

Central and North West London NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

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)
RV314	Fairlight Avenue	Fairlight Avenue	NW10 8AL
RV3AN	Hillingdon Hospital Mental Health Centre (Colham Green Road)	2 Colham Green Road	UB8 3NN
RV355	Roxbourne complex	Roxbourne Lodge and House	HA2 0UE
RV3CA	Kingswood Centre	Kenton ward	NW9 9QY
RV351	Horton Rehabilitation Services	Birch Villa Ascot Villa Westfield House	KT19 7HA

Summary of findings

Rushett House

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for long stay/rehabilitation mental health wards for working age adults of **good** because:

Patients were provided with care in clean and safe environments. Environmental and ligature risk audits were undertaken regularly and mitigation plans were in place where necessary. Some services did not meet same sex accommodation guidelines.

There were some areas in the service, in particular at Horton, where there were high vacancy rates for nursing staff, however, managers had access to temporary staff, usually regular bank staff and the trust was taking action to actively recruit into vacant posts.

Staff had a good understanding safeguarding processes locally and were confident in reporting concerns. Incidents were reports and learning from incidents was disseminated through the service.

Risk assessments and care plans were up to date and regularly reviewed. There were strong multi-disciplinary teams based in the services who provided a wide range of support for patients on the wards. There were varying experiences of working with agencies external to the trust, depending on availability and coordination with services depending on their location. Staff had a good understanding of the Mental Health Act and the Mental Capacity Act.

Patients reported that they received good care and we observed kind and thoughtful interactions with staff. There were regular meetings on wards for patients to feedback information about the services. Availability of advocates varied but there was information on the wards about contacting advocates. Wards were well-equipped with rooms for activities although there were significant differences between the wards within this service.

Services were able to adapt to meet the needs of the local communities and there was access to interpreting services and food to meet cultural and religious needs.

The services had a strong recovery focus which staff embraced enthusiastically. The senior leadership within the service was visible and accessible. Staff told us that they felt confident in raising concerns. Information available at a ward level related to staff training and there is additional work being done to extend the amount of data available but currently this is monitored through ward managers. The service has participated in some research programmes and is working on a new online version of care planning to involve people more in their own care plan process.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

Care was provided in clean and hygienic environments.

The environment of each service was very different and safety had been considered to reflect the needs of people using the services. Individual risk assessments were in place and being followed.

There were high staff vacancy levels at the Horton site but recruitment was ongoing and safe staffing levels were being maintained. Most people did not have activities or leave cancelled on the basis of staff shortages.

Staff had a good understanding of safeguarding processes and how to raise alerts. Incidents were reported, and information and feedback following incidents was shared through the division.

Good



Are services effective?

We rated effective as **good** because:

Patients received timely assessments after admission and these were reviewed and updated regularly.

There were strong multi-disciplinary teams on all wards including medical and nursing staff as well as psychologists, occupational therapists, art therapists, music therapists and activity workers. These multi-disciplinary teams worked well together to ensure a range of treatment with a recovery focus was offered to patients. Patients had regular physical health checks which were recorded.

Staff had access to regular supervision and team meetings took place. There was a good understanding of the Mental Health Act and Mental Capacity Act which was evidenced through speaking with staff and records on the wards.

Good



Are services caring?

We rated caring as **good** because:

We observed kind and respectful interactions between staff and patients. Most patients told us that they had positive experiences of the service and that they were treated with care and dignity.

All wards had meetings which sought the views of patients and ensured that actions were taken as a result of input from patients.

There were efforts to involve families in patient's care and opportunities to access advocacy services.

Good



Summary of findings

Are services responsive to people's needs?

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

- In some areas information on how to complain was not clearly displayed and sometimes verbal complaints were not addressed using the complaints process where the patient would have liked to access this procedure.

There were clear pathways through the rehabilitation service. Admissions and discharges were planned and the assessment process checked that people referred were appropriate for rehabilitation services.

Wards were suitably equipped and furnished to meet the needs of patients with outside access and a range of facilities. Most patients told us that the food was good and there were some facilities to practice catering skills particularly on the open rehabilitation wards.

The service provided many ways of meeting peoples individual needs in terms of their religion, culture and language. Information was available in different languages and formats. Most wards had access for people with mobility difficulties.

Requires improvement



Are services well-led?

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

Staff throughout the rehabilitation services embodied the trust values and told us that they felt proud of working for the service and the trust. Staff felt supported by their managers both at a local level and by more senior managers through the service and the trust.

Information was available at ward level regarding team performance although this was not extensive and relied on team manager's understanding of the ward level information. Senior managers in the service had a good knowledge of the wards and units they were responsible for and where the strengths and weaknesses of the service were.

There were some projects being undertaken to ensure that the service was innovative.

Good



Summary of findings

Information about the service

Inpatient rehabilitation wards are for patients who have complex and enduring mental health problems, and where previous accommodation has been unable to meet their needs.

In London, we visited:-

2 Colham Green Road which is 15 bed open rehabilitation unit which is a 10 bed unit and 5 studio flats.

Roxbourne Complex and Annex which are two 14 bed open rehabilitation units with a self-contained 5 bedded lodge

Fairlight which is 12 bed open rehabilitation ward.

Kenton ward which is 10 bed locked male rehabilitation ward based at Kingwood Centre.

