

# West London NHS Trust

## Inspection report

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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.

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.

## Ratings

### Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

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

## Background to the trust

This trust changed its name midway through our inspection, from West London Mental Health Trust to West London NHS Trust, to better reflect the range of services provided.

The trust serves a population of 800,000 people across the London Boroughs of Hammersmith and Fulham, Ealing and Hounslow. It employs more than 3,300 staff. Staff provide care and treatment for around 99,000 people and answer over 50,000 calls to the trust helpline every year. The trust has a turnover of £263 million and, after adjustments, made a surplus of just over £6 million in 2017/2018. 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). It also provides some local community healthcare services, in some cases it is subcontracted to do so by another NHS trust. The trust is about to expand its community healthcare provision.

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 (these services extend to the London Borough of Brent)
- Community health inpatient services

The trust also provides the following services:

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

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, Hounslow and child and adolescent mental health services in Brent.

The trust has been inspected seven times since 2015. We conducted a comprehensive inspection of the trust in 2015 and another which was published in 2017.

In 2015 we found the high secure hospital and forensic services to be inadequate (at that time they were inspected together as one service), three services were rated as requires improvement and the other five as good. We rated the trust as requires improvement overall; the main concerns were staffing levels, the use of restrictive practices and poor staff engagement. The trust's configuration of community services has changed since then so it is difficult to make direct comparisons between 2015 and 2018 for those services.

# Summary of findings

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 due to their inadequate rating in 2015. This was a focused inspection so they were 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 to check whether a warning notice we had issued for staffing could be lifted. and to follow up some incidents that had been reported. We found there had been improvements to staffing, but we issued a requirement notice because the data in respect of patient activities was poor quality. 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 remains in place.

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 5 – Fit and proper persons: directors
- Regulation 9 – Person centred care
- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding
- Regulation 15 – Premises and equipment
- Regulation 17 – Good governance
- Regulation 18 - Staffing

As a result we asked the trust to make improvements to some of the ward and clinic room environments and how they were safely managed; use of the Mental Capacity Act and Deprivation of Liberty Safeguards; record keeping; physical healthcare checks; the high use of physical restraint and restrictions to manage patients' behaviour; the availability of accurate up-to-date information about the performance of teams and wards; the low rates of staff supervision; low staffing levels due to difficulties with recruitment and poor staff morale and the recruitment checks for non-executive directors. Some issues only affected specific services.

## Overall summary

**Our rating of this trust improved . We rated it as Good** ● ↑

# Summary of findings

## What this trust does

West London NHS Trust provides mental health and an increasing range of 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.

## 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 six services as part of our ongoing checks on the safety and quality of healthcare services:

- Forensic inpatient/secure wards
- Mental health crisis services and health based place of safety
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Child and adolescent mental health ward
- Community-based mental health services for adults of working age

An inspection of Broadmoor hospital took place in June 2018 in order to fit in with the re-licencing of all the high secure hospitals by the Secretary of State for Health and Social Care. CQC inspection findings are taken into account during this process (which is still in progress).

We did not re-inspect acute wards for adults of working age and psychiatric intensive care units, as we carried out a focused inspection in January 2018 to look at some specific aspects of the care and treatment provided on these wards. As it was a focused inspection we did not re-rate this core service at that time so the original rating remains in place. However, whilst we identified significant improvements, we asked the trust to act to address a few concerns. They have indicated that these issues have been resolved, but we will return at a later date as we want to check the improvements are sustained.

## What we found

### Overall trust

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

# Summary of findings

- We inspected five key questions for seven core services; a total of 35 key questions. The rating improved for 21 key questions and for two questions it went up by two ratings. Two ratings decreased from good to requires improvement, but the overall picture was of a trust that had made significant improvements.
- At this inspection we rated one service as outstanding, four services as good and two services as requires improvement. The two largest inpatient services provided by the trust, forensic and high secure, were outstanding and good. Forensic services had improved from inadequate to outstanding within a three year period.
- When these ratings were combined with the other existing ratings from previous inspections, there was one outstanding service, five good services and four services requiring improvement.
- We carried out a focused inspection of acute wards for adults of working age and psychiatric intensive care unit, one of the services requiring improvement, in January 2018. This service was not re-rated as we only looked at specific issues, but we found that it had made significant improvements in key areas. At a time of high pressure on acute mental health beds in London, the trust was able to provide patients with access to a bed when needed. Bed occupancy on the acute wards was at 87% and patients were no longer being placed in beds outside the trust unless they required a specialist service not provided by the trust. This was a major improvement since our inspection in 2017 when acute patients had to sleep in the trust's rehabilitation wards, and the improvement had been sustained throughout 2018. This is not evident from the current rating for acute services which pre-dates the improvement.
- We rated well-led for the trust overall as good.
- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to make the necessary changes to provide high quality care to their local communities.
- The trust had a strong, cohesive senior leadership team which had succeeded in changing the culture of the organisation for the better and which was well regarded by trust staff and external organisations. The chief executive officer was recognised as an inspiring leader.
- The board had good oversight of all operational issues. The system of committees and sub-committees ensured that both achievements and concerns were escalated appropriately. There were comprehensive clinical governance arrangements in place which were inclusive of staff and patients. We found senior leaders already had plans in place to address all but one of the concerns we identified.
- The trust had a strong grip on its finances. In 2017-18 the trust fully delivered on its £9.4m cost improvement plans (CIPs). It had reduced its agency spend and was working to drive it down further.
- The trust was fully committed to working in partnership with patients and, increasingly, carers. There were many examples of coproduction. For example, the design and delivery of training and staff induction. Patients were involved in the development of their care and treatment plans, as well as ward matters and clinical governance. The trust engaged effectively with inpatients, outpatients and the local community.
- Patients were actively encouraged, through paid and other opportunities, to get involved in service development. Patient representatives were supported to participate in a range of meetings and events and de-briefed afterwards. There were similar opportunities for carers. Senior leaders led by example and worked closely with patients and carers at meetings and on projects.
- Staff engagement (as shown by the staff survey) had improved. The experience of doctors in training was now positive (as shown by the General Medical Council survey). Leaders were very visible within the trust. The trust prompted staff to raise concerns with support from the Freedom to Speak Up Guardian. There was low take up to date, but local champions had been recruited to start raising awareness. Staff told us they had lots of different opportunities to raise issues with management.

