

# West London NHS Trust

## Inspection report

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## Ratings

### Overall trust quality rating

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

## Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

The Evidence appendix appears under the Reports tab on our website here: [www.cqc.org.uk/provider/RKL/reports](http://www.cqc.org.uk/provider/RKL/reports). A detailed Use of Resources report is available under the Inspection summary tab ([www.cqc.org.uk/provider/RKL/inspection-summary](http://www.cqc.org.uk/provider/RKL/inspection-summary)).

## Background to the trust

West London NHS Trust serves a population of 800,000 people across the London Boroughs of Hammersmith and Fulham, Ealing and Hounslow. It employs 3,700 staff. Staff provide care and treatment for around 100,600 people and answer over 61,000 calls to trust helplines every year. At the time of the inspection the trust had achieved their control total for 2018-19. For the current year the trust had signed up to a control total surplus of £7.5m. The trust provides some national specialist mental health services, including The Cassel (for people with personality disorders) and Broadmoor Hospital (one of three high secure hospitals in England). The trust also provides local community healthcare services and is lead provider for Ealing Community Partners. In addition, it is subcontracted by another NHS trust to provide a few community healthcare services.

The service provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Forensic inpatient/secure wards
- Mental health crisis services and health-based places of safety
- Community-based mental health services for older people
- Community-based mental health services for adults of working age
- Specialist community mental health services for children and young people
- Community health inpatient services
- Community healthcare adults
- Community healthcare children

The trust also provides the following services:

- High secure hospital (Broadmoor)
- Specialist mental health services (The Cassel)

# Summary of findings

The trust operates from eight registered locations including five hospitals, Lakeside Mental Health Unit in Hounslow, St Bernard's in Ealing, Hammersmith and Fulham Mental Health Unit, The Cassel in Ham, Clayponds Hospital and Broadmoor in Bracknell Forest. The trust provides community mental health and community health services from a number of team bases in the London boroughs of Hammersmith and Fulham, Ealing and Hounslow.

The trust has been inspected eight times since 2015. We conducted a comprehensive inspection of the trust in 2015, 2017 and 2018.

In 2015 we rated the trust as requires improvement overall; the main concerns were staffing levels, the use of restrictive practices and poor staff engagement.

In 2016 we inspected the trust's gender identity clinic (the report appears on our website under other specialist services) and found there were governance issues. However, this service has transferred to another trust so there have been no subsequent inspections of this clinic.

In 2016 we also went back to forensic services. This was a focused inspection so this core service was not re-rated at that time as we only looked at specific areas. We still had concerns about staffing, recording of restraint and seclusion and ward manager access to incident reports.

At the comprehensive inspection published in 2017 we rated the trust as requires improvement overall. We rated it as good for one key question (caring) and requires improvement for four key questions (safe, effective, responsive and well-led). All core services still required improvement, except for community-based mental health services for older adults which were rated outstanding for caring and good for all the other key questions (safe, effective responsive and well-led).

In July 2017, we returned to Broadmoor for a focused inspection. We found there had been improvements to staffing. We did not re-rate the service following this inspection because we only looked at specific issues.

In January 2018, we inspected the core service acute wards for adults of working age and psychiatric intensive care units because we had rated it inadequate for the responsive key question in 2017. We found significant improvements, particularly in relation to managing bed occupancy, but we did not check everything as this was a focused inspection. Therefore, we did not re-rate the core service and the previous rating remained in place.

We carried out another comprehensive inspection in December 2018 and found the trust had made significant improvements. The culture within the trust had changed for the better. When core services required improvement, it was due to the under-performance of a minority of teams, rather than wider systemic issues. The trust was rated requires improvement for safe. This was predominantly due to estate issues. Overall the trust was rated good with outstanding for caring. West London Forensic Services were rated outstanding.

Prior to the current inspection the trust was in breach of the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 – Safe care and treatment
- Regulation 17 – Good governance
- Regulation 18 - Staffing

The breaches were linked to specific core services; there were no trust-wide breaches. The breaches that occurred related to staff shortages, data quality, incident reporting and feedback, timeliness of repairs, unsuitable ward environments, safeguarding and risk assessment processes, waiting list monitoring, access to management information, medicines reconciliation, equipment monitoring, access to emergency medicines and supervision recording.

# Summary of findings

## Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as **Good** ● → ←

# Summary of findings

## What this trust does

West London NHS Trust provides mental health and community healthcare services from five main hospitals and other locations in west London and Berkshire. This includes a range of local and national inpatient and community services for people of all ages. It is a major provider of forensic mental health services. It is the lead partner for Ealing Community Partners.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected four services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care unit (PICU)
- Specialist community mental health services for children and young people (CAMHS)
- Perinatal services
- Child and adolescent mental health ward

We returned to the acute wards and PICU because we saw significant improvements during a focused inspection in 2018 and we wanted to see if they had been sustained. We did not re-rate the service in 2018 as we only looked at specific issues.

We inspected community CAMHS as they were rated requires improvement at our last inspection of the service in 2017.

Perinatal mental health services had never been inspected before, so we included them to better understand the strengths and risks associated with this service.

We included a focused inspection of the child and adolescent mental health ward as we had been notified of some incidents on the ward and because it was overdue for refurbishment.

Three Mental Health Act monitoring visits to Avonmore Ward, Finch Ward and The Wells Unit took place concurrently with our inspection. They have been reported on separately.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as good because:

# Summary of findings

- We rated the trust as good for effective, responsive and well-led. Caring was rated as outstanding and safe as requires improvement. We rated three of the four core services we inspected this time as good and one as requires improvement. In rating the trust, we took into account the previous ratings for the core services not inspected this time.
- We rated well-led for the trust overall as good.
- The overall rating for West London NHS Trust remained as good overall and it was evident that many improvements had been made. Leaders had completely revitalised much of the trust infrastructure, such as information governance, repairs and maintenance, complaints investigations, data quality and performance monitoring, which underpinned the clinical work. This put their clinical leadership teams in a strong position to develop their services further and improve consistency in order to achieve their ambition to become an outstanding trust.
- The trust had sustained and, in many areas, enhanced the core service improvements required following our last comprehensive inspection in 2018. In three of the four core services we inspected this time we found that all the requirements and recommendations from our previous inspections had been rigorously addressed with board level monitoring.
- Where problems remained, they were linked to individual teams, rather than issues with the trust's systems or processes.
- The trust had particular strengths in the following areas; leadership at all levels, the positive culture of the organisation, the strong patient-focus, partnership working, pro-active engagement and co-production with patients, carers, staff and other stakeholders, creative recruitment and retention, training and development opportunities for staff and timely and effective completion of action plans and similar.
- Patients and carers spoke well of staff.
- Staff told us the trust had become a kinder place to work and they had confidence in their leaders who were very visible. The trust had implemented new practices to root out any accidental or deliberate unfairness to staff.
- The new Broadmoor Hospital demonstrated a bespoke and well-designed clinical environment for patients and staff and patient transfers to the new building had been without fault.
- There were several areas of outstanding practice which are detailed in this report.

