the Mental Capacity Act but some needed to learn more about how to apply this in practice.

Our findings

Home treatment teams

Assessment of needs and planning of care

- Assessments were completed following a referral. Where possible joint assessments were completed across several of the teams. At Hounslow if a person was being assessed for the first time two staff members would go to assess the person. Daily meetings across teams were held to discuss people's care and the support they required. If urgent, these referrals were prioritised.
- The home treatment teams worked well with the inpatient wards. We observed a meeting with a patient from an inpatient ward to discuss their suitability for being discharged to the care of the Hounslow team. The purpose of the meeting and role of the home treatment team was described and specific areas were discussed with the person around supporting them with their current needs.

Record-keeping

- There was a variable standard of record keeping across the teams. We found examples across teams where there were gaps in the recording of information on the electronic system. For example care plans we viewed

were limited in detail and were not always goal specific or personalised. In one person's care record at the Hounslow team, physical health and safeguarding was discussed but it was not recorded that any action had been taken in respect of both. There was a variation in the quality of recorded risk assessments and these were not always being updated as needed. Staff were often recording changes in the patients progress notes. There was a risk that information about a person's current care could be missed.

- All three teams had gaps in recording whether medication had been administered on the paper prescription charts and people's allergy status was not always recorded on their prescription. Each patient had a prescription chart, and staff were meant to make a record on the persons prescription chart, as well as their electronic care record, whenever they delivered, administered or supervised the administration of any medicines to people in the community. In Hammersmith and Fulham we looked at prescription charts and electronic records for six people. One person was prescribed a medicine to be taken when required, however we could not tell from their prescription chart or electronic care records whether they had been given any supplies of this medicine. An entry had been made on another person's prescription chart indicating that they had taken a dose of a medicine, however the entry on their electronic care record said that they had refused this dose. Another person had not received a visit by the crisis team on one day, so their medicines had not been supervised on that day. This was significant, as in some cases, it was not always clear whether patients had received their medicines.
- The trust wrote to us following the inspection and outlined action they taken in relation to the gaps on prescription charts and the safe management of medication. Meetings had been held with the teams across the trust and a trust wide task and finish group had been established to focus on medicines management.
- There was an expectation from senior management in the trust and managers in the service that care records would be looked at in supervision. However supervision completion rates were low across all teams. Therefore it was unclear how regularly people's care records would be checked.

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.

Best practice in treatment and care

- NICE guidance was followed for prescribing medication. Additionally staff could access local prescribing guidelines via the trust intranet.
- Psychology access in teams differed in each borough. The trust informed us that consistency around this would be achieved through the urgent care pathway transformation programme. All teams had access to psychology input each week. This time could be utilised to support people to be signposted to the appropriate level of psychological intervention.
- There was a variation in how often patients were assessed for their physical needs between the home treatment teams and a disconnect between what was expected from senior managers and within the team on how often this should be completed. We were told by the Hammersmith and Fulham and Hounslow teams that medical staff saw approximately 50 per cent of patients under the care of the team. Physical health screenings, routine blood tests and medical reviews would be carried out if identified as a need but these did not happen routinely. There did not appear to be a clear view on how physical health was being managed across the teams. We raised the physical health strategy with the clinical lead for urgent care in the trust who confirmed this required clarification.
- Staff in the home treatment teams were engaged in the CORE studies, however staff across teams informed us they were doing limited or no local audits. Therefore the quality monitoring systems were not in place for the teams to identify inconsistencies and thereby effectively improve the quality of their service. Staff informed us that they were plans to complete relevant local audits.
- The trust informed us they were currently recruiting new dual diagnosis champions to work alongside the dual diagnosis lead within the Hounslow and Hammersmith and Fulham teams.

Skilled staff to deliver care

- Staff working across the teams or accessed by the teams were made up of staff from a range of professional backgrounds including, nursing, medical, social work,

administrative, occupational therapy, support workers and psychology. There were lead roles within teams. For example in Hammersmith and Fulham there were leads for dual diagnosis and police liaison.