In Epsom, Horton Rehabilitation Services, we visited:-

Birch Villa which is 15 bed locked male rehabilitation ward

Ascot Villa which is 15 bed locked mixed rehabilitation ward

Westfield House which is a 16 bed open mixed rehabilitation ward which is divided into 3 and 4 bed flats.

Rushett House which is a 26 bed open mixed rehabilitation ward which is divided into 3 and 4 bed flats.

Our inspection team

The team that inspected the Long stay rehabilitation mental health wards for working

age adults consisted of a two CQC inspectors, one CQC Head of Inspection, two experts by experience, three Mental Health Act reviewers, one senior mental health nurse, one occupational therapist and one consultant psychiatrist.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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.

During the inspection visit, the inspection team in London visited:-

- visited five wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 36 patients who were using the service
- spoke with the managers for each of the wards

Summary of findings

- spoke with 37 other staff members; including doctors, nurses, occupational therapists, support workers, activity coordinators
- interviewed the service director with responsibility for these services
- attended and observed three hand-over meetings and three multi-disciplinary meetings.

In Horton we:

- visited four wards and looked at the quality of the ward environments and observed how staff were caring for patients
- interviewed the matron for the site
- interviewed three ward managers

- spoke with 2 deputy ward managers
- spoke with one pharmacist
- spoke with 4 other staff members including nurses, doctors, psychologists and occupational therapists.
- Spoke with 16 people who used the service
- Attended one multi-disciplinary meeting

We also:

- collected feedback from patients using comment cards.
- reviewed 40 treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.
- Carried out three Mental Health Act Review visits

What people who use the provider's services say

We spoke with patients and their relatives. Most were positive about their experience of care on the wards. They told us that they found staff to be very caring and supportive, and most patients were involved in decisions about their care.

Patients have the opportunity to provide feedback through the trust 'Meridian' system, however, between 1/4/2014 and 27/2/2015, only one piece of feedback had been collected in this way. Some wards also carried out surveys. We looked at the last surveys carried out on Kenton ward for (December 2014), Rosedale Court

(October 2014) and Colham Green Road (October 2014) where five patients had contributed and most of the feedback was positive regarding activities available, quality of food and the cleanliness of the ward.

At Horton, we saw minutes from a meeting coordinated by a user group with people on the wards at the site. This was a more general discussion and feedback included some concerns about staff attitude and information regarding medicines which were actioned as a result of the meeting.

Good practice

- Staff across the services had a very good understanding of the Mental Capacity Act and were able to demonstrate good documentary evidence of using the Act in practice.

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to improve the long stay / rehabilitation mental health wards for working age adults

- The trust must ensure in all the rehabilitation services that information is available to inform patients how to

make a complaint. They must ensure verbal complaints are addressed and if needed have access to the formal complaints process and that learning also includes verbal as well as written complaints.

Summary of findings

Action the provider SHOULD take to improve Action the provider SHOULD take to improve the long stay / rehabilitation mental health wards for working age adults:

- The trust should ensure that maintenance issues are addressed across the London services in a timely manner.
- The trust should review the layout of Fairlight and Colham Green to try and achieve the greatest level of gender separation to promote people's safety and dignity.
- The services should keep blanket restrictions under review such as levels of observation, access to hot drinks and the impact of the front door at Colham Green being opened only by an electronic lock controlled from within the staff office to ensure the least restrictive measures are in place that reflect peoples' individual needs.
- The trust should ensure that staff at Fairlight had consistent access to information necessary to provide support and care for people through the electronic patient record system.
- The London services should ensure that staff have an understanding of the role of independent mental health advocates and general advocates within the services so that patients can be supported to access the most appropriate service.
- The trust should ensure that where investigations are needed as part of incident enquiries that these take place in a timely manner especially where staff are suspended.
- The trust should look at the arrangements for patients to have or replace keys for their rooms to ensure they could lock their rooms without having to rely on staff doing this for them.
- The trust should support staff to have an improved knowledge of incidents across the trust from other divisions so the learning can be put into practice.

Central and North West London NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Roxbourne Lodge and House	Roxbourne Complex
Fairlight	Fairlight Community Rehabilitation Unit
2 Colham Green Rd	Hillingdon Hospital
Birch Villa Ascot Villa Westfield House Rushett House	Horton 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 showed a good understanding of the Mental Health Act, Code of Practice and guiding principles. Staff training in the Mental Health Act was mandatory.

Consent to treatment and capacity requirements were met and treatment forms were attached to medication charts where applicable. We found that a few units stored the forms in different places making them difficult to locate for audit purposes. At Horton, a minor point was raised about statutory consultees not placing notes of their consultation with the second opinion approved doctor on the patients' record (code of practice 24.54).

Detailed findings

Records showed that patients' rights and status under the Act were explained to them on admission, and at regular intervals to ensure they understood. There was one record at Horton where a patient was noted not to understand information given and this was not followed up, despite the section 3 being renewed.

Staff told us that they received support and legal advice on the implementation of the Mental Health Act and the Mental Capacity Act.

We found all Mental Health Act documentation was clearly recorded and up to date. Renewals of detention and hospital manager's hearings were timely.