However:

- The trust still has a number of sites which are not fit for delivering modern health services.
- The trust had not paid sufficient attention to its child and adolescent mental health ward (The Wells Unit) whilst it was waiting for a decision from commissioners and this had led to a drop in standards. The trust gave six months' notice to NHS England to end the contract shortly after our site visit concluded.
- Some specific safety issues had not been resolved within certain inpatient wards, although the trust was working to address them.
- The trust had not yet fully implemented the accessible information standard.

## Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- The ward environment at The Wells Unit was not fit for purpose.
- Improvements were needed to ensure that all inpatients who received rapid tranquilisation had appropriate physical health checks completed afterwards.

# Summary of findings

- Some specific safety issues associated with physical health checks and recording of and storage of medicines had not been resolved within certain inpatient wards, notably on Askew psychiatric intensive care unit (PICU). There was not always consistent recording of risk assessments, care plans and safeguarding information on The Wells Unit. The trust was working to address the issues.
- Within a few teams there was some inconsistency with the storage of patient information in the electronic patient record system. This made it hard to find. There were also some difficulties in accessing uploaded documents in a timely way.

However:

- Inpatient wards and clinic areas were safe, clean, well equipped, well furnished, well maintained and, for the most part, fit for purpose.
- The core services inspected had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. The number of patients on the caseloads of staff in the community teams was manageable.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff responded promptly to sudden deterioration in a patient's health. Staff monitored patients on waiting lists to detect and respond to increases in level of risk.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff regularly reviewed the effects of medicines on each patient's physical and mental health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and mostly reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission or at first contact. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented
- Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

# Summary of findings

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Each team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers had made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Staff supervision sessions were not being reliably recorded electronically, although staff told us they received supervision regularly.

## Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- The trust as a whole was very patient-centred. Staff at all levels wanted patients to experience the best possible outcomes and did their best to facilitate this.
- There were many examples of staff and leaders going the extra mile to support patients, including those with protected characteristics. The trust stepped forward to provide support for one patient with complex needs who was not their responsibility, but who needed intensive skilled intervention to improve the quality of their life.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients had easy access to independent advocates.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Some patients were involved in the co-design of materials for training on prevention and management of violence and aggression; on a few wards patients were invited to participate in safety huddles. In perinatal services, staff always involved patients in pre-birth care planning and actively sought their feedback on the quality of care provided.
- Co-production with patients and carers was increasingly well developed with opportunities for co-design and co-presentation in many areas, such as in the short film to introduce the trust's community child and adolescent mental health services.
- Patients at Broadmoor Hospital had played a significant role in the design of the new hospital and the artwork within it. Forensic patients had re-designed a staff training room.
- Staff informed and involved families and carers appropriately. The trust had received its first Triangle of Care star for its work with carers.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Staff assessed and treated patients who required urgent care promptly. Staff followed up community patients who missed appointments.



# Summary of findings

- Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. The trust had sustained this good practice for over two years at a time of immense pressure on beds across London. Discharge was rarely delayed for other than clinical reasons.
- The service ensured that patients were supported to make a smooth transition to other services when this was required or in their best interests.
- The design, layout, and furnishings of most wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom and they could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and inpatients could access hot drinks and snacks at any time.
- Staff supported inpatients with activities outside the service, such as work, education and family relationships.
- The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

However:

- Some young people and families waited a long time for an assessment or to start treatment. In Ealing, young people had to wait for up to three years to access a neurodevelopment assessment and this impacted on every aspect of their lives. The trust had worked to improve this and had raised it with commissioners of the service.
- The accessible information standard had not been fully implemented.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- The trust had been effective in addressing all the requirements and recommendations identified at previous inspections.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively throughout the trust and that performance and risk were managed well.
- Clinical teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities, including audits and accreditation.

However:

- The trust had let standards slip in The Wells Unit whilst waiting for an external decision about refurbishment.

# Summary of findings

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each core or additional service and for the whole trust. They also show the current ratings for services not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in perinatal services and community child and adolescent mental health services, as well as trust-wide outstanding practice, with regard to the recruitment of internationally educated nurses and patient co-production.

In addition, during the well-led review, we found there was outstanding practice at Broadmoor Hospital although we did not specifically inspect the service on this occasion.

For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including three breaches of legal requirements that the trust must put right in the core services we inspected. These related to aspects of premises and equipment, safe care and treatment and governance in some of the core services inspected. There were no trust-wide breaches. We found 16 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued three requirement notices to the trust. Our action related to breaches of three legal requirements in three core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

The trust was very patient-centred. Its commitment to meaningful co-production with patients and, increasingly, with carers and staff was exemplary. Previously we had noted West London Forensic Services were outstanding for their patient engagement and at this inspection we saw that other services were catching up, even though their patients tended to be less accessible. We noted the way experts by experience were supporting the development of materials used by perinatal services to inform and advise patients; the experts by experience were now using their skills on a pan-London basis.

The trust successfully transferred nearly 200 high risk patients without incident to the new Broadmoor Hospital in an exceedingly complex operation. This demonstrated superb relational security.

# Summary of findings

The trust had continued with its creative approach to recruitment, including the employment of a cohort of internationally educated nurses (IENs) who they supported to register with the Nursing and Midwifery Council (NMC). These initiatives meant that some services were fully staffed for the first time in recent history. We saw the level of detailed planning that had taken place to make this happen. The level of support offered to IENs was exceptional and drew on the experience of other trusts.

The trust provided five months of intensive support to another trust using a team of five Broadmoor and West London Forensic Service staff in order to improve the quality of life for a patient with very complex needs. They continue to provide less intensive support. The trust was under no obligation to offer this support, but decided to do so as their staff had the skills to assist and it was in line with the trust's values.

The service had supported and developed an experts-by-experience group. The well-established group met regularly with leaders of the service to advise on service delivery and development.

The group had co-produced a range of information materials to promote the service. This included leaflets, a video and web pages. Additionally, experts-by-experience had contributed to the development of care pathways locally and across London through participating in training and networking events.

Experts-by-experience also designed greetings cards for the service to send when patients give birth.

The trust had worked hard on the transitions commissioning for quality and innovation (CQUIN) outcomes that they had to report on. Community child and adolescent mental health services had effective local protocols for joint working between agencies involved in the care of children and young people. Senior managers had completed a joint working protocol between children and adult mental health services to effectively support children and young people moving to adult services.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

We found areas for improvement including breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 15 Premises and equipment; Regulation 12 Safe care and treatment and Regulation 17 Good governance.

There were six things the trust must put right in relation to breaches of these three regulations. There are another 19 things that were identified at previous inspections that we have not yet checked. In addition, we found 16 things at this inspection that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with three legal requirements in three services. There were other requirements outstanding from earlier inspections in six services that we did not inspect in 2020.