- Referrals were made to approved mental health professional's or section 12 doctors to undertake Mental Health Act assessments where required.
- The teams had access to psychologists for reflective practice sessions.
- Staff across all teams received mandatory training and appraisals and attended staff meetings.
- There were good opportunities for staff development. For example in Hounslow two support workers were being supported by the trust to undertake nurse training.
- The trust informed us that appraisal rates were lower at this time of the year as they set annual objectives with appraisals being completed by the end of June.
- Since June 2014 until May 2015 supervision rates were low across all teams. For example in May 2015 supervision completion across all teams were between 26 – 28 per cent. The rates fluctuated from December 2014, where on several occasions only one person had completed supervision. This meant there was a lack of continuity for staff being supervised and a risk that management staff were not alerted to people who might require additional support or monitoring.

Multi-disciplinary and inter-agency team work

- All teams had twice daily multi-disciplinary handover meetings where risk was discussed and care planned. In Hammersmith and Fulham senior clinicians held a weekly case review to discuss cases of concern. In Hounslow, during handover, the nurse in charge gave every staff member a patient to discuss, updates were discussed and the white board updated to reflect changes in care. If there was a change in care this was updated in the trust's electronic progress notes. Discussion of involving others, for example the police, carers and plans around patient engagement were discussed.
- All teams were proactive in working with other community teams around the triage of new referrals. For example teams worked closely with referring teams to

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.

support their understanding of why patients had been referred. In Ealing, a number of referrals were coming through from community recovery teams, so joint visits between teams, were facilitated.

- There were good working relationships with external agencies across all teams including social services, GPs, the police, and housing and voluntary organisations; such as Mind and Age Concern.

Mental Capacity Act

- Staff had received training on the Mental Capacity Act (MCA) which was incorporated within the mental health law training in the trust.
- It was acknowledged within the trust that the understanding and application of the MCA had not been embedded amongst all staff. This was reflected in discussions we had with managers of the teams who felt this was an area that required improvement within their own teams.
- Some staff we spoke with demonstrated knowledge of the principles of the MCA but did not always feel confident in how to apply the law to their practice. For example some staff expressed confusion around what to document around capacity.

Adherence to the MHA and the MHA Code of Practice

- Staff had received mandatory training in the trust on the Mental Health Act. Overall staff appeared to understand the requirements of the Act.
- Across the teams when people left inpatient wards under section 17 leave staff could support people whilst they were in the community.
- Teams could access AMHPs for an MHA assessment if required.
- Teams could access mental health advocacy services if needed.

Health based places of safety

Assessment of needs and planning of care

- In the records we reviewed initial risk assessments, physical health assessments and referrals for mental health assessments were completed as appropriate.

Best practice in treatment and care

- The trust completed annual audits of the section health based place of safety service to identify issues across the service. The trust's last annual audit report for the 136 services was published in November 2014 for 2013 / 2014. Some findings included the repeated use of S136 for 11 patients especially in Hounslow. There had been no uses of the police station as a place of safety. Risk factors (identified in 66% cases) included self-neglect and self-harm 57%, violence 11%, medication-related risks 9%. The audit identified there was significant missing documentation around the arrival times of doctors and AMHPs. This demonstrated that trust continually monitored the effectiveness of service delivery.

Skilled staff to deliver care

- The places of safety were staffed by staff from the other inpatient wards at the locations they were based. Each place of safety had a unit coordinator who was responsible for ensuring the place of safety was staffed appropriately on a 24/7 basis.
- There was no specific training for supporting patients in the health based place of safety. Instead staff were required to shadow experienced staff to ensure they could coordinate duties effectively.
- Each month reflective sessions were used to discuss any complex issues faced in the last month and any learning from this.

Multi-disciplinary and inter-agency team work

- The trust had developed good links with other services and within the trust. Each unit with a place of safety carried out a monthly multi-agency meeting with police and social services. Regular safe and security meetings were held in house with nursing, A & E, security and liaison psychiatry. Security information was shared across the trust.
- We saw in records that good liaison took place with other agencies including drug and alcohol services, GPs and CAMHS and the home treatment teams were involved in the assessment process.