# Summary of findings

- The trust was committed to improving the safety of staff, patients and the wider community and there were a number of initiatives and programmes in place to try to achieve this. The arrangements for lone-working in the community had improved and good relational security was now well established in forensic services.
- The trust was actively participating very effectively in local care systems and with NHS partners and academic institutions to drive progress and develop new models of care, such as community mental health rehabilitation services. The trust's participation in the North London partnership for forensic services meant that an increasing number of patients were receiving their care closer to home.
- The trust had succeeded in becoming a learning organisation; staff learned from success and also when things went wrong. This was achieved through mortality review meetings, clinical improvement meetings, team meetings, supervision, newsletters and emails. A trust-wide learning from experience event was scheduled to take place soon after our inspection.
- Staff at all levels were supported to enhance their skills and knowledge through a wide variety of training, mentoring and coaching opportunities. Courses ranged from popular two-hour sessions to professional qualifications.
- The trust had invested in the development of leadership skills. It offered all staff employed at band 3 or above the opportunity to develop them. In order to address the under-representation of black and minority ethnic (BME) staff in leadership roles, specific training was available for this group of staff. Graduates from the programme attended a BME forum and were consulted about issues relating to BME under-representation. The trust ensured a person with a BME background was present on all interview panels for staff at band 8 or above.
- The trust was recognised as a Stonewall champion and had an active lesbian, bisexual, gay, transgender (LGBT+) network and made a point of being inclusive of all sexual orientations. The chief executive was included in the Financial Times 2017 OUTstanding Global Leading Public Sector LGBT+ executives list. Rainbow lanyards were in use to let patients know who they could approach if they wanted to discuss their sexuality or gender identity. We heard how the trust was working on some guidance about meeting the needs of individuals who identified as transgender.
- The trust maintained a high level of compliance with mandatory training. It made it compulsory for all mandatory training to be up-to-date before specialist training could be accessed.
- The trust worked to improve the quality of patients' lives in hospital and in the community. Patients were supported to understand their condition and to acquire vocational skills and academic qualifications. The recovery college operated from a central base in west London and convenient satellite sites and Broadmoor had its own recovery college.
- Staff and patient successes were celebrated. Teams and staff who had 'gone the extra mile' for patients were recognised by senior leaders and colleagues. There were regular awards and events for both patients and staff and they told us they felt valued as a result.
- The trust had a range of measures in place to support staff returning to work from long-term sick leave and was particularly mindful of the needs of staff who had been injured at work. Affected staff told us they could not fault the support they received.
- The trust supported staff, patients and carers to develop the skills and knowledge required to carry out quality improvement work. Many projects were underway and the trust was making progress with coordination and monitoring outcomes.

# Summary of findings

- Clinicians were fully involved in digital developments to make sure they were fit for clinical use. We saw how the electronic patient information system was regularly adjusted to better capture important information, such as physical health checks. The trust had just introduced a new dashboard which showed managers how their ward or team was performing. A manager who was an early-implementer showed us its potential, but training was still being rolled out so its impact could not be fully assessed.

However:

- Whilst we found significant improvements in most of the teams and wards we inspected, in most core services there was at least one team or ward which was not up to the standard of the rest. This lack of consistency impacted on the ratings we could award. The trust were aware that these wards and teams needed to improve and additional support was being provided.
- Recruitment and retention of staff remained an issue for the trust; matters were improving and the trust was finding some creative solutions, but there was still a negative impact on the workload of some teams and the continuity of patient care.
- The Tony Hillis wing at St Bernard's hospital, which was the site for several inpatient services and other facilities, was not a suitable place to provide modern healthcare. It presented risks to the health and well-being of patients due to antiquated electrical, plumbing and heating systems which required constant repair and the number of ligature anchor points that had to be monitored. Parts of the current Broadmoor Hospital were also not fit for purpose, although a new hospital was being built next door.
- The trust did not have good oversight of the performance of its health-based places of safety. In part, this was because activity within the three suites was mainly reported via the wards from which staff were drawn to work in them. This meant most of the data gathered was absorbed into the ward data and was not easily identifiable as data related to the health-based places of safety.
- The trust needed to make sure there was more consistency in the storing of patient records, both paper and electronic. Staff kept records, but not always in the same place as their colleagues which made them hard to find, especially in an emergency situation.