### **Acute wards for adults of working age and psychiatric intensive care units** (May 2020)

- The trust must ensure that patients' who receive rapid tranquilisation have appropriate physical health checks completed afterwards. Regulation 12(1)(2)(a)(b)
- The trust must ensure that all staff follow trust systems and processes when administering, recording and storing medicines. Regulation 12(1)(2)(g)

# Summary of findings

## **Specialist community mental health services for children and young people** (May 2020)

- The trust must ensure that it continues its work to ensure that children and young people can access assessment and treatment in the neurodevelopmental teams in a timely fashion. Regulation 17(1)(2)(a)

## **Child and adolescent mental health ward** (May 2020)

- The trust must ensure the ward environment is fit for purpose and does not compromise the safety and wellbeing of patients or staff. Regulation 15(1)(c)(e)
- The trust must ensure that risk assessment and management processes are implemented effectively so clear plans are in place that deliver safe care and treatment in a timely way. Regulation 12(1)(2)(a)(b)(c)
- The trust must ensure that governance systems deliver assurance that safe and effective care and treatment is delivered to patients. Regulation 17(1)(2)(a)(b)(c)

## **Long stay or rehabilitation mental health wards for working age adults** (from December 2018)

- The trust must ensure risk assessments, and associated documents, for patients on Glyn Ward are regularly updated.
- The trust must ensure there are sufficient permanent nursing staff on Glyn Ward to meet the needs of the patients, including having regular one-to-one meetings with their named nurse.
- The trust must ensure Glyn Ward patients have the same quality of recovery care plan goals and access to rehabilitation opportunities as Mott House patients when they have similar assessed needs.
- The trust must ensure staff receive regular supervision at Glyn Ward and Mott House.

## **Wards for older people with mental health problems** (from December 2018)

- The trust must make sure all restraint incidents are identified and recorded.

## **Community-based mental health services of adults of working age** (from December 2018)

- The trust must ensure the Ealing Early Intervention Service has sufficient numbers of staff to provide care co-ordination to all patients that require it. Staff must have manageable caseloads, in line with national recommendations, to enable them to deliver the full package of care to patients with first episode psychosis.
- The trust must ensure that Ealing West Recovery Team has a robust system in place to safely monitor patients on the waiting list, and ensure staff screen and prioritise referrals in a timely manner.
- The trust must ensure out-of-date medicines at Ealing West Recovery Team are removed from storage, or kept in separate storage if used only for training, to prevent the risk of inadvertent use.
- The trust must ensure staff in recovery teams assess patients in a timely manner, in line with the 28-day trust target. They should ensure a smooth transfer of patients from the early intervention teams.

## **Mental health crisis services and health-based places of safety** (from December 2018)

- The trust must ensure that systems are in place to gain assurance about the service delivered by the health based places of safety. This includes checks of the safety of the premises; accurate records of when patients attend the service or if the service is closed; records of incidents that take place within the service such as the use of restraint; and that patient records are completed and stored consistently.
- The trust must ensure that staff in the CATTs record risk consistently so that all staff can quickly gain a clear understanding of current patient risk.

# Summary of findings

- The service must ensure that medicines reconciliation is strengthened in the CATTs to ensure that medicines management is safe.

## **High secure** (from June 2018)

- The provider must continue to ensure there are sufficient staff and that where there are staff shortages, these have minimum impact on patients' access to activities, treatment and rehabilitation.
- The provider must ensure that episodes of seclusion are reviewed in line with the Mental Health Act Code of Practice and that these reviews are recorded and that reasons for long term segregation are clearly available in care records
- The provider must ensure that they consistently maintain and monitor medicines at their correct temperatures and promptly remedy any faults that arise.
- The provider must ensure that medicines are monitored and used within their manufacturer's recommended expiry dates.
- The provider must review equipment available for emergency use to ensure systems in place to ensure expiry dates are adhered to are effective.
- The provider must review the accessibility of adrenaline for anaphylaxis use so that it is immediately accessible when needed in an emergency as recommended in the Resuscitation Council (UK) guidelines.

## **Community health inpatient services** (from November 2016)

- The trust must ensure that all staff receive regular supervision and that this is recorded.

We told the trust that it should take action to comply with minor breaches that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These 16 actions related to the whole trust and three services. There were an additional 35 actions outstanding from inspections in prior to the current inspection which related to seven services that we did not inspect in 2020.

Action the trust **SHOULD** take to improve

## **Trust wide** (May 2020)

- The trust should implement the accessible information standard in full.
- The trust should with its efforts to ensure all staff groups record the clinical and / or management supervision provided to aid monitoring.
- The trust should ensure all mortality reviews are seen more promptly by the Mortality Review Group so any learning can be quickly identified.

## **Acute wards for adults of working age and psychiatric intensive care units** (May 2020)

- The trust should ensure that all staff on Askew Ward use personal alarms. The trust should also ensure that staff concerns regarding safety on this ward are addressed.
- The trust should ensure that it continues its work to fully embed the training in safeguarding staff had received into practice.
- The trust should ensure that improvements are made in the way staff on Kingfisher Ward record incidents that involve restraint.
- The trust should ensure that the current audit programme is strengthened so that it provides robust assurance regarding medicines, administration of rapid tranquilisation, reporting of restraint and MHA documentation.

# Summary of findings

- The trust should ensure that all staff discharge their responsibilities under the Mental Health Act well, including maintaining records to show when patients' rights had been discussed with them.

## **Child and adolescent mental health ward** (May 2020)

- The trust should ensure that staff receive appropriate specialist training so that safe, effective care and treatment is delivered to patients.
- The trust should ensure that learning from lower level incidents is shared with the team and that lessons learnt are implemented.
- The trust should ensure that the actions and outcomes in relation to safeguarding concerns are appropriately recorded.
- The trust should support staff to ensure that they can access all information relating to patients' historical care and treatment.

## **Specialist community mental health services for children and young people** (May 2020)

- The trust should ensure that staff are able to access electronic records systems when they need them.
- The trust should ensure that staff are consistent in how information relating to children and young people's care plans, risk assessment and risk management is recorded in their care and treatment records.
- The trust should ensure that staff identified as having responsibilities to develop user involvement have sufficient protected time to complete this work.
- The trust should continue to support staff to utilise electronic supervision systems to ensure that accurate data regarding supervision frequencies and overall compliance is available.

## **Long stay/rehabilitation mental health wards for adults of working age** (from December 2018)

- The trust should continue work to develop the future model of care for patients accessing rehabilitation services.
- The trust should ensure the appointment of the ward manager on Glyn Ward takes place as planned, so the staff feel supported and receive appropriate guidance.
- The trust should ensure the clinic room is clean and organised and first aid equipment is within date on Glyn Ward.
- The trust should ensure patient privacy and dignity is maintained on Glyn Ward and that physical health monitoring does not happen in communal areas of the ward.
- The trust should ensure maintenance issues are attended to in a timely way.
- The trust should ensure staff on Glyn Ward have opportunities to discuss issues together, such as at team meetings, so any problems related to the day-to-day running of the ward can be resolved.