Mental Capacity Act

- Staff had received training on the Mental Capacity Act (MCA) which was incorporated within the mental health law training in the trust.

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.

- It was acknowledged within the trust that the understanding and application of the MCA had not been embedded amongst staff. Some staff we spoke with demonstrated knowledge of the principles of the MCA but did not always feel confident in how to apply the law to their practice.
- In Hammersmith & Fulham more focussed sessions on the MCA within the health based places of safety had been carried out with regards to decision making in the suite.
- The pan London form for each admission had a tick box for 'consent to admission'. However this did not provide details of the decision making process to demonstrate whether capacity to consent was present or not.

Adherence to the MHA and the MHA Code of Practice

- The documentation in respect of the Mental Health Act was generally good. MHA assessments were regularly completed by a section 12 doctor and an AMHP.
- The documentation around 136 admissions recorded the required information including when a person's rights had been discussed with them.

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- Staff demonstrated a good knowledge and understanding of patients using the service.
- Feedback we received from patients using the service was generally positive. Teams were supportive and that they treated them with respect. People described having good relationships with staff. Staff listened to and supported people with their care and with other aspects, including medication and employment opportunities.

However a number of patients said they saw a number of different staff from the home treatment teams and would prefer to see the same staff for continuity. Some people fed back that they would like more time with staff on visits. The method for collecting feedback from patients and other people involved in their care and the response rates varied between teams.

Our findings

Home Treatment Teams

Kindness, dignity, respect and support

- Staff demonstrated a good knowledge and understanding of patients using the service. Staff showed a good understanding of each persons individual needs. In multi-disciplinary team meetings we found that staff reflected the wishes and views of the people they were discussing. On home visits, it was clear that staff had an understanding of patient's needs.
- Overall patients were consistently positive about the care they received from staff delivering care. They described having good relationships with staff, and that they and people involved in their care were able to contact staff outside of a scheduled visit and would receive a prompt response. They described feeling listened to and well supported by staff with their care including medication and employment opportunities. Some patients said staff had sought consent from them to share their information with other bodies.
- Patients said they did not know how to access an advocate if needed, and they did not receive copies of

their care plans. One person told us they were not aware of what was going to happen next in relation to their care and they had been with one team for two months. A number of patients said they saw a number of different staff and would prefer to see the same staff for continuity. Some patients feedback that they would like more time with staff on visits.

The involvement of people in the care they receive

- The method for collecting feedback from patients and carers varied between teams. The team in Hammersmith and Fulham had recently started a folder to collate survey feedback from people. The feedback that had been sought so far was generally positive. In Hounslow the team had a digital device that staff were meant to take out on visits, however we were told this did not happen regularly or consistently. The teams should consider ways to ensure they collect regular feedback from people who have used their services to inform improvement in service delivery.
- We saw examples from care records where there had been good family and carer involvement and people we spoke with confirmed this. At Hounslow the manager confirmed that they are not good at giving patients copies of their care plans this but said that people knew their crisis / contingency plans. They were given a leaflet with the relevant numbers on.
- Carers' assessments were offered to people when appropriate.

Health based places of safety

Kindness, dignity, respect and compassion

- Staff we spoke with across the locations described how they would support patients through the section 136 process in a considerate manner and ensure they were treated in a way to uphold their privacy and dignity at all times.

The involvement of people in the care they receive

- We saw examples from care records where families' have been involved in the person's care where appropriate.
- Advocacy service and interpreters were available for patients to access from the places of safety.

Are services caring?

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

- The trust informed us that that did not collect patient and carers feedback specifically for 136 admissions. This was acknowledged as an area of development for the trust.

Are services responsive to people's needs?