In some units we found that old section 17 leave forms on the electronic patients' record were not marked as void. The section 17 leave form did not have a space to record who had received copies of the authorisation as required by the code of practice. In some files it was not possible to link the risk assessment to the care plan or to the authorisation of section 17 leave

At Horton an independent mental health advocacy (IMHA) service visited weekly and made additional visits to support patients at specific meetings such as CPA meeting.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had attended training related to the Mental Capacity Act.

We saw evidence of good understanding and use of the Mental Capacity Act. For example, in the locked rehabilitation services at Horton, there was a patient who was detained who was refusing to have physical healthcare treatment for a specific condition. This had been handled very appropriately with a capacity assessment. It was agreed that they did have capacity to refuse treatment but this was regularly reviewed. At Kenton ward, we saw that

staff discussed capacity during handovers and ensured that issues relating to capacity were recorded. Patients told us that staff asked for their consent before being providing care and treatment, such as taking blood samples.

Best interests meetings took place as needed and were recorded.

At Horton, ten applications for Deprivation of Liberty Safeguards authorisations had been made to the supervisory bodies and the assessments were taking place. In one case, it had been agreed that the person referred should be detained under the Mental Health Act.

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 **good** because:

Care was provided in clean and hygienic environments.

The environment of each service was very different and safety had been considered to reflect the needs of people using the services. Individual risk assessments were in place and being followed.

There were high staff vacancy levels at the Horton site but recruitment was ongoing and safe staffing levels were being maintained. Most people did not have activities or leave cancelled on the basis of staff shortages.

Staff had a good understanding of safeguarding processes and how to raise alerts. Incidents were reported, and information and feedback following incidents was shared through the division.

example, the upstairs nurses' station (by the bedrooms) was positioned to have a clear line of view. Where this was not possible, there were high mounted mirrors. For the open rehabilitation units at Horton this level of observation was not needed.

- The wards all had environment risk assessments which included ligature risks. This information was shared with the trusts health and safety advisor for advice. The approach between locked and open rehabilitation services varied reflecting the needs of the patients. On the locked wards at Horton the work needed to minimize ligature risks had been identified but the dates for this work to commence was not yet known. The units were managing risk on an individual basis and providing higher levels of observation where needed. Managers we spoke with told us the policy was that any patients identified at risk of self-harm through ligatures should not be placed in open rehabilitation wards. As a consequence work to reduce ligatures was not planned in these areas although traditional taps on the sinks in the ensuite bathrooms at 2 Colham Green Road had been replaced.
- On the locked rehabilitation wards at Horton, bedrooms areas for males and females were separate and had ensuite bathrooms. There was also a separate male and female lounge as well as the main shared lounge.
- Fairlight and Colham Green Road were open rehabilitation services provided in a more domestic environment. There were no female only bathrooms in either of the services. The staff were very aware of the needs of the individual people using the service to ensure they would not present a risk to each other from living in this environment. The trust should review the layout of these services to try and achieve the greatest level of gender separation to promote people's safety and dignity.
- In the open rehabilitation flats at Horton – the flats were male or female. There was an unusual arrangement whereby people from three flats came together to eat in one of the flats. These dining areas were in some cases

Our findings

Safe and clean ward environment

- The physical environments and the provisions for patient safety were very different between the locked and open rehabilitation services.
- On Fairlight, Colham Green and Roxbourne full observation to all parts of the wards was not possible due to the age and design of the buildings. These were open rehabilitation services and so the high levels of observation were not needed. However bedroom doors in these services were being fitted with observation panels as part of a trust policy and this work was ongoing.
- On Kenton ward which was a locked ward, there were some parts of the ward which had blind spots which were acknowledged by staff. This was mitigated by staff checking corridor areas regularly. On Birch and Ascot villas in Horton which were locked rehabilitation services where observation was important, the wards were laid out to try and promote clear observations. For

Are services safe?

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in female flats and so people had to walk past female bedrooms. Nobody using the service complained about this arrangement and the bedrooms were locked and did not have observation panels.

- Clinic rooms were fully equipped and accessible. They were checked daily at least and the emergency medication was in place and in date.
- All the services we visited were clean and had reasonable furnishings. At Horton, maintenance took place quickly where necessary. However, in the London services, staff we spoke with on Fairlight, Roxbourne and Colham Green said response times from the estates department were slow. On the day of our inspection at Fairlight a wastepipe had burst and the maintenance team attended within the hour of being called.
- Staff working on all wards in the London services and on Birch and Ascot Villas were provided with portable alarms. The alarm systems identified where the staff member who needed help was located. Staff from adjoining units would help if required.

Safe staffing

- The trust had reviewed staffing levels on all the wards to ascertain the establishment numbers. Additional staff were booked if patients needed 1:1 support. After a review, a decision had been made to increase the establishment staffing numbers on Kenton ward which meant that there was some adaptability and the service was able to adjust to meet the needs of patients.
- In each ward there was a clear laminated notice indicating the staff on duty that day. The numbers of staff on the wards normally reflected the rotas. There were some exceptions when a member of staff was unable to work at the last minute.
- The wards at Horton had about 30% of nursing (qualified and unqualified) vacancies. There was an active ongoing programme of recruitment involving measures such as close work with the local university. The staffing levels were maintained using bank and agency staff. The service had delayed opening a new unit on site until enough staff had been recruited. The vacancy levels were lower in London services although there were some vacancies and work was being done to recruit across the service. Vacancies were identified on the divisions risk register as an area of continued work.