## **Forensic inpatient / secure wards** (from December 2018)

- The trust should ensure that patients with long term conditions including diabetes have care plans in place which address their physical health needs.
- The trust should ensure that staff understand the escalation processes when the outcomes of physical health monitoring need to be brought to the attention of medical staff.
- The trust should ensure that seclusion records reflect the checks which have taken place according to the Mental Health Act Code of Practice and that any changes in the circumstances of seclusion are recorded.

# Summary of findings

- The trust should continue to ensure that the physical environment at Tony Hillis wing is maintained in a way that ensures patient care is prioritised.
- The trust should ensure that staff across the service have a good understanding of the Mental Capacity Act and feel confident in using it in the context of their work in forensic services.
- The trust should continue to ensure that staffing levels particularly of nursing staff on the wards, are maintained at a level so they do not impact on quality of patient care including access to leave.
- The trust should continue to ensure that concerns around quality of food for patients in the Tony Hillis wing is addressed and work on improving patient food for patients in those wards is prioritised.

## **Wards for older people with mental health problems** (from December 2018)

- The trust should review its efforts to recruit and retain registered nurses for the service.
- The trust should make sure care plans on Meridian Ward are completed to the same standard as those on other wards.
- The trust should make sure there is more equal access to therapeutic activities.
- The trust should make sure all staff have a record of their supervision to ensure this is provided at the frequency set out in its policy.
- The trust should make sure all ward signage meets the standard set by The Limes.
- The trust should make sure matrons have direct access to performance data for the services they manage.

## **Community-based mental health services for working age adults** (from December 2018)

- The trust should continue the work on the recruitment and retention of staff to ensure all teams have sufficient staff and caseloads are manageable.
- The trust should ensure risk assessments and care plans are updated following changes in circumstances. The trust should ensure care plans are personalised and reflect the patient's current circumstance. The trust was updating the electronic patient system to make this easier.
- The trust should ensure that Ealing West Recovery Team has robust risk systems in place to safely assess and manage patient risk.
- The trust should ensure that the physical health improvement work is embedded in all teams to ensure patients' physical healthcare needs are met.

## **High secure** (from June 2018)

- The trust should ensure that staff record capacity to consent to treatment clearly in patient records.
- The trust should ensure that nursing handovers share key risk information in a consistent manner for staff coming onto shift.
- The trust should ensure that staff across the hospital have a greater understanding and awareness of the Freedom to Speak Up Guardian role.
- The trust should ensure personal alarms are replaced in a timely way.

## **Community-based mental health services for older people** (from February 2017)

- The trust should ensure that the cognitive impairment and dementia service (CIDS) continues to implement actions to ensure nurse caseloads comply with the trust target.

# Summary of findings

- The trust should ensure there are clear actions in place in relation to improving the safety and suitability of the premises used by the Hammersmith and Fulham CIDS.
- The trust should ensure that all staff receive supervision in line with trust policy.
- The trust should ensure that action is taken to ensure waiting times for assessments do not exceed the agreed target of six weeks.

## **Community health inpatient services** (from November 2016)

- The trust should ensure that staff on Magnolia ward have access to regular team meetings.
- The trust should ensure that ongoing work takes place to engage staff and keep them informed especially while the service is going through further review and change.
- The trust should ensure that the service moves towards well organised patient records without a combination of paper and electronic records.
- The trust should ensure that managers have access to clearly presented performance information about all aspects of the service in an easy to understand format to inform their management work.

All 'musts' and 'shoulds' outstanding from inspections between 2016 and 2018 will be followed up at the next inspection of the relevant core services.

For more information see the areas for improvement section of this report.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as good because:

- There was a strong and stable board and senior leadership team who were capable, committed, accessible and very patient-focused. Leaders had taken decisive steps to address the requirements and recommendations from previous inspections and actions from Mental Health Act visits.
- The trust had a clear, well-communicated vision and was in the process of reviewing its current strategy with the participation of all stakeholders.
- The trust was committed to partnership working for the benefit of its patients and other health and social care organisations. It was an active member, often a leader, of numerous local and London-wide partnerships. Hounslow Safe Space was an attempt to relieve some pressure faced by local emergency departments and had the potential to improve the patient experience too.
- The trust had managed its finances well and was on schedule to meet its targets for 2019/20. When savings were necessary, they were not implemented in a way that compromised the quality of its services.
- Oversight and governance were well developed and the trust board and other senior leaders were well informed about the risks and challenges in all areas of the trust's work.



# Summary of findings

- The current leadership team had successfully delivered the new Broadmoor Hospital and patients had transferred without incident in a complex operation.
- The culture of the trust had improved beyond all recognition since 2015; there was a positive 'can do' attitude throughout the services we visited. Staff told us the trust had become a kinder place to work. New measures, such as a fair shifts allocation charter and restorative resolution for minor disciplinary matters had been introduced to increase fairness and reduce bullying and harassment.
- The trust was in a strong position with regard to the Workforce Race Equality Standard (WRES) but was not complacent.
- Recruitment had improved and the trust was creative in its approach. Whilst it remained an ongoing challenge, some wards now had a full complement of nursing staff for the first time in recent history. The trust had recruited some internationally educated nurses and their support to them was exemplary.
- There was good oversight of the application of the Mental Health Act and, the trust was in the process of increasing support around the Mental Capacity Act in anticipation of new legislation.
- The trust had sustained improvements it had previously made to the way it investigated and responded to complaints and serious incidents. Robust policies and procedures now underpinned practice.
- Health and safety had received even more focus and the staff team with the lead for this area had been strengthened. The trust was rolling out a new tool to assess the safety culture within teams. Ligation risks had been subject to scrutiny and mitigations and fire safety continued to be systematically reviewed.
- Repairs and maintenance had benefited from the introduction of new systems to streamline processes and the employment of a dedicated contracts manager.
- The trust had been assessed at 100% compliant (for the first time) with Emergency Preparedness, Resilience and Response (EPPR).
- Steps had been taken to make safeguarding systems as easy as possible for staff and central safeguarding team members were more visible within teams to provide advice and support.
- A clinical summary portal was being rolled out, with appropriate training, to help clinicians to formulate and manage patient risk.
- The trust had responded robustly to an audit by the Information Commissioners Office and there were multiple workstreams and a new team in place to ensure full compliance with all information governance regulations.
- Managers had much improved access to performance data which enabled them to monitor their service. The trust board received an aggregated integrated performance report which was clear and informative.
- The trust engaged well with its patients, staff and, increasingly, its carers. Co-production with patients and carers was well-developed and now reaching all parts of the trust. We saw some exceptional examples involving patients who had gained insight into their illness and been helped on their recovery journey as a result.
- Quality Improvement work was well established and expanding. The trust participated in 100% of the national audits for which it was eligible and conducted 21 trust-wide audits in addition, as well as local ones.
- The trust was continuing to work on reducing restrictive practices, despite the increased acuity of the patient group. The Safewards initiative was rolled out to the majority of relevant wards and incidents of restraint, rapid tranquillisation, seclusion and segregation were thoroughly reviewed.