Our full Inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – [www.cqc.org.uk/provider/RKL/reports](http://www.cqc.org.uk/provider/RKL/reports).

## Are services safe?

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

- At this inspection we rated safe as requires improvement in six of the services and good in the one service. When these ratings were combined with the other existing ratings from previous inspections, eight of the trust services were rated requires improvement and two were rated good. In part, this reflected the lack of consistency across many of the services. We found plenty of good practice amongst most teams, but poor practice by a few weaker teams meant that we could not award a higher rating.
- Staff recruitment and retention had improved, but there was still an impact on the workload of some teams and professions and the quality and continuity of patient care. Some caseloads, for example in the Ealing Early Intervention Service, were almost twice as large as the recommended size.
- The Tony Hillis wing at St Bernard's and parts of Broadmoor hospital were not fit for the delivery of modern healthcare. There were plans to replace or refurbish both, but in the meantime patients and staff were having to cope with buildings that only increased risk.



# Summary of findings

- Seclusion, when used, was not always reviewed in line with the Mental Health Act Code of Practice and it was not always clear why.
- Risk assessments and risk management plans were not always updated following incidents, for example, in the trust's crisis services. This was necessary for teams working on a shift system supporting people during a mental health crisis. All staff needed to be able to see the latest information at a glance.
- Records, both electronic and paper were not always stored consistently. Staff in the same team stored similar records in different places, making it hard to find, especially in an emergency.
- There were some recording issues in relation to the length of time patients were spending in the health-based places of safety. Staff were not accurately recording the detention start time. It was not clear whether multidisciplinary reviews were always taking place during episodes of seclusion.
- The pharmacy staffing levels were not always sufficient to make sure all aspects of medicines safety were covered, particularly in teams based in the community.
- Some teams were not operating safely. For example, Ealing West Recovery Team had been identified as in need of support and plans were in place to strengthen the team. In the meantime, the waiting list was not being closely monitored and caseloads were unmanageable.

However:

- The trust was working creatively to increase recruitment and retention. For example, it had commissioned an external organisation to conduct exit interviews to find out the real reasons for staff leaving and had made changes as a result. A workforce plan was closely monitored through a sub-committee of the board.
- In services where restrictive interventions took place, the trust was working hard to reduce them. Many blanket restrictions had been lifted and, where they remained, staff and patients recognised them and understood why they were needed.
- The trust achieved a high uptake of mandatory training. Staff could not access specialist training until they had completed all mandatory courses. Wards and teams with the highest rate of compliance were entered into a prize draw.
- Lone-working procedures had been strengthened and new trackers had been introduced for staff working in the community and this improved staff safety.
- The facilities for delivering primary healthcare services to forensic patients were excellent. The primary healthcare centre was fully equipped and included a dental surgery.

## Are services effective?

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

- At this inspection we rated effective as outstanding in two of the services, good in four services and requires improvement in one service. When these ratings were combined with the other existing ratings from previous inspections, two of the trust services were rated outstanding, six were rated good and two required improvement.
- Patients' mental and physical health was assessed on or soon after admission or first appointment and care plans reflected the needs identified.
- The trust made sure care and treatment was in line with national guidance and best practice. Patients had timely access to psychological therapies and other recommended therapeutic interventions.



# Summary of findings

- The trust had made substantial progress in relation to screening and monitoring patients' physical health. For example, they had introduced physical health clinics in their community-based mental health services for patients who found it difficult to engage with their GP services.
- The trust worked hard to encourage patients to make healthy lifestyle choices. For example, a range of age-appropriate challenges and rewards were in place on the child and adolescent mental health unit.
- The trust ensured that staff received an annual appraisal of their performance.
- The trust made sure staff in the majority of services received regular supervision and many staff also participated in reflective practice sessions. In contrast, staff working on the rehabilitation wards and one of the older people's wards did not receive supervision at the frequency outlined in the trust's own policy.
- The trust had electronic records systems in place which enabled relevant staff to access patient notes. Inpatient services could see what care and treatment patients had received from other trust teams prior to admission and community teams could access notes from inpatient stays.
- The trust had strong multidisciplinary teams and members worked well together for the benefit of patients. There was evidence of close working with GPs and other agencies and information was shared appropriately.
- Trust staff were, on the whole, very well informed about both the Mental Health Act and the Mental Capacity Act and, in relevant services, about issues of consent for children and young people. Good practice was underpinned by advice, support and training from experienced staff in the Mental Health Act office.

However:

- There were inconsistencies between the two rehabilitation wards which meant patients on one ward received more educational and vocational opportunities and more focused recovery plans than patients on the other ward.