Good 

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

Summary of findings

We rated responsive as **good** because:

- The home treatment teams were meeting the target for gatekeeping admissions to inpatient beds.
- Across the home treatment teams, staff tried to offer patients flexible appointments to reflect their individual circumstances.
- For over a year no patient under a section 136 had been held in a police cell.
- Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served.

The trust has agreed timeframes with North West London commissioners for urgent referrals. Some patients were having to wait longer than they should. Also at night if a patient needed to see a healthcare professional the only option was to go to A&E as the home treatment teams could only offer advice by phone. People using the services needed more information about how to make a complaint.

Our findings

Home treatment teams

Access, discharge and transfer

- The trust had agreed timeframes with North West London commissioners for urgent and routine referral and treatment plans to be agreed with individuals. However the time taken to see people could vary from person to person. Staff across teams told us they would prioritise urgent referrals arrange to meet the person as soon as possible.
- For example in Hammersmith and Fulham following a referral a suitable time to assess a person would be agreed with the referrer. In some cases the team could take between 24 – 36 hours to respond to a referral. NICE guidance says that when a person is referred in a crisis they should be seen by specialist mental health secondary care services within 4 hours of referral.
- Referrals were received into teams from a variety of sources including from other community teams,

psychiatric liaison and self-referrals from people known to the team. Referrals from GPs were directed via the assessment teams. Ealing received the highest number of referrals of all three teams.

- At times when 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. People were not excluded if they would benefit from treatment.
- Hammersmith and Fulham discussed they wanted to do more inreach work with other teams and inpatient wards when they have a full staff compliment.
- The home treatment teams were responsible for gatekeeping all admissions to inpatient beds. Most teams were achieving, or close to achieving, 95% for this indicator 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. The impact was that a person in a crisis could end up further away from home. West London had recently started accessing beds in the independent sector to meet the demand for admissions.
- The average length of stay with a team varied from a few weeks to a longer period. The person's length of input would be dependent on individual need and complexity of support required.
- Across the teams, we found that people were given flexibility in when they could see staff and where. Most people 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. Staff told us that if they had to cancel a visit or a person was not available during their scheduled visit this would be risk assessed and plans put in place to support the individual and staff would escalate concerns if required. This would also be flagged at daily handovers.
- The teams did seven day follow up with people following discharge from a service when required.

Are services responsive to people's needs?

Good 

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

- The trust operated a 24 hour 7 day a week advice and support line. Calls were taken by contact centre staff and information was passed to the team which provided the callers service. They could signpost people who contacted the trust outside of hours.
- The home treatment teams only had one person working at night in each of the teams. They were able to speak to patients but if needed patients would be advised to attend A & E where they could access mental health support face to face.
- The trust submitted a business case on improving access to urgent care to the clinical commissioning groups in October 2014. The clinical commissioning groups had agreed the business case for a 24/7 single point of access which will mean that the home treatment team is able to provide assessments in a more responsive and appropriate environment over a 24 hour period. The trust had been working with a trust with a leading reputation in this area to review their current model of 24/7 access in order to make improvements to service provision. For example it was found that emergency admissions peaked between the hours of 7 and 11pm indicating the need for more out of hours support.

Meeting the needs of all people who use the service

- The team used interpreters where needed. Some staff across teams spoke a range of different languages.
- Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served. For example in preparation for Ramadan, staff in Ealing were offering patients different appointment times to fit around their prayer times.
- 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.
- Some of the teams had developed links with local support groups such as Mind and drug and alcohol services, which they could signpost people to.
- Staff in teams said they could access mental health or mental capacity act advocacy services if required.

- The mechanism to record data on ethnicity in teams varied. If completed appropriately this data would support teams to provide an effective service that met local cultural and individual needs.

Listening to and learning from concerns and complaints

- Staff across the teams said they had received few formal complaints in the last 12 months.

Formal complaints were investigated in line with the trust's complaints procedure. Learning was identified from complaints and this was shared with the team. One formal complaint raised in Ealing led to an outcome where the team improved their liaison with families.