However:

# Summary of findings

- Despite the excellent accommodation at the new Broadmoor Hospital, the trust still has a number of sites which are not fit for delivering modern health services.
- The trust had not paid sufficient attention to its child and adolescent mental health ward (The Wells Unit) whilst it was waiting for a decision from commissioners and this had led to a drop in standards. The trust gave six months' notice to NHS England to end the contract shortly after our site visit concluded.
- The trust had not yet fully implemented the accessible information standard.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jun 2020	Good ↔ Jun 2020	Outstanding ↔ Jun 2020	Good ↔ Jun 2020	Good ↔ Jun 2020	Good ↔ Jun 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

### Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Mental health	Requires improvement ↔ Jun 2020	Good ↔ Jun 2020	Outstanding ↔ Jun 2020	Good ↔ Jun 2020	Good ↔ Jun 2020	Good ↔ Jun 2020

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

### Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
<b>Overall*</b>	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2016	Good Feb 2017

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ Jun 2020	Good ↑ Jun 2020	Good ↔ Jun 2020	Good ↑↑ Jun 2020	Good ↑ Jun 2020	Good ↑ Jun 2020
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018
Forensic inpatient or secure wards	Good Dec 2018	Good Dec 2018	Outstanding Dec 2018	Good Dec 2018	Outstanding Dec 2018	Outstanding Dec 2018
Wards for older people with mental health problems	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Community-based mental health services for adults of working age	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Requires improvement Dec 2018
Mental health crisis services and health-based places of safety	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Specialist community mental health services for children and young people	Good ↑ Jun 2020	Good ↔ Jun 2020	Good ↔ Jun 2020	Requires improvement ↔ Jun 2020	Good ↑ Jun 2020	Good ↑ Jun 2020
Community-based mental health services for older people	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
High secure hospital	Requires improvement Aug 2018	Good Aug 2018	Outstanding Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Perinatal services	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
<b>Overall</b>	Requires improvement ↔ Jun 2020	Good ↔ Jun 2020	Outstanding ↔ Jun 2020	Good ↔ Jun 2020	Good ↔ Jun 2020	Good ↔ Jun 2020

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Specialist community mental health services for children and young people

Good 

## Key facts and figures

West London NHS Trust provides specialist community child and adolescent mental health services (CAMHS) to children from birth to 18 years old and their families living in the London boroughs of Ealing, Hammersmith and Fulham and Hounslow.

CAMHS services are divided into Tier 2 and Tier 3 services. Tier 2 services provide support to children and young people with mild to moderate emotional wellbeing and mental health problems.

Tier 3 services provide a specialised service for children and young people with more severe, complex and persistent mental health problems. These services consist of multidisciplinary teams in each borough working in three sub-teams providing specialist interventions. This included neurodevelopmental teams, adolescent teams and children and families' teams.

The Children and Families Team provides assessment and intervention for children and families aged 0-14 whose mental health is considered severe and complex and where there is significant impairment of function. The Adolescent Team provides assessment and intervention for adolescents and families aged 14-18 whose mental health is considered severe and complex. The Neurodevelopmental Team works with children and young people aged 6 to 17. It provides assessment for suspected neurodevelopmental conditions, such as Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder or Tourette's Syndrome, and post-diagnostic support and therapeutic intervention where there are co-morbid mental health difficulties.

This inspection looked at Tier 3 services provided by the trust.

Our inspection was short notice announced to ensure that everyone we needed to talk to was available.

Our inspection team for this core service comprised two CQC inspectors, three CQC inspection managers and five specialist professional advisors. We inspected the service over three days.

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 patients' needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the service. During this inspection we:

- toured the waiting area, appointment rooms and the working environment at the Heart of Hounslow, Ealing children and adolescent mental health teams (CAMHS) and Hammersmith and Fulham CAMHS
- interviewed the clinical director and the operational lead for the service
- interviewed the consultant psychiatrist team leads for each team

# Specialist community mental health services for children and young people

- spoke with 38 other members of the multi-disciplinary team and team managers, including a registered nurse, psychologist and child wellbeing practitioner
- interviewed 24 people who had used the service including young people, parents and carers
- reviewed the care records of 27 young people using the service
- spoke with members of partnership agencies to gain their feedback
- attended multidisciplinary team meetings and observed two clinical assessments
- reviewed records relating to the overall quality of the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had made the required improvements since our last inspection in November 2016. This included ensuring environments met young people's and visitors' needs, ensuring medical equipment worked, ensuring staff learnt from incidents and improved staff engagement across the children and adolescent mental health service.
- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly.

However:

- Some pathways within the service were not always easy to access. Some young people and families waited a long time for an assessment or to start treatment. In Ealing, the wait for 55 young people and their families to access a neurodevelopment assessment had been in excess of three years.
- Staff could not always access electronic records easily. We noted during the week of the inspection that there was a delay in staff being able to access documents that had been uploaded. Staff, particularly in Hounslow, commented on how the delays caused disruption to their work.

# Specialist community mental health services for children and young people

- Across the teams we visited, staff were recording children and young people's care and treatment plans and risk information in different parts of the trust electronic system. This meant there could be delays in accessing key information across teams.
- Staff identified as having responsibilities to develop user involvement felt they did not have enough protected time to complete this work.
- Some line managers were not confident in using the electronic system to upload supervision records and continued to maintain paper supervision records. This meant that data regarding the frequency and overall compliance with supervision was not accurate.

## Is the service safe?

**Good** 

Our rating of safe improved. We rated it as good because:

- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff regularly reviewed the effects of medications on each patient's physical and mental health. Staff followed a safe and secure process for storing and recording forms used for prescriptions.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Staff could not always access electronic records easily. We noted during the week of the inspection that there was a delay in staff being able to access documents that had been uploaded. Staff, particularly in Hounslow, commented on how the delays caused disruption to their work.
- Across the teams we visited, staff were recording children and young people's care and treatment plans and risk information in different parts of the trust electronic system. This meant there could be delays in accessing key information across teams.



# Specialist community mental health services for children and young people

## Is the service effective?

**Good** ●

Our rating of effective improved. We rated it as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

## Is the service caring?

**Good** ●

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.

## Is the service responsive?

**Requires improvement** ●

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Some pathways within the service were not always easy to access. Some young people and families waited a long time for an assessment or to start treatment. In Ealing the wait for some young people and their families to access a neurodevelopment assessment was up to three years.

# Specialist community mental health services for children and young people

However:

- The service's referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Staff followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Is the service well-led?

**Good** 

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. Staff reported high morale amongst the teams and felt supported by their senior leadership, including the new clinical director. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The trust had made improvements to their quality and performance data which was easily accessible to team managers.
- Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

However:

- Staff identified as having responsibilities to develop user involvement felt they did not have enough protected time to complete this work.
- Some line managers were not confident in using the electronic system to upload supervision records and continued to maintain paper supervision records. This meant that data regarding the frequency and overall compliance with supervision was not accurate.