## Are services caring?

Our rating of caring improved. We rated it as outstanding because:

- At this inspection we rated caring as outstanding in two of the services and good in five services. When these ratings were combined with the other existing ratings from previous inspections, three of the trust services were rated outstanding and seven were rated good.
- The trust promoted patient involvement at every opportunity. Patients were supported to get involved in service development and in decision-making about their own care and treatment. Staff at all levels worked in partnership with patients and, increasingly, carers. Patients were involved in staff recruitment.
- Trust staff helped both patients and carers to understand mental health conditions and their treatment, through informal discussions, meetings and courses at the trust's recovery college.
- The trust paid peer support workers and service user consultants to assist them with quality improvement projects, to co-produce and co-deliver training and to become involved in many other projects. Patients told us this was inspirational and gave them hope for their own recovery.
- The trust worked very effectively with an external organisation to get patient feedback on their services and to coproduce a range of events, publications and internal documents. They successfully engaged with both inpatients and patients in the community.
- Trust staff treated patients with kindness, compassion and respect. There were many opportunities for patients to make their views known. For example, senior managers attended the monthly patients' forum at Broadmoor and action plans were in place to address issues raised.

# Summary of findings

- The trust held various carers meetings and, with patients' consent, worked in partnership with carers to support recovery using a model called 'triangle of care'. Both patients and carers were involved in a crisis care forum where they were encouraged to provide honest feedback on the support they had received during a mental health crisis.

## Are services responsive?

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

- At this inspection we rated responsive as good in six of the services and requires improvement in one service. When these ratings were combined with the other existing ratings from previous inspections, seven of the trust services were rated good, two were rated requires improvement and one was rated inadequate.
- In January 2018 we carried out a focused inspection of the acute wards and psychiatric intensive care unit that were inadequate for the responsive key question to see if they had improved. We did not re-rate the service as we only looked at specific issues, but we found that there had been significant improvements to the experience of patients using these services. Patients now had access to a bed when needed and most were being discharged in a timely manner. Patients who were admitted for acute care were no longer sleeping on non-acute wards. Bed occupancy on the acute wards was at 87% and patients were not placed in beds outside the trust unless they needed a specialist service not provided by the trust.
- The trust had systems and resources in place to support good discharge planning. For example, discharge planning started at the point of referral in many of the services and the trust worked effectively in partnership with other organisations to make sure there were robust community options.
- The trust had made it easy for people to contact the trust for help and support through the single point of access. Patients told us they could get help by phone when needed. The crisis assessment and treatment teams (CATTs) had recently extended their working hours and now provided a 24/7 service in response to patient need.
- The trust provided patients with opportunities for education and vocational training tailored to their needs. The West London recovery college had moved to a new base in the community, but also operated a number of satellite sites and there was a recovery college at Broadmoor too. Many courses were co-designed and co-delivered with patients or carers.
- The trust had an inclusive approach. For example, patients could identify staff who could be approached if they wanted to discuss issues related to sexuality and gender identity because they wore rainbow coloured lanyards. Patients in high secure services who wanted to support their peers in this way had piloted the use of rainbow wristbands. Following this successful initiative, the wristbands were due to be made available to other patients in February 2019.
- The trust's complaints procedure was widely publicised and complaints were responded to in line with the standards laid out in the trust's policy. Any lessons learned were shared with the relevant team and, when appropriate, trust-wide.

However:

- The recovery teams were not meeting the trust's 28 day target to see the patient for their initial assessment from the day of their referral.

## Are services well-led?

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

# Summary of findings

- There had been a sustained improvement in staff engagement and morale. Staff felt respected, valued and proud to work for the trust. Staff were willing to go the extra mile to meet the needs of patients and this work was being recognised and celebrated. This was reflected in the improved engagement scores for the previous two years in the staff survey and in the General Medical Council (GMC) survey where medical trainees were very positive about the support they received from the trust.
- The chief executive was recognised as being an inspirational leader who had championed many of the improvements taking place. People internal and external to the trust said how much they respected the work she had led and the collaborative manner in which this had been done. Clinicians were now engaged in the work of the trust, for example, clinicians were leading on the development of trust strategies and in the development of information systems.
- The culture of the trust had improved and was more open and transparent. Staff felt able to raise concerns without fear of retribution and had access to the Freedom to Speak Up Guardian where needed, although the numbers of staff accessing this support were quite low. The trust did not have a blame culture and positively supported staff to learn from when things went wrong.
- Senior leaders were visible and approachable and recognised the importance of visiting services and speaking to people who use those services, their carers and staff. This was now central to the role of the leadership team. Other engagement took place including listening events, leadership blogs and an improved website and intranet.
- The trust had a clear vision that was recognised and put into practice by staff throughout the organisation. Whilst work on the trust strategy was not yet complete, there was a clear sense of direction with a desire to provide integrated physical and mental health care services within their current geographical areas. This was reflected in the recent change to the name of the trust to make it clear that it was not just providing mental health services.
- The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust was working well with other stakeholders including regulators, commissioners, other providers and third sector organisations to improve services for people with physical and mental healthcare needs within the geography served by the trust.
- Collaborative work with people who use services was integral to the operation of the trust. This led to a range of co-produced initiatives to enable patients to be actively involved in improving the delivery of care and promoting opportunities to enable people to develop skills and become more independent. For example, in the high secure, forensic and one rehabilitation ward people were accessing a wide range of educational and employment opportunities.
- The trust was very clear about the risks they were facing and had management plans showing how these were being managed. These plans identified who had responsibility for the necessary actions and the assurance processes in place.
- The trust was working to improve career progression and address discrimination for black minority ethnic (BME) staff. This included an award winning BME leadership development programme. The trust also had a visible and active LGBT+ network. It was recognised that there was more to do and that further networks, such as for staff with lived experience, were just getting started.
- Staff had good access to a range of learning and development opportunities. For example, any staff in band 3 roles or above who aspired to or were already in leadership or management roles were supported to extend their skills and knowledge. The trust took full advantage of established schemes, such as Capital Nurse, to enhance opportunities for new or existing staff, as well as local initiatives, such as their 'two hours to learn' sessions.
- The trust was making progress with their quality improvement programme and had set ambitious targets going forward. Staff across the trust felt engaged in this work.