- Permanent staff were the first point of cover for any gaps in the rota but bank and sometimes agency staff were used in each ward. We saw the systems in place for accessing these staff and how their local induction was organised.
- Throughout the inspection we saw that ward managers were able to bring in staff for 1:1 observations and access agency staff if needed.
- At the wards in Horton and at Kenton ward, staff including qualified staff were present in communal areas of the wards. In the open London rehabilitation wards, managers told us that due to limited staffing levels this was not possible. Patients we spoke with at Roxbourne said they would like to see more staff available in their communal areas.
- Each patient had a named nurse and the goal is for patients to have a session with their named worker at least once a week. This was being achieved in all the wards we inspected and managers showed us the supervision systems they used to check this occurred.
- Patients had access to regular leave and activities and these were rarely cancelled due to staff absence.
- All staff had to complete training on physical interventions which is refreshed annually. There were enough staff on the three locked rehabilitation units we visited to carry out these interventions.
- During the week there was a consultant psychiatrist available either in person or via telephone in all the wards we visited. At night and weekends there is an on-call doctor available if needed.

Assessing and managing risks to patients and staff

- Patients all had risk assessments upon admission and these were reviewed at multidisciplinary meetings. However, in Colham Green, Roxbourne and Fairlight, records we reviewed did not always formally record the review dates of the risk reviews.
- There were two examples of where blanket restrictions were in place that did not reflect people's individual needs. The first was that all patients on the locked rehabilitation services and the open rehabilitation wards in London were being checked by staff every hour during the day and on the open rehabilitation wards at Horton, every two hours during the day. Staff were not

Are services safe?

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able to explain why this blanket approach was in place. Also some of the patients we spoke to commented that they did not feel comfortable with these regular checks. We reviewed the trust observation policies which included scope to reduce this level of observation on rehabilitation wards if clinically justified. We drew this to the attention of senior managers who indicated that they would review this practice.

- The second blanket restriction was that on the locked rehabilitation wards at Horton, hot water was not available to make drinks and people had to ask for a hot drink. Whilst staff said there were concerns about safety from hot water, other alternatives such as flasks were not available.
- At Colham Green, an open rehabilitation ward, the front door was opened only by an electronic lock controlled from within the staff office. We have asked senior managers to assess the impact this has on the freedom of movement of informal patients. In the other open rehabilitation wards we visited there was complete freedom to enter or leave the areas by day. All the patients on the locked rehabilitation wards were detained.
- People's needs were regularly reviewed and if additional staff were needed for closer observation this would be provided. Searching patients happened very rarely and only based on individual risk and was negotiated with the person as part of their care plan and risk assessment.
- In six months prior to the inspection there had been 11 occasions when restraint had been used on Birch and 8 on Ascot. Of these 2 had been face down. On Kenton ward, there had been 3 occasions when restraint had been used, of which one had been face down. Staff were clear that face down restraint should not be used. They said that training was updated and everyone had refresher training once a year. The staff were skilled in de-escalating incidents.
- None of the units had seclusion rooms. Ascot Villa in Horton did have a room labelled as the "de-escalation room". This sign was being changed. Birch Villa had an interview room. These were described by staff and patients as areas where they could go for some space away from other people on the ward. Staff stayed with the person and the door was not locked. People said they only stayed in there for periods of up to 15 minutes and could leave when they wished to do so.
- Safeguarding training was part of the mandatory training. A member of staff on each ward was assigned to the role of safeguarding lead and we interviewed these staff. They were very knowledgeable about safeguarding procedures and policies. They told us they were confident of the systems in place to protect people, and they all felt they had good professional relationships with local authority safeguarding leads. Other staff we spoke with knew how to recognise abuse, who their safeguarding leads were and how to raise alerts.
- We checked the medicines arrangements on each ward including the storage and dispensing. In London wards, a pharmacist or technician visited each ward every week to check stocks and provide advice to staff and patients on medication issues. In Horton, a pharmacist visited the site twice a week but there were arrangements to obtain medicines on other days if needed. The pharmacist said they are involved in complex prescribing decisions. They also provide training to staff and conduct regular clinical audits relating to medicines. On each ward all patients were at different phases of medication management ranging from staff dispensing to patients administering their own. We saw the assessments and plans which enabled this to happen. In the flats at Colham Green, there was a locked medicines cabinet in each room and patient's had the key in line with their individual care plan.
- Whilst pressure ulcers were rare there was one person at Horton, who had developed a pressure ulcer on their heel. This was being investigated. All the steps had been taken to help the wound to heal and prevent further pressure ulcers. This involved working closely with the tissue viability nurse and other care professionals. A comprehensive care plan was in place.
- All the wards had rooms available for patients to meet with families including young children. The locked rehabilitation wards had appropriate space off the ward.

Track record on safety

Are services safe?