# Specialist community mental health services for children and young people

## Outstanding practice

The service had worked hard on the transitions commissioning for quality and innovation (CQUIN) outcomes that they had to report on. The service had effective local protocols for joint working between agencies involved in the care of children and young people. Senior managers had completed a joint working protocol between children and adult mental health services to effectively support children and young people moving to adult services.

## Areas for improvement

Action the trust **MUST** take:

- The trust must ensure that it continues its work to ensure that children and young people can access assessment and treatment in the neurodevelopmental teams in a timely fashion. Regulation 17(1)(2)(a)

Action the trust **SHOULD** take:

- The trust should ensure that staff are able to access electronic records systems when they need them.
- The trust should ensure that staff are consistent in how information relating to children and young people's care plans, risk assessment and risk management is recorded in their care and treatment records.
- The trust should ensure that staff identified as having responsibilities to develop user involvement have sufficient protected time to complete this work.
- The trust should continue to support staff to utilise electronic supervision systems to ensure that accurate data regarding supervision frequencies and overall compliance is available.

# Child and adolescent mental health wards

Requires improvement 

## Key facts and figures

The Wells Unit is a Tier 4 medium secure forensic service, providing care and treatment to male adolescents aged between 13 and 18 years old. Patients receive care and treatment here if they have mental health needs and if they pose a serious risk of harm to self or others. The service is commissioned by NHS England.

The unit is located within Medway Lodge on the Three Bridges medium secure site and it is part of West London Forensic Services. The unit has ten bedrooms but is currently commissioned to provide care and treatment to a maximum of seven patients. On the first two days of our visit four patients were staying on the ward; one was discharged before the third day of inspection. All patients were detained under the Mental Health Act 1983.

We last inspected the service in October 2018 and rated the service as 'good' overall with 'outstanding' in effective.

At our last visit the unit was scheduled to decant to another ward temporarily whilst major refurbishment works were carried out. This was expected to happen in April 2019 but has been delayed due to ongoing discussion with commissioners about the future of the service. Since our last visit there has also been a change in the profile of patient needs, with more patients being admitted with conduct behaviour, as well as other mental health needs.

Due to the delay in refurbishing the ward, some reported incidents and the change in patient mix we decided to conduct a focused inspection to check whether these factors had had any impact on the quality of services. We looked at two of our key questions during this visit, to see how safe and well-led the service. Our on-site inspection was carried out over three non-consecutive days.

As this was a forensic ward, the trust received one week's notice of our visit. the trust advised us of some immediate changes they were planning to address concerns identified so we returned to check they had been implemented.

The team that inspected the service comprised of two CQC inspectors and two specialist advisors who had knowledge and experience of working in CAMHS and forensic services. To gain further assurance on what progress the service had made after we raised our initial concerns, two CQC inspection managers also visited the ward and spoke with senior staff. We inspected the service over three days.

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# Child and adolescent mental health wards

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 patients' needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the service. During this inspection we:

- completed two tours of the service (pre and post-repairs)
- spoke with two patients
- spoke with five registered nurses and two health care facilitators
- spoke with seven members of the nursing team as a group
- spoke with members of the multi-disciplinary team including the clinical psychologist, pharmacist and teachers provided by an external organisation,
- spoke to the ward manager and consultant psychiatrist
- spoke with the senior nurse and the service director
- spoke with the clinical director and the executive director responsible for this service
- observed a team handover and 'safewards' meeting
- looked at five care records for current patients and one previous patient
- reviewed a range of other documents, policies and procedures related to the service.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The ward environment was not fit for purpose. The ward did not provide a therapeutic environment. There were some poor lines of sight and measures to manage and mitigate the risks from these were not always followed. The seclusion room was inappropriately located. The building was waiting for refurbishment, but commissioners had not confirmed this could proceed. There were also some outstanding repairs, which were completed by the end of the inspection.
- Risk assessments and risk management plans needed further work to make sure they all joined up and there was no discrepancy between risk assessments and the plans to manage the risks. The service audited this immediately we told them there was a problem and acted on their findings.
- Further specialist training was needed to ensure that staff from diverse forensic and CAMHS backgrounds had the right skills and experience to meet the needs of patients.
- Whilst governance systems were in place, these were not operating effectively at ward level to ensure that performance and risk were managed well.

# Child and adolescent mental health wards

- Aspects of the service, such as repairs and maintenance, were not being attended to as promptly as they should have been. Some staff felt the ward had been left behind and they told us the refurbishment delays were frustrating and demoralising.
- It was not always easy to access historical records that related to patient care and treatment. Staff did not always maintain complete safeguarding records. Improvements were needed to ensure that learning from lower level incidents was always shared and the identified actions were implemented.

However:

- The wards had enough nurses and doctors. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider promoted equality and diversity in its day-to-day work. Staff felt able to raise concerns without fear of retribution.
- The trust has a strong track record in responding to inspection requirements and recommendations in a timely way. They addressed our concerns during the inspection period.

## Is the service safe?

**Requires improvement** ●

Our rating of safe went down. We rated it as requires improvement because:

- The ward environment was not fit for purpose. The ward did not provide a therapeutic environment. There were some poor lines of sight and measures to manage and mitigate the risks from these were not always followed. The seclusion room was inappropriately located. The building was waiting for refurbishment, but commissioners had not confirmed this could proceed. There were also some outstanding repairs, which were completed by the end of the inspection.
- Risk assessments and risk management plans needed further work to make sure they all joined up and there was no discrepancy between risk assessments and the plans to manage the risks. We found several examples where risks had not been anticipated and managed which had led to incidents. The service audited this immediately we told them there was a problem and acted on their findings.
- Further specialist training was needed to ensure that staff from diverse forensic and CAMHS backgrounds had the right skills and experience to meet the needs of patients. Patient safety incidents may have been reduced if staff had been better supported in assessing and managing risk whilst promoting patients' privacy and dignity.
- Staff did not always maintain complete safeguarding records. Whilst staff took appropriate action to address safeguarding concerns, improvements were needed in how these actions and their outcomes were recorded in patient care and treatment records.
- It was not always easy to access historical records that related to patient care and treatment, which could impact upon the quality and safety of care. Otherwise staff had good access to clinical information, and it was easy for them to maintain high quality clinical records.
- Improvements were needed to ensure that learning from lower level incidents was always shared and the identified actions were implemented.

# Child and adolescent mental health wards

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The team had access to a safeguarding lead.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The ward had learned from serious incidents and made improvements to safety as a result. The safewards initiative had been introduced. Regular safety huddles were also due to be introduced. Managers investigated incidents. When things went wrong, staff apologies and gave patients honest information and suitable support.
- Following feedback, the service implemented changes to make sure risk was at the forefront of all staff agendas. These changes took place before the end of the inspection period and we found staff were better informed as a result.

## Is the service effective?

**Outstanding** 

Our rating of effective stayed the same. We did not inspect the effective key question during this focused inspection.

## Is the service caring?

**Good** 

Our rating of caring stayed the same. We did not inspect the caring key question during this focused inspection.