# Summary of findings

- The trust had invested in systems to manage information, particularly relating to patient care to provide staff at different levels of the organisation with the data they needed to deliver services and gain assurance. Further work was needed to develop the system and support staff to understand and make good use of the data.
- The trust had a strong grip on its finances. An example of a sustained improvement had been the reduced use of paying for inpatient beds in the independent sector. This was because of the hard work undertaken to manage the flow of patients accessing services for acute mental health needs. This had also improved the quality of care for patients as they received their treatment locally and did not need to move between services.

However:

- There were several areas where work had started but further improvements were needed. This included ensuring all staff had regular supervision; implementing staff networks especially for people with lived experience, completing the implementation work on the accessible information standards, improving the systems to manage serious incidents so they are addressed in a timely manner, ensuring service lines were effectively providing assurance, delivering high quality training for Mental Health Act hospital managers, ensuring maintenance and IT issues are addressed in a timely manner and staff were kept informed of progress. In all these cases the trust was aware of the issue and was actively working to make the necessary improvements.

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## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them 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 most of the trust's services. The trust worked in partnership with patients to involve them in their care and treatment plans, to get their views on how the services were run and to help improve services. The commitment to meaningful patient involvement was impressive and seen throughout the trust.

There were specific areas of outstanding practice in many of the services. For more information, see the outstanding practice section of this report.

## Areas for improvement

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 12 Safe care and treatment; Regulation 17 Good governance and Regulation 18 Staffing.

There were 21 things the trust must put right in relation to breaches of these three regulations. In addition, we found 36 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 requirement notices in respect of the three regulations that had been breached in six services

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

# Summary of findings

## 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

We found examples of outstanding practice in the following services.

### Forensic inpatient or secure wards

Co-production within the wards, divisions and service line was well-embedded. Patients were consulted for feedback about decisions being made within the service and they sat on all levels of meetings across the service. The HOPE team championed peer support work. Patients provided input into training for staff and other patients at the Recovery college, were part of all staff interviews and had a well-established forum which held management to account effectively.

The occupational therapy team within the hospital provided opportunities for patients to develop and grow personally within vocational pathways which helped them to find work within the hospital but also in the local community.

The service had made significant improvements on the reduction of blanket restrictions. There were few blanket restrictions across the service and patients were empowered to challenge any potential restrictions at monthly forums.

### Child and adolescent mental health ward

Staff supported patients to live healthier lives. Working in partnership with a dietitian, the unit had introduced a token system for snacks and drinks. This was linked to a quality improvement project called “eat healthy plate”. This encouraged the patient to choose healthier snacks and drinks to promote a healthier lifestyle. In the summer of 2018 the unit piloted a project where participating patients could win prizes for successfully completing fitness challenges. On completion, details of the project, including patient views, had been published in the trust’s quarterly magazine.

### Wards for older people with mental health problems

At The Limes there was excellent use of ‘This is me’ life history documentation to provide person-centred care. On Jubilee Ward patients had a notice board in their bedrooms which displayed information about their life history, interests and preferences to remind both them and staff about things that mattered in their lives.

### Community-based mental health services of adults of working age

The teams could discharge patients to a service called primary care plus. It was a good step-down service for people experiencing mental health problems, but who needed extra support over and above what was available from their GP. It helped prevent the need for referral back into secondary services due to relapse in people’s mental health.

### Mental health crisis services and health-based places of safety

Nursing staff in Hounslow CATT had had opportunities to undertake specific quality improvement projects which had been supported by the trust to improve areas they had identified as problematic. For example, one nurse had worked on a project to create a nurse development framework, supported by a practice development nurse. This was now being rolled out throughout the trust.

# Summary of findings

## High secure

Staff throughout the hospital were strongly committed to promoting the patient voice and empowering patients in their own care. Patients were also involved in the strategic development of the hospital. Staff were responsive to patients' individual needs and this was evident through the way that staff interacted with patients and from patients' feedback about the quality of care they received from staff members. Patients and staff gave us examples of going beyond expected duties to ensure that the individual needs of patients were met.

Patients' individual needs were met in a person-centred way which incorporated a sensitivity and understanding of cultural, spiritual, personal and religious needs. This included access to a range of chaplaincy support which provided creative support for patients with a wide range of spiritual and religious needs which was delivered sensitively. We saw that there was a programme of events which highlighted the need to understand different cultures and backgrounds. The hospital promoted an inclusive culture for patients who identified as gay and transgender. Through a range of events, policies and the work of the Equality and Diversity Forum, the hospital ensured that patients from a wide variety of backgrounds felt an intrinsic part of the hospital community

The hospital had carers' strategic forums and patient forums which were consulted on the future direction of the hospital and trust in a meaningful way and the organisation listened and responded to patient feedback and had made changes to plans on the basis of feedback.