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

- There were no serious untoward incidents in the last year associated with this core service. However staff told us and we saw the evidence of Trust wide learning which was shared with staff via emails and bulletins.
- Over a year ago, there was a death of an informal patient at Horton who left the site and was found dead in a local forest. Staff were aware of this incident and the importance of keeping an eye on everyone and alerting the police if necessary.
- Staff were aware of incidents that had taken place within their site and of wider safety alerts and bulletins provided by the trust following serious incidents. Feedback was discussed at the ward staff meetings. Learning from incidents was a standing item on the Horton and London care quality meetings. It was also a standing item on the monthly management meeting. We saw this was also discussed at the operational managers meetings across London and Horton sites and the service director monitored this across the service with a thematic report regarding incidents having been provided at the January 2015 service meeting.
- Staff received full support after a serious incident. This included seeking medical advice as needed. A debrief meeting took place. Opportunities for reflective practice in team meetings were available. Access to occupational health and counselling services was arranged as needed.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents using the electronic system.
- Managers we spoke with were confident all incidents were reported as necessary.

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.

Summary of findings

We rated effective as **good** because:

Patients received timely assessments after admission and these were reviewed and updated regularly.

There were strong multi-disciplinary teams on all wards including medical and nursing staff as well as psychologists, occupational therapists, art therapists, music therapists and activity workers. These multi-disciplinary teams worked well together to ensure a range of treatment with a recovery focus was offered to patients. Patients had regular physical health checks which were recorded.

Staff had access to regular supervision and team meetings took place. There was a good understanding of the Mental Health Act and Mental Capacity Act which was evidenced through speaking with staff and records on the wards.

Our findings

Assessment of needs and planning of care

- Admissions to rehabilitation services were planned. All patients had a comprehensive assessment in place on admission.
- All patient records included a full physical examination and we saw ongoing monitoring of any health problems. In addition, GPs ensured each patient had an annual physical health check.
- Care plans were of a standard format and up to date. However they were usually written in the third person, which did not give a personalised feel. The goals were holistic but there was no specific recovery tool being used to give them a focus. The records we checked were recovery orientated.
- The trust used a patient record system called Jade which contained secure electronic records and was available via computers on each ward. However at Fairlight there had been a longstanding problem with the connection to the Trust's IT system. This meant staff could not rely on the system throughout the day or night.

Best practice in treatment and care

- Access to psychologists and psychological therapies varied between services, primarily due to vacancies within the department. Patients who transferred to Colham Green from the acute units were able to continue with any therapy started there. At Horton, patients had access to a psychologist and psychology assistant and were offered support on an individual basis. The psychologists also offered some group work. Some of the nursing staff across the wards had been trained to use therapies and were using this as a part of their work.
- Physical health care was mainly provided through the patients GP but medical staff we spoke with told us they would sometimes undertake this if the patient did not have a registered GP. There was access to a specialist dental service. Optician appointments were made using high street opticians or by arranging one to visit the ward. Individual health conditions were being managed appropriately. There were staff who were designated smoking cessation leads to support patients to reduce their smoking.
- All the patients were assessed using HoNOS scale and these were updated for CPA reviews. Occupational therapists in each ward used the model of human occupation screening tool (MoHOST) to record patient outcomes. On Kenton ward, the Bromley drug use screening tool (DUST) was used when appropriate.
- A range of audits took place on each ward which included making sure care plans and risk assessments were up to date. Managers had also done audits to ensure supervisions and appraisals were up to date. There were also medication audits by the pharmacy staff. At Colham Green we were shown an initial audit where managers were looking at the impact of inpatient stays on the person and their relapse rates.

Skilled staff to deliver care

- In all wards we visited there was a strong multi-disciplinary team. In addition to medical and nursing staff there were psychologists, occupational therapists, activity workers, sessional pharmacists, art therapists and music therapists.
- All new staff completed a corporate induction. There was mandatory training and the staff and their

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.

managers were reminded when this needed to be refreshed centrally. Staff had access to managerial and clinical supervision monthly. All staff had an annual appraisal.

- Staff were very positive about the training they could access to support them to perform their role. In terms of training for staff on supporting people's rehabilitation, there had been some local training and also training provided by the recovery college. The recording of this training was not held centrally so it was hard to get accurate figures. Staff at Horton also spoke very positively about the training they are undertaking on supporting people with a personality disorder.
- Generally staff performance issues are addressed through ongoing supervisions. At the time of the inspection two staff were suspended from Rushett and this investigation was taking several months and causing staffing issues in the service.

Multi-disciplinary and inter-agency team work

- There were a range of multi-disciplinary meetings including ward rounds and CPA reviews. Four ward rounds were observed and showed good multi-disciplinary working where everyone participated. This also showed us how staff knew the individual patients very well.
- Regular handovers took place between shifts enabling the sharing of essential information. These occurred three times a day on each ward. We observed two handovers. No written notes were taken of handovers which meant that information shared verbally could not be referred to later in the shift. However, information may be recorded on an individual basis.
- Staff told us that care coordinators in the community were invited to CPA reviews and kept them updated via email and phone contact. However, due to the geographical location at Horton, some of the staff told us that maintaining contact with care coordinators could be challenging.

Adherence to the MHA and MHA Code of Practice

- Staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles. Staff training in the Mental Health Act was mandatory.