## Is the service responsive?

**Good** 

Our rating of responsive stayed the same. We did not inspect the responsive key question during this focused inspection.

## Is the service well-led?

**Requires improvement** 

Our rating of well-led went down. We rated it as requires improvement because:

# Child and adolescent mental health wards

- Whilst governance systems were in place, these were not operating effectively at ward level to ensure that performance and risk were managed well. Leaders had not identified some of the issues within the unit, such as the disjointed way some of the risk assessment and risk management information was being used and the inconsistent recording of decisions about safeguarding.
- Aspects of the service, such as repairs and maintenance, were not being attended to as promptly as they should have been, because it was expected they would be solved by the delayed refurbishment. Some staff felt the ward had been left behind and they told us the refurbishment delays were frustrating and demoralising.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- The provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff felt able to raise concerns without fear of retribution.
- The trust has a strong track record in responding to inspection requirements and recommendations in a timely way and sustaining the associated improvements. They addressed our concerns during the inspection period and in March the trust board was due to decide about how the refurbishment and other matters could be taken forward with commissioners.

## Areas for improvement

We found areas for improvement in this service.

Action the trust **MUST** take to improve child and adolescent mental health wards:

- The trust must ensure the ward environment is fit for purpose and does not compromise the safety and wellbeing of patients or staff. Regulation 15(1)(c)(e)
- The trust must ensure that risk assessment and management processes are implemented effectively so clear plans are in place that deliver safe care and treatment in a timely way. Regulation 12(1)(2)(a)(b)(c)
- The trust must ensure that governance systems deliver effective assurance that safe and effective care and treatment is delivered to patients. Regulation 17(1)(2)(a)(b)(c)

Action the provider **SHOULD** take to improve child and adolescent mental health wards:

- The trust should ensure that staff receive appropriate specialist training so that safe, effective care and treatment is delivered to patients.
- The trust should ensure that learning from lower level incidents is shared with the team and that lessons learnt are implemented.
- The trust should ensure that the actions and outcomes in relation to safeguarding concerns are appropriately recorded.
- The trust should support staff to ensure that they can access all information relating to patients' historical care and treatment.



# Acute wards for adults of working age and psychiatric intensive care units

Good 

## Key facts and figures

The acute wards for adults of working age and psychiatric intensive care units (PICU) provided by West London NHS Trust are part of the trust's local services clinical service unit. The wards are situated on three sites, Lakeside Mental Health Unit, St Bernard's and Hammersmith and Fulham.

Lakeside Mental Health Unit (MHU) has four acute wards for adults of working age: Grosvenor Ward accommodates up to 17 female patients, Kingfisher Ward accommodates up to 20 male patients, Finch Ward accommodates up to 17 female patients and Kestrel Ward accommodates up to 19 male patients.

Hammersmith and Fulham Mental Health Unit (MHU) has three acute wards for adults of working age: Ravenscourt Ward accommodates up to 20 male patients, Avonmore Ward (innovation ward) accommodates up to 20 male patients, Lillie Ward (innovation ward) accommodates up to 16 female patients. Askew Ward is a PICU; it has 12 beds and is for men only.

St Bernard's Hospital has two acute wards for adults of working age. Horizon Ward has 14 beds for male patients. Hope Ward has 17 beds for female patients.

The last inspection of the service took place in January 2018. At that focused inspection, we did not re-rate the acute wards for adults of working age and psychiatric intensive care units.

The last comprehensive inspection of the service took place in November 2016. At that inspection, we rated acute wards for adults of working age and psychiatric intensive care units as requires improvement overall.

This inspection was announced at very short notice. Our inspection team for this core service comprised of CQC inspectors, pharmacist inspectors, CQC inspection managers, an expert by experience (a person or carer with direct experience of this sort of service), Mental Health Act reviewers and specialist clinical advisors.

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 patients' needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were interacting with patients
- spoke with 44 patients who were using the service
- interviewed all ward managers, three matrons, the service manager for Lakeside MHU and the deputy head of operations

# Acute wards for adults of working age and psychiatric intensive care units

- spoke with 58 other staff members individually, including doctors, registered mental health nurses, clinical support workers, activity coordinators, occupational therapists, domestic cleaning staff, pharmacy and clinical psychologists; this included some staff who work predominantly at night
- reviewed 40 care and treatment records
- observed two multidisciplinary team meetings, two community meetings for patients, three patient safety huddles, three shift handovers, one seclusion briefing, one senior and managers' meeting, one music group session, two bed management meetings and one social café group
- carried out a specific review of medicines management on Askew PICU, Kestrel, Finch, Kingfisher and Ravenscourt wards; we also reviewed medicine administration charts across all the wards
- looked at a range of trust policies, procedures and other documents relating to the running of the service
- completed Mental Health Act review visits to Finch and Avonmore wards; these were reported on separately to the trust.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and usually followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Improvements were needed to ensure that patients who received rapid tranquilisation had appropriate physical health checks completed afterwards.
- Whilst the service had systems and processes in place to safely prescribe, administer, record and store medicines, further work was needed to ensure staff always followed these.
- Some staff on Askew Ward were not using personal alarms. A few staff on this ward told us they did not feel safe on the ward and managers were investigating their concerns.
- Further work was needed to fully embed the training in safeguarding staff had received into practice.
- Improvements were needed in how staff on Kingfisher Ward reported incidents where the patient had been restrained.

# Acute wards for adults of working age and psychiatric intensive care units

- The current audit programme had not identified issues with medicines, administration of rapid tranquilisation, reporting of restraint and Mental Health Act documentation that we found during the inspection.
- Improvements were needed to ensure that all staff discharged their responsibilities under the Mental Health Act well. For example, staff did not always update records to show that patients had been explained their rights in a timely manner.

## Is the service safe?

**Requires improvement** ●

Our rating of safe stayed the same. We rated it as requires improvement because:

- Improvements were needed to ensure that patients who received rapid tranquilisation had appropriate physical health checks completed afterwards.
- Whilst the service had systems and processes in place to safely prescribe, administer, record and store medicines, further work was needed to ensure staff always followed these.
- Some staff on Askew Ward were not using personal alarms. A few staff on this ward told us they did not feel safe on the ward and managers were investigating their concerns.
- Further work was needed to fully embed the training in safeguarding staff had received into practice.
- Improvements were needed in how staff on Kingfisher Ward reported incidents where the patient had been restrained.

However:

- Wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff regularly reviewed the effects of medication on each patient's physical health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and mostly reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

## Is the service effective?

**Good** ●

Our rating of effective improved. We rated it as good because:

# Acute wards for adults of working age and psychiatric intensive care units

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented
- Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers had made sure that staff explained patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the trust's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The current audit programme had not identified issues with medicines, administration of rapid tranquilisation, reporting of restraint and Mental Health Act documentation that we found during the inspection.
- Improvements were needed to ensure that all staff discharged their responsibilities under the Mental Health Act well. For example, staff did not always update records to show that patients had been explained their rights in a timely manner.