The trust had developed a reciprocal arrangement with a local acute hospital trust. This meant that nursing staff from Broadmoor received training in the treatment of minor injuries which aimed to avoid acute hospital attendance for patients. In return they provided the acute hospital with training around the management of patients with mental health difficulties. This helped both trusts and benefitted people in the local community.

The hospital had developed quick access information, presented on one page of paper, about the specific ligature and environmental risks on each ward along with the key mitigations. This made it very easy for staff, especially staff new to the ward, to be aware of the environmental risks. • The hospital continued to fully engage in research across disciplines from a central Broadmoor Hospital Research Hub which collated research evidence. Staff across the hospital presented nationally about research which took place at Broadmoor and hosted monthly learning events which focussed on learning in high secure settings.

## Areas for improvement

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 12 Safe care and treatment; Regulation 17 Good governance and Regulation 18 Staffing.

There were 21 things the trust must put right in relation to breaches of these three regulations. There are another 13 things that were identified at previous inspections that we have not yet checked. In addition, we found 36 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.

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.



# Summary of findings

## 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 six services. There were an additional two requirements outstanding from earlier inspections in three services that we did not inspect in summer 2018.

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

(from January 2018)

- The trust must ensure that data quality is sufficiently robust to provide assurance that they have an oversight of the numbers of incidents of seclusion across the service.
- The trust must ensure that members of staff have a good understanding of incidents which need to be reported through the incident reporting system and how to make accurate reports.
- The trust must continue to undertake work in progress to ensure that ward environments are safer and that the risk of blind spots on the wards are mitigated.
- The trust must continue with on-going work to improve the safety of access to seclusion rooms, for patients who cannot be secluded on the wards to which they are admitted.
- The trust must ensure that there is a system in place to make sure all urgent repairs are carried out in a timely way, including to clinical equipment such as fridge thermometers, especially when there are potential risks to the safety of patients and staff.
- The trust must continue the work it is undertaking to recruit additional nursing staff, particularly to the St Bernard's site.
- The trust must ensure that staff have an understanding of the trust policy in relation to safeguarding and use the policy in a consistent manner in order to protect patients effectively from abuse.

### Long stay or rehabilitation mental health wards for working age adults

- The trust must ensure risk assessments, and associated documents, for patients on Glyn Ward are regularly updated (Regulation 12).
- 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 (Regulation 18).
- 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 (Regulation 12).
- The trust must ensure staff receive regular supervision at Glyn Ward and Mott House (Regulation 18).

### Wards for older people with mental health problems

- The trust must make sure all restraint incidents are identified and recorded (Regulation 12).

### Community-based mental health services of adults of working age

- 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 (Regulation 18).



# Summary of findings

- 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 (Regulation 12).
- 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 (Regulation 12).
- 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 (Regulation 12).

## **Mental health crisis services and health-based places of safety**

- 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 (Regulation 17).
- 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 (Regulation 12).
- The service must ensure that medicines reconciliation is strengthened in the CATTs to ensure that medicines management is safe (Regulation 12).

## **Specialist community mental health services for children and young people**

(from November 2016)

- The trust must ensure the systems for feedback and learning from incidents is effective.
- The trust must ensure there is a system in place to ensure medical and emergency equipment is regularly reviewed.
- The trust must ensure all clinic environments meet the needs of service users.
- The trust must ensure team managers have access to timely and accurate management information to support their role.
- The trust must continue to work to improve staff engagement across CAMHS.

## **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.

# Summary of findings

## Community health inpatient services

(from November 2016)

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

## Action the trust SHOULD take to improve

Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

These 36 actions related to the whole trust and six services. There were an additional 22 actions outstanding from inspections in prior to the current inspection which related to four services that we did not inspect during the summer of 2018.

## Trust wide

- The trust should continue to promote the Freedom to Speak Up Guardian to ensure that all staff who want to raise concerns know how to do so.
- The trust should complete and publish the corporate and clinical strategies.
- The trust should continue its work to address all discrimination against staff throughout the trust including the strengthening of staff networks including for staff with lived experience.
- The trust should complete the implementation work to comply with the accessible information standards.
- The trust should continue its work to ensure serious incidents are addressed in a timely manner, that the investigations are of a consistently high standard and that relatives and carers are always supported appropriately to participate in the investigations where they wish to do so.
- The trust should review the processes for gaining assurance on the performance, risk management and quality of care in the service lines.
- The trust should review the training delivered to the MHA hospital managers to ensure it meets their needs and supports them to perform their role.
- The trust should continue their work to ensure IT and maintenance issues are addressed in a timely manner and that staff who report the issues are kept updated on progress.
- The trust should continue their work to develop the dashboards of live information to support managers to undertake their roles and provide information for assurance when needed.

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

(from January 2018)

- The trust should ensure that on-going work to manage and mitigate the risk of ligature anchor points continues.
- The trust should continue to work on improving the patient voice in care plans and through the care planning process, making sure the language used is accessible to patients.
- The trust should continue to work on improving staff and ward managers' access to data which supports them to improve their services and understand the performance of the ward, including accurate supervision data.
- The trust should continue to work to ensure that patients have access to clinical psychology input.

# Summary of findings

## **Long stay/rehabilitation mental health wards for adults of working age**

- 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**

- 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.
- 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.