- Consent to treatment and capacity requirements were met and treatment forms were attached to medication charts where applicable. We found that a few units stored the forms in different places making them difficult to locate for audit purposes. At Horton, a minor point was raised about statutory consultees not placing notes of their consultation with the second opinion approved doctor on the patients' record (code of practice 24.54).
- Records showed that patients' rights and status under the Act were explained to them on admission, and at regular intervals to ensure they understood. There was one record at Horton where a patient was noted not to understand information given and this was not followed up, despite the section 3 being renewed.
- Staff told us that they received support and legal advice on the implementation of the Mental Health Act and the Mental Capacity Act.
- We found all Mental Health Act documentation was clearly recorded and up to date. Renewals of detention and hospital manager's hearings were timely.
- In some units we found that old section 17 leave forms on the electronic patients' record were not marked as void. The section 17 leave form did not have a space to record who had received copies of the authorisation as required by the code of practice. In some files it was not possible to link the risk assessment to the care plan or to the authorisation of section 17 leave
- At Horton an IMHA service visited weekly and made additional visits to support patients at specific meetings such as CPA meeting.

Good practice in applying the MCA

- All staff had attended training related to the Mental Capacity Act.
- We saw evidence of good understanding and use of the Mental Capacity Act. For example, in the locked rehabilitation services at Horton, there was a patient who was detained who was refusing to have physical healthcare treatment for a specific condition. This had been handled very appropriately with a capacity assessment. It was agreed that they did have capacity to refuse treatment but this was regularly reviewed. At Kenton ward, we saw that staff discussed capacity

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.

during handovers and ensured that issues relating to capacity were recorded. Patients told us that staff asked for their consent before being providing care and treatment, such as taking blood samples.

- Best interests meetings took place as needed and were recorded.

- At Horton, ten applications for Deprivation of Liberty Safeguards authorisations had been made to the supervisory bodies and the assessments were taking place. In one case, it had been agreed that the person referred should be detained under the Mental Health Act.

Are services caring?

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

Summary of findings

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

We rated caring as **good** because:

We observed kind and respectful interactions between staff and patients. Most patients told us that they had positive experiences of the service and that they were treated with care and dignity.

All wards had meetings which sought the views of patients and ensured that actions were taken as a result of input from patients.

There were efforts to involve families in patient's care and opportunities to access advocacy services.

gradual introduction to their new environment. One patient we spoke with had been admitted recently and confirmed it had not been a stressful process. We saw the information packs which each ward had devised containing a wealth of information about the ward, its routines and activities available. Staff told us they could get these published in a variety of languages and formats if required.

- Patients told us they were routinely invited to their care planning meetings and ward rounds. Some patients told us that they had a copy of their care plan whilst others said they were not aware of them. At Colham Green we saw patients were provided with copies of their care plans which were left in a wall mounted sleeve in their rooms.
- In each ward we visited we saw posters advertising the local advocacy service both for informal and detained patients. Although the amount of contact information and detail about the service offered did vary from ward to ward. We were told by staff at the wards in London that an advocacy worker would sometimes come to the wards but these visits were not part of the weekly programme. Staff we spoke with were not always aware of the local advocacy arrangements or how best to contact them. We did note that one member of staff was allocated as a PALS contact person and this information was on the patient's notice boards. At Horton, an advocate from Kingston Advocacy Group (KAG) visits the site once a week and more frequently if required.
- Families and carers were routinely invited to review meetings but staff told us that access to public transport can limit their attendance both in London and at Horton. Rooms were identified in each ward for relatives to see people in private. Families and carers could also access courses at the recovery college. At the Horton site, we heard that staff have supported a few patients to re-connect with relatives they had not seen for a number of years.
- At Horton, each ward had a daily community meeting while in London wards had a weekly community meeting. We saw the notes made available within the wards about actions and suggestions for activities or changes to the routines. In London, we saw how each ward undertook patient satisfaction surveys throughout the year, and how the results and actions were included into the community meetings. Examples of changes

Our findings

Kindness, dignity, respect and support

- Throughout our visit to all the wards, we saw positive and caring interactions between staff and the patients. Staff were respectful, for example knocking on doors before entering bedrooms. However, some patients we spoke with at Roxbourne and Fairlight told us some night staff would knock and immediately enter their rooms without waiting to be asked. We fed this back to senior managers who told us they would address this.
- With very few exceptions, patients we spoke with were positive about the support and treatment they received from the staff.
- All the staff we spoke with told us they had been able to build up relationships and understanding of the patients in their care. They told us that due to the longer term contact they had with patients, this resulted in them developing good insight into the behaviours of patients and they were able to provide confident and consistent support.

The involvement of people in the care they receive

- Staff described to us the process of how new patients were introduced to the wards. They said this was at a pace the patient dictated and was designed to provide a

Are services caring?

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

patients have suggested and which have been made included such things as; changes to menus, new activities to be undertaken and places to visit. At Horton, efforts had been made to establish a service user forum on the site but there had been limited attendance so far.

We saw minutes from one of the meetings. Patients showed potential staff around the site when they come for interviews. Patients from other sites came to Horton to help with PLACE inspections.

- We saw that some individual care plans had details about what actions should happen in particular scenarios which had been agreed with patients.

Are services responsive to people's needs?

Requires improvement 

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

Summary of findings

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

- In some areas information on how to complain was not clearly displayed and sometimes verbal complaints were not addressed using the complaints process where the patient would have liked to access this procedure.

There were clear pathways through the rehabilitation service. Admissions and discharges were planned and the assessment process checked that people referred were appropriate for rehabilitation services.