- Common complaints across the teams were from people who were not happy with seeing different staff. Where possible in Hammersmith and Fulham the shift coordinator would check if a staff member had visited a person before and would encourage them to see the person again if they were on shift.
- Most people we spoke with did not know to raise a complaint. Several staff we spoke with were able to describe the informal process for managing concerns but not 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.

Health based places of safety

Access, discharge and transfer

- The place of safety locations received admissions for their respective boroughs but were able to take people outside the borough where agreed. If all the place of safety suites were in use, patients could with approval be placed on wards within the mental health services.
- For over a year no patient under a section 136 had been held in a police cell. However in order to keep the patient and staff safe, some patients have had to be cared for in a seclusion room rather than the place of safety once they arrive at the trust.
- If there was a shortage of beds people could end up staying in the place of safety for longer than needed.

Are services responsive to people's needs?

Good 

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

The trust beds were considered as an overall total in the trust rather than by locality. So if a bed could not be accessed in the person's local area, the next nearest borough would be contacted.

- The health based place of safety could receive under 18 year olds if needed.
- Staff across the 136 locations said that access to AMHPs could impact on how long it took for people to be assessed. The place of safety services were working to an internal target of 4 hours for a person to be assessed and said they would not always be able to meet this. For instance, if a person was intoxicated this could cause delays.
- Outside of hours the emergency duty team managed the MHA assessments. This happened across the three boroughs. In Ealing and Hounslow they found that the out of hours provision was not as flexible for completing assessments. Feedback from carer groups and patient forums indicated that the transition through the Ealing assessment team to the Ealing home treatment team was not seamless. In response they opened an assessment clinic on Saturdays to ensure the service was more responsive.
- A review, of the health based place of safety at Lakeside, requested by the director of nursing in the trust was undertaken in May 2015 to have a better understanding of the structure put in place to manage the clients admitted on a S136 and identify any specific areas that could be improved.

The facilities promote recovery, comfort, dignity and confidentiality

- On occasion if the police brought in a person they could, due to associated risks be transferred to a seclusion

room. In all areas where a patient required seclusion, they would need to be escorted through a clinical area. This could compromise privacy and dignity although staff assured us that that corridors would be cleared to ensure a person's privacy and dignity when transferring them to the seclusion room.

Meeting the needs of all people who use the service

- The mechanism to record data on ethnicity across the health based places of safety was poor. If completed appropriately this data would support teams to provide an effective service that met local cultural and individual needs. The trust wrote to us following the inspection and informed us that this had been raised at a police liaison meeting in May 2015. Action had been taken. Unit coordinators were informed to begin recording this. This was to be audited monthly in preparation for the next police liaison meeting.
- The team used interpreters where needed. Some staff spoke a range of different languages. There was a lack of 132 rights leaflets in different languages in Hounslow. The trust wrote to us following the inspection and informed us that leaflets in different languages were now in place.
- Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served. For example in Ealing the catering services responded quickly to people's cultural and dietary needs.

Listening to and learning from concerns and complaints

- Staff tried to resolve issues raised locally where possible.

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.

Summary of findings

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

- Governance processes across the home treatment teams were not working well. Audits were not always taking place. There were variations for example in the quality of record keeping, the regular supervision of staff, supporting patients with their physical health and staff understanding and use of the Mental Capacity Act. These could all potentially present a risk to the safety of patients.

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. The trust was working with local commissioners to improve access to crisis care.

Our findings

Home treatment teams

Vision and values

- Staff we spoke with reflected the values of the trust. They were committed and caring about the people they worked with to deliver care. Teams were supporting people in the least restrictive way in the community.

Good governance

- Some local governance processes were in place. Quality assurance arrangements had been strengthened to ensure there was a clear structure for issues to be fed from teams up to board level and back down again. We saw minutes from the clinical improvement groups from across teams which discussed a range of areas pertinent to improving patient care.
- All the teams had key performance indicators about gate-keeping to ensure that all referrals that may need admission to hospital were seen by the team.
- Monitoring of incidents and complaints took place, with action plans developed as learning points from these.
- However across teams we were told there were limited or no local audits being completed. We came across some issues during the inspection around staff's varied understanding of the Mental Capacity Act and

inconsistencies around record-keeping. This meant that teams did not have effective quality monitoring systems in place to identify where the gaps in knowledge and record-keeping were and therefore take action to promote consistency in amongst staff.