## **Child and adolescent mental health ward**

- The trust should make sure its refurbished seclusion room protects patients' privacy and dignity and if the room is used in the interim.
- The trust should ensure meals are always served at the recommended temperatures.

## **Wards for older people with mental health problems**

- 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.

# Summary of findings

- 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**

- 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.

## **Community-based mental health services for older people**

(from November 2016)

- 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.
- 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.

## **Specialist community mental health services for children and young people**

(from November 2016)

- The trust should ensure that staff record when cleaning toys and resources has taken place and have a system in place to monitor this.
- The trust should ensure all staff know how to respond to a raised alarm in the therapy rooms.
- The trust should ensure mandatory training is completed.
- The trust should work to improve the patient record system to move away from multiple records and ensure information is recorded consistently so it can be located when needed.
- The trust should continue to roll out the new young person care plan format and to record the involvement of the young person and their family in the care planning process.
- The trust should ensure staff complete their appraisal and supervisions are recorded consistently and to a high standard.
- The trust should ensure training on the MCA includes Gillick competency for staff working with young people.
- The trust should ensure that consent to treatment and consent to share information is recorded.

# Summary of findings

- The trust should ensure staff know about local advocacy services so they can pass this information to young people when needed.
- The trust should continue to work with commissioners to reduce waiting times for neurodevelopmental services, reduce waiting times for access to specific psychological therapies and ensure that young people are supported to attend their initial assessment within 18 weeks.

## 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 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 in 2016 and 2018 will be followed up at the next inspection of the relevant core services.

## 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 improved. We rated it as good because:

- There had been a sustained improvement in staff engagement and morale. Staff felt respected, valued and proud to work for the trust. Staff were willing to go the extra mile to meet the needs of patients and this work was being recognised and celebrated. This was reflected in the improved engagement scores for the previous two years in the staff survey and in the General Medical Council (GMC) survey where medical trainees were very positive about the support they received from the trust.

# Summary of findings

- The chief executive was recognised as being an inspirational leader who had championed many of the improvements taking place. People internal and external to the trust said how much they respected the work she had led and the collaborative manner in which this had been done. Clinicians were now engaged in the work of the trust, for example, clinicians were leading on the development of trust strategies and in the development of information systems.
- The culture of the trust had improved and was more open and transparent. Staff felt able to raise concerns without fear of retribution and had access to the Freedom to Speak Up Guardian where needed, although the numbers of staff accessing this support were quite low. The trust did not have a blame culture and positively supported staff to learn from when things went wrong.
- Senior leaders were visible and approachable and recognised the importance of visiting services and speaking to people who use those services, their carers and staff. This was now central to the role of the leadership team. Other engagement took place including listening events, leadership blogs and an improved website and intranet.
- The trust had a clear vision that was recognised and put into practice by staff throughout the organisation. Whilst work on the trust strategy was not yet complete, there was a clear sense of direction with a desire to provide integrated physical and mental health care services within their current geographical areas. This was reflected in the recent change to the name of the trust to make it clear that it was not just providing mental health services.
- The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust was working well with other stakeholders including regulators, commissioners, other providers and third sector organisations to improve services for people with physical and mental healthcare needs within the geography served by the trust.
- Collaborative work with people who use services was integral to the operation of the trust. This led to a range of co-produced initiatives to enable patients to be actively involved in improving the delivery of care and promoting opportunities to enable people to develop skills and become more independent. For example, in the high secure, forensic and rehabilitation services people were accessing a wide range of educational and employment opportunities.
- The trust was very clear about the risks they were facing and had management plans showing how these were being managed. These plans identified who had responsibility for the necessary actions and the assurance processes in place.
- The trust was working to improve career progression and address discrimination for black minority ethnic (BME) staff. This included an award winning BME leadership development programme. The trust also had a visible and active LGBT+ network. It was recognised that there was more to do and that further networks, such as for staff with lived experience, were just getting started.
- Staff had good access to a range of learning and development opportunities. For example, any staff in band 3 roles or above who aspired to or were already in leadership or management roles were supported to extend their skills and knowledge. The trust took full advantage of established schemes, such as Capital Nurse, to enhance opportunities for new or existing staff, as well as local initiatives, such as their 'two hours to learn' sessions.
- The trust was making progress with their quality improvement programme and had set ambitious targets going forward. Staff across the trust felt engaged in this work.
- The trust had invested in systems to manage information, particularly relating to patient care to provide staff at different levels of the organisation with the data they needed to deliver services and gain assurance. Further work was needed to develop the system and support staff to understand and make good use of the data.

# Summary of findings

- The trust had a strong grip on its finances. An example of a sustained improvement had been the reduced use of paying for inpatient beds in the independent sector. This was because of the hard work undertaken to manage the flow of patients accessing services for acute mental health needs. This had also improved the quality of care for patients as they received their treatment locally and did not need to move between services.

However:

- There were several areas where work had started but further improvements were needed. This included ensuring all staff had regular supervision; implementing staff networks especially for people with lived experience, completing the implementation work on the accessible information standards, improving the systems to manage serious incidents so they are addressed in a timely manner, ensuring service lines were effectively providing assurance, delivering high quality training for Mental Health Act hospital managers, ensuring maintenance and IT issues are addressed in a timely manner and staff were kept informed of progress. In all these cases the trust was aware of the issue and was actively working to make the necessary improvements.