## Is the service caring?

**Good** 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Good** 

# Acute wards for adults of working age and psychiatric intensive care units

Our rating of responsive improved. We rated it as good because:

- Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could access hot drinks and snacks at any time.
- Staff supported patients with activities outside the service, such as work, education and family relationships.
- The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

## Is the service well-led?

**Good** 

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

## Areas for improvement

Action the provider **MUST** take to improve:

- The trust must ensure that patients' who receive rapid tranquilisation have appropriate physical health checks completed afterwards. Regulation 12(1)(2)(a)(b)
- The trust must ensure that all staff follow trust systems and processes when administering, recording and storing medicines. Regulation 12(1)(2)(g)

Action the provider **SHOULD** take to improve:

- The trust should ensure that all staff on Askew Ward use personal alarms. The trust should also ensure that staff concerns regarding safety on this ward are addressed.

# Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that it continues its work to fully embed the training in safeguarding staff had received into practice.
- The trust should ensure that improvements are made in the way staff on Kingfisher Ward record incidents that involve restraint.
- The trust should ensure that the current audit programme is strengthened so that it provides robust assurance regarding medicines, administration of rapid tranquilisation, reporting of restraint and MHA documentation.
- The trust should ensure that all staff discharge their responsibilities under the Mental Health Act well, including maintaining records to show when patients' rights had been discussed with them.

# Perinatal services

Good 

## Key facts and figures

The West London tri-borough perinatal mental health service was set up in 2016 by West London NHS Trust. It operates as a single service with team offices in three London Boroughs: Ealing, Hounslow and Hammersmith and Fulham.

Staff provide assessment, care and treatment to women with mental health needs during pregnancy, at the time of birth and the year after birth. Pre-conception consultations are also available. Staff support women and their families by providing information and advice, holistically assessing needs and ensuring effective and well-coordinated care and treatment.

The service leads on strategic and developmental work with partner agencies to ensure effective care pathways for women with mental health needs in the perinatal period.

The trust does not provide an in-patient perinatal mental health service.

This was a comprehensive inspection which was announced five working days in advance to ensure that everyone we needed to talk to was available.

The CQC has not previously inspected this service.

The inspection team comprised a CQC inspector and a specialist advisor, who was a nurse with knowledge and experience of perinatal mental health services.

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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?

# Perinatal services

- Is it caring?
- Is it responsive to patients' needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the service. During this inspection we:

- visited the Ealing and Hounslow team offices
- spoke with the service manager, the lead consultant manager and a team manager
- spoke with two experts-by-experience who worked with the service and had direct knowledge of the service provided
- spoke with seven staff, including consultant psychiatrists, nurses, a psychologist and a social worker
- spoke with a specialist midwife who had knowledge of the service
- reviewed five patient care and treatment records, including risk assessments and care plans
- read a range of policies, procedures and other documents relating to the operation of the community mental health teams.

## Summary of this service

We rated this service as good because:

The leaders of the service had the vision, capability and drive to ensure that care pathways for women with perinatal mental health continually improved.

- Patients and partner organisations reported that staff were skilled, caring and motivated.
- Partnership work with other agencies was well-developed at both the strategic and operational level. The service led on work with other organisations to improve the care pathway. There were clear operational policies and referral systems and working relationships were positive.
- Staff organised pre-birth planning conferences which were very effective in ensuring that patients with severe and enduring mental health problems and their infants received holistic care and support.
- Staff were fully aware of the diverse cultural background of patients. They worked sensitively with patients and their support network to provide effective support. Patients said their views were always respected.
- The service had a proven track-record of successful and creative work in partnership with experts-by-experience to develop the service.
- The service responded promptly to crisis situations and managed risks effectively. Staff ensured that any safeguarding concerns were acted on.
- Staff reported an open and supportive team culture with many opportunities to learn and develop their skills.

## Is the service safe?

**Good** 



# Perinatal services

We rated safe as good because:

- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients, children and others well. They responded promptly to sudden deterioration in a patient's health. Staff worked with patients, their families and other agencies to develop pre-birth plans, crisis plans and plans for managing risks during the perinatal period. Staff monitored patients and responded to increases in level of risk.
- Staff understood how to protect patients and children from abuse and the service worked well with other agencies to do so.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The teams had a good track record on safety. Staff recognised incidents and reported them appropriately. Staff followed the trust's personal safety protocols.

## Is the service effective?

**Good** 

We rated effective as good because:

- Staff comprehensively assessed the mental health needs of patients who were pregnant or who had an infant under one year old. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients. This was based on national guidance and best practice for patients with perinatal needs. Staff ensured that patients and infants had good access to all the care and support they needed to promote their health and wellbeing.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives.
- Each of the three teams had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The service had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly.

# Perinatal services

## Is the service caring?

**Good** ●

We rated caring as good because:

- Staff consistently treated patients with a kindness and respect. They fully understood the individual needs of patients.
- Staff empowered patients to understand their mental health needs and manage their care and treatment during their pregnancy, at the time of birth and up until their infant was one year old.
  - Staff always involved patients in pre-birth care planning and actively sought their feedback on the quality of care provided.
  - Staff ensured that families and carers were supported appropriately.
  - The service had developed an expert-by-experience group which ensured patient involvement in every aspect of the team's ongoing work and service development.

## Is the service responsive?

**Good** ●

We rated responsive as good because:

- The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care for women with perinatal mental health needs.
- The service had clear referral criteria and the service was easy to access.
- Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed-up patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Is the service well-led?

**Good** ●

We rated well-led as good because:

- Leaders had the experience, enthusiasm and capability needed to deliver care and treatment and drive improvement across the pathway for perinatal mental health.
- Staff were highly motivated and felt respected, supported and valued by their leaders. They reported that the provider promoted equality and diversity in its day-to-day work and provided opportunities for career progression.
- Our findings from the other key questions demonstrated that governance processes were effective at team level and that performance and risk were managed well.

# Perinatal services

- Leaders had ensured that experts-by-experience were supported to be fully involved in the development of the service.
- The service was well-regarded by patients and partner organisations.
- Leaders recognised the importance of analysing data about outcomes and were making improvements in this area.
- The service engaged actively in local and national quality improvement activities. Leaders acted to improve the service in response to external reviews of the service.

## Outstanding practice

The service had supported and developed an experts-by-experience group. The well-established group met regularly with leaders of the service to advise on service delivery and development.

The group had co-produced a range of information materials to promote the service. This included leaflets, a video and web pages. Additionally, experts-by-experience had contributed to the development of care pathways locally and across London through participating in training and networking events.

Experts-by-experience also designed greetings cards for the service to send when patients give birth.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### 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

#### 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

# Our inspection team

Helen Rawlings, Head of Inspection, led this inspection. An executive reviewer, Martin Gower, Chair of Midlands Partnership NHS Foundation Trust, supported our inspection of well-led for the trust overall. The team included 21 CQC inspection staff, nine specialist advisers, and an expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.