Wards were suitably equipped and furnished to meet the needs of patients with outside access and a range of facilities. Most patients told us that the food was good and there were some facilities to practice catering skills particularly on the open rehabilitation wards.

The service provided many ways of meeting people's individual needs in terms of their religion, culture and language. Information was available in different languages and formats. Most wards had access for people with mobility difficulties.

- There were pathways through the rehabilitation services so patients could move from locked to open rehabilitation during admission episodes as a planned part of the pathway. In Horton this could include moving into cottages on the site in line with individual programmes of rehabilitation.
- In the London wards, we were told by staff how they had built up good relationships with local authority housing departments and housing associations, within each borough. This was to provide good communications between agencies when planning discharge arrangements. However, due to limited availability of appropriate accommodation to meet all the patients' needs there had been delays in discharging patients on each of the wards we visited. Staff we spoke with told us how they often provided support to patients in accessing furniture, grants and benefits as part of the discharge process. This was due to the absence of or very limited dedicated social work time.
- At Horton, there was an on-site bed manager. They contacted commissioners and care managers on behalf of individual patients. Despite this, there had been 7 delayed discharges in the last six months, largely due to the challenges of finding alternative appropriate placements and agreeing this with commissioners. Where discharges took place they were gradual and carefully planned with information shared with appropriate professionals. At the time of the inspection, there were 3 delayed discharges at Horton and none in the London services.

Our findings

Access, discharge and bed management

- As a specialist service work had taken place with the various commissioners to develop the service in line with people's needs and commissioning intentions. Staff told us the rehabilitation service had developed in response to the need for people to have placements near their homes. The service had a 'placement efficiency project' which specifically looked at moving people nearer to their own communities.
- Patients were not admitted until previous patients had been discharged which ensured that there was access to a bed when patients returned from leave. A rehabilitation nurse attended the trust discharge planning meetings locally and the criteria for admission were based on the person's potential for rehabilitation.

The ward optimises recovery, comfort and dignity

- All the wards we visited had a range of rooms and facilities, including areas for activities, therapeutic interventions, clinics, kitchens and communal areas. Colham Green did not have a dedicated activity room but instead they were using the dining area to undertake activities. There was an on-site recovery college at Horton which could provide a larger space where needed.
- On each ward there was a room identified where patients could meet with visitors. There were no dedicated quiet rooms on the wards, but patients had their own rooms where they could go for somewhere quiet. At Horton there were also meeting rooms and a tea shop in the recovery college.

Are services responsive to people's needs?

Requires improvement 

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

- Although most patients, including those in locked rehabilitation wards, had a mobile phone there were payphones available on each ward.
- In London, all the wards we visited had their own gardens or outside spaces easily accessible from the ground floor. At Horton, this service was based on a site in attractive grounds which means that everyone had access to outside space. On the locked rehabilitation ward, people were able to smoke outside at set times or more frequently if agreed on an individual basis.
- Patients were complimentary about the meals at all the sites we visited. At Horton, the main issue raised by patients was that if someone was late for a meal then the hot food would be thrown away and only snacks were available. This was confirmed by staff. The occupational therapists undertook cooking sessions with individual patients, which included shopping and preparing the food. Patients were able to order take-away meals. Different options were available to patients wanting meal options.
- On the open rehabilitation wards, they had a kitchen area which patients could access throughout the day to make hot drinks and occasional snacks. In London, at night from about 11pm staff explained to us they would negotiate with patients over access as they were trying to develop normal sleep patterns. In the locked rehabilitation wards in Horton, only water was available to patients. They had to ask staff if they wanted a hot drink. Staff said this was because they were concerned about the risk of people getting burnt.
- Patients could personalise their bedrooms in terms of pictures, own possessions and bedding. However, as each room is intended only to be temporary accommodation, patients were not able to re-decorate their rooms.
- In the London services, patients all had small lockable safes in the bedrooms along with a cupboard and chest of drawers. However, not all patients had keys to their rooms. At Colham Green the locks on the main bedrooms (not the en suite) were the same and staff kept a master key for access. This meant those patients were unable to access their rooms if the door was locked. At Horton, patients all had keys to their rooms, although quite often these were lost. When this

happened, patients had to ask staff to open and shut the doors on their behalf. In practice, this meant that doors were sometimes left unlocked and possessions were at risk of going missing.

- In all the wards we visited during the week there was a range of therapeutic activities available, on an individual and group basis. Patients had access to the recovery college onsite at Horton or the site based in London. Patients told us how they were able to leave the wards to participate in a range of community based activities, such as college courses or recreational pursuits. At the weekends and in the evenings there were less structured programmes, usually with more leisure activities such as visits, games and films. Patients we spoke with were satisfied with the range of activities available. Patients and staff spoke very positively about the courses provided by the recovery college.

Meeting the needs of all people who use the service

- Ground floor disabled accessible accommodation was available in each of the wards, although some corridors in Fairlight were narrow and there were some small steps and the corridors in the open rehabilitation units at Horton were also very narrow. Whilst there was a ramp to the back door at Fairlight the main entrance had a flight of steep steps but no handrail.
- We saw information leaflets about the wards, services, advocacy arrangements in each ward. We were told by managers that they can access leaflets in different languages and formats via the Trust, to meet the needs of any non-English speaking patients.
- Food was available to reflect peoples' religious and cultural choices via the cook chill provider. When wards are undertaking communal cooking we saw the arrangements for ensuring religious and cultural needs were catered for.
- The service had identified and created links with local religious groups. Each ward in London utilised a room or a room in the hospital (Kenton ward) to act as a multi-faith room. At Horton, there was a multi-faith room on site. A member of staff on Kenton ward was able to explain to us how they had worked with someone from the traveller community and their family while being sensitive to their culture.