Leadership, morale and staff engagement

- There had been a lot of changes across the services. Morale amongst some teams was variable.
- 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. Staff also said they felt under pressure to take on more referrals so people can be discharged as soon as possible.
- In Ealing there were concerns that the manager was now managing the assessment team as well as the home treatment team. Staff expressed concerns about some of the changes and how well thought through they were. For example although staff were positive about the prospective opening of the recovery house in Ealing, they were anxious about how they would support this work effectively on top of their existing workload. Managing this safely was high on the urgent care service lead's agenda.
- Some staff across teams said they did not always feel informed by the trust or involved in the decision making where this may impact on their work. Some staff said that although they were consulted about decisions this was often after they were able to discuss what impact this may have on their work.
- Staff across teams received general updates in 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.

Commitment to quality improvement and innovation

- Ealing were due to be the first borough to have a recovery house. This service would have 17 beds and provide an alternative to an inpatient admission where this would be deemed appropriate. There was an expectation that staff from the home treatment team would provide in reach support by referring people into the service and visiting people while they were there.

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 Hammersmith and Fulham team was involved in a piece of research with UCL on the use of peer-support workers as a longer term intervention for people discharged from crisis care. Following discharge from the team, staff identified people to complete 10 sessions with a peer-support worker.
- The home treatment teams had worked with University College London (UCL) as part of an evidence based quality review. This had formed part of the work to review urgent and inpatient services going forward. The home treatment team have been engaged in the CORE studies over the last 12 months, which had involved 3-6 monthly reviews of the service and a review of the fidelity of the model.

Health based places of safety

Vision and values

- The trust had been working with the police, local authority and other agencies to develop effective policies and protocols for the use of the places of safety to ensure the principles of the crisis care concordat work were firmly implemented.

Good governance

- Monitoring of incidents took place, with action plans developed as learning points from these. The opportunities for sharing experience and learning between the places of safety was good.

Leadership, morale and staff engagement

- There was strong leadership at a local and service level across the health based places of safety. The trust had good oversight of the health based places of safety and had plans in place to facilitate improvements in this area.

Commitment to quality improvement and innovation

- From the Mental Health Crisis Care: London Borough of Ealing report in December 2014 it was found that AMHPs were not routinely involved in undertaking Mental Health Act (MHA) assessments in line with the MHA code of practice guidance. People were being discharged without an AMHP being contacted which led to a delay in assessments being completed. Changes had taken place and AMHPs were now routinely involved or consulted with. Admissions had increased in Ealing. During the day it was easier to access AMHPs, however it was harder to access AMHPs outside of hours due to resource issues.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

People were not being protected against the risks associated with unsuitable premises.

At Lakeside mental health unit the health based place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their privacy.

In addition females could not be admitted to the place of safety on the male ward. Female 136 admissions were taken through a separate entrance onto Grosvenor ward at Lakeside where they would be taken to an interview room as an alternative setting to the place of safety.

The place of safety was not suitable for the service provided.

This was a breach of Regulation 15 (1) (c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The trust did not have systems and processes which were operated effectively in the home 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.

Governance processes across the home treatment teams were not working well. Audits were not always taking place. There were variations for example in the quality of record keeping, the regular supervision of staff, supporting patients with their physical health and staff understanding and use of the Mental Capacity Act.

This section is primarily information for the provider

Requirement notices

The trust did not maintain an accurate, complete and contemporaneous record for each patient and other records necessary for the management of the regulated activity.

The records across the teams were not consistent and accurate especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met.

This was a breach of Regulation 17 (1)(2)(a)(b)(c)(d)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
The trust did not ensure that staff employed in the home treatment teams had received regular supervision.

This was a breach of regulation 18 (2)(a)