Are services responsive to people's needs?

Requires improvement 

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

Listening to and learning from concerns and complaints

- Some patients we spoke with knew how to raise a complaint although many said they were not sure other than by speaking to their named nurse. In the wards in London, we did not see posters or information explaining the formal complaint process but saw information about the PALS contact and information about contacting CQC. At Horton, most patients told us that they did not know how to complain. We did not see posters or information explaining the process.
- Managers and staff told us they tried to respond to any verbal comments or complaints immediately to sort them out. We saw the evidence at each weekly community meeting where patients were asked if they had any comments. We were told by managers this was also repeated during the one to one sessions with their named nurse. The service had no formal complaints recorded for the previous six months. At Horton, the matron for the site confirmed there was not a record of verbal complaints. This meant it was not possible to check trends or learn from complaints. Some patients told us that they did not feel their complaints had been satisfactorily addressed.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

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

Staff throughout the rehabilitation services embodied the trust values and told us that they felt proud of working for the service and the trust. Staff felt supported by their managers both at a local level and by more senior managers through the service and the trust.

Information was available at ward level regarding team performance although this was not extensive and relied on team manager's understanding of the ward level information. Senior managers in the service had a good knowledge of the wards and units they were responsible for and where the strengths and weaknesses of the service were.

There were some projects being undertaken to ensure that the service was innovative.

Our findings

Vision and values

- Staff in all the wards had variable knowledge of the organisation's values. Information about the trust's values were evident on all sites. The staff working at Horton and on Kenton ward felt very well connected to the trust and knew of its visions and values. Staff at all levels were proud of the service, passionate about the focus of rehabilitation and spoke enthusiastically about putting people at the heart of services.
- Staff knew the names of senior staff in the organisation and the local rehabilitation senior management team who were visible. They said there were regular visits from senior rehabilitation staff and on occasions from board members. Staff told us the CEO weekly newsletters were accessible on the trust intranet and felt she was accessible.

Good governance

- The wards and units were all well managed and this was a reflection of the skills and abilities of the individual managers we met. There were clear trust processes to inform staff and managers about the non-completion of mandatory training. All other information was collected

on a manual basis. Senior managers in the division had a good understanding of the strengths and weaknesses of the division on the basis of data which was collected both at ward level and centrally. Each ward was implementing having a specific risk register. We saw the risk register for Kenton ward which demonstrated that the ward manager had a good understanding of its performance, strengths and weaknesses.

- We were told by managers that the systems were in various stages of development to reflect and interpret the performance of the rehabilitation service and the individual wards. These included; sickness reporting, staff turnover, training, patient episodes of care. Managers told us they worked closely with the rehabilitation business manager when reporting and developing new key performance indicators. Currently though, most performance data related to training.
- The ward managers told us they felt they had the autonomy and support to run their wards, including the ability to manage their own budget. In the London, open rehabilitation wards, the provision of administrative support was part time but they told us they could usually get urgent administrative support if there was a need.
- The new divisional structure meant that the services were not always able to evidence learning which was not related to significant serious incidents from other areas of the trust. For example, the forensic rehabilitation service which sat in a different division to the rehabilitation service. This meant that there was a risk that learning about positive experiences as well as incidents, may not be captured across the trust in similar services.

Leadership, morale and staff engagement

- Staff sickness rates varied significantly between wards and between sites. Staff sickness at Horton varied between 0.5% on Birch to 7% on Westfield. In London, on the open rehabilitation wards, the sickness levels were below the trust target of 3% on all sites. On Kenton ward, there had been higher rates of sickness in Jan and Feb over 10%. These sickness rates were being managed on all sites.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff on all wards we visited told us that they knew the trust had a whistleblowing policy and would know where to find it if necessary and that they would feel comfortable raising concerns with their managers.
 - Staff were very positive about working in the rehabilitation services. They felt the managers were supportive and knowledgably. There were opportunities for training and career development and good local team working.
 - Qualified staff told us there were opportunities to have leadership training and also gain professional qualifications. They told us this had not always been the case in the Trust but appreciated the new opportunities.
 - All the staff we spoke with were keen to develop areas of innovative practice but acknowledged this was a developing area of work. At Colham Green, the manager has introduced the productive mental health ward programme, which aims to improve the effectiveness, safety and reliability of the ward.
 - The service was participating in research with Imperial College on care pathways for people with long term psychosis.
 - The service was also developing an electronically based care plan document where patients could input their own care plan information and add pictures, music and other information important to them. This was currently being trialled to improve patient involvement.
- Commitment to quality improvement and innovation**

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints
Diagnostic and screening procedures	The trust did not have an effective system to inform people of how to make a complaint.
Treatment of disease, disorder or injury	There was a lack of information in some rehabilitation services to inform people how to make a complaint.
	There was not a central register of verbal complaints and it was possible that where patients wanted a formal response to their complaint this was not happening.
	This is a breach of Regulation 19(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.