## 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 ↔ Dec 2018	Good ↑ Dec 2018	Outstanding ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018

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 ↔ Dec 2018	Good ↑ Dec 2018	Outstanding ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018
<b>Overall trust</b>	Requires improvement Dec 2018	Good Dec 2018	Outstanding Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018

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 2017	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 ↔ Feb 2017	Requires improvement ↔ Feb 2017	Good ↔ Feb 2017	Inadequate ↔ Feb 2017	Requires improvement ↔ Feb 2017	Requires improvement ↔ Feb 2017
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
Child and adolescent mental health wards	Good ↔ Dec 2018	Outstanding ↑↑ Dec 2018	Good ↔ Dec 2018	Good ↑ Dec 2018	Good ↔ Dec 2018	Good ↑ 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	Requires improvement ↔ Feb 2017	Good ↔ Feb 2017	Good ↔ Feb 2017	Requires improvement ↔ Feb 2017	Requires improvement ↔ Feb 2017	Requires improvement ↔ Feb 2017
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
<b>Overall</b>	Requires improvement ↔ Dec 2018	Good ↑ Dec 2018	Outstanding ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018

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.

# Child and adolescent mental health wards

Good  

## Key facts and figures

The Wells Unit is a national medium secure service for adolescent males between 13-18 years of age, who have a mental health problem in conjunction with a serious risk of harm to self or others.

The unit has 10 beds however it is commissioned for 6.74, therefore seven is the maximum number of beds occupied across the contracting period. On the day of inspection, there were five patients with one patient on long-term leave in the community. All patients were detained under the Mental Health Act (1983).

This inspection was announced the week before we arrived.

At the last inspection in November 2016 the Wells Unit was rated overall as requires improvement. Therefore, we inspected all the key questions to see if improvements had been made.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection, the inspection team:

- completed a tour of the service
- spoke with two patients and one carer
- spoke with the consultant psychiatrist
- spoke with the ward manager
- spoke with the service director
- spoke with seven members of the multi-disciplinary team including a speech and language therapist, occupational therapist, social worker, junior doctor, family therapist and teaching staff
- observed a multi-disciplinary team ward round
- observed a care programme approach meeting
- spoke to one registered nurse and one healthcare assistant
- observed a handover for nursing staff
- looked at five patients' records
- reviewed five medicine administration records
- looked at a range of policies, procedures and documents related to the service.

## Summary of this service

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

- The care and treatment provided was in line with national guidance for children and young people. The unit had adopted a therapeutic model of care, the “wellness and recovery action plan” (WRAP), and staff had received training to deliver it. A range of therapy and was available for all patients.

# Child and adolescent mental health wards

- Staff were skilled in helping distressed patients to calm down and there had been few incidents of restraint. When restraint did occur, the standard of recording had improved. Any incidents were analysed and learning from them was shared with the staff team.
- The premises were safe, secure, clean and well-maintained. The environment was regularly checked.
- Risks for individual patients and the environment were discussed, documented and managed. Staff were aware of them.
- Most staff had attended most mandatory training sessions, including training on the Mental Capacity Act and consent for under 18s. This was an improvement since our last inspection.
- Medicines were managed in line with best practice.
- Patients' mental and physical health was assessed and monitored. Staff knew how to identify improvement and deterioration using appropriate tools.
- Patients were encouraged and supported to make healthy lifestyle choices using challenges and reward schemes. Patients had access to equipment that encouraged activity, such as an outdoor sports pitch, gym and table tennis table.
- Staff were supported in their roles through supervision meetings, annual appraisals, regular reflective practice discussions and training and development opportunities. Staff told us their morale was good.
- Patients said staff treated them well and they and their families or carers were routinely involved in meetings to discuss their care plans. They also had opportunities to give their feedback about the unit and carers could attend the trust's quarterly carers meetings.
- A buddy system was in place so existing patients supported new patients to get used to the unit.
- Admissions and discharges were well planned and discharge planning started immediately to minimise the risk of delay.
- Staff were responsive to individuals' needs and care plans took account of patients' cultural, religious and social needs. Staff knew how to access interpreters and materials in a range of languages if needed. When appropriate patients were supported to attend activities in the community.
- There had been two formal complaints about the service and information about how to complain was on display and staff knew what to do on receipt of a complaint.
- Senior managers were visible and supported quality improvements. The unit regularly audited some aspects of its work and was participating in a national quality scheme.

However:

- The seclusion room did not fully protect patients' privacy and dignity.
- Meals were not always served at the recommended temperatures.
- Patients were not enthusiastic about the main meals provided.

## Is the service safe?

Good   

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

# Child and adolescent mental health wards

- The service managed patient safety incidents well. Staff were trained to calm down patients who were in distress, so restraint was not often used. Staff recognised incidents and reported them appropriately. Appropriate risk assessments were in place and staff knew how to manage risks. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service had suitable premises and equipment and looked after them well. The timeliness of repairs and maintenance had improved. There was sufficient space for education and therapy sessions on the unit. There was immediate access to toilet facilities in the seclusion room which was an improvement since our last inspection. Equipment was available to monitor patients' physical health. There was a high standard of cleanliness and regular environmental and perimeter checks to keep patients safe and secure.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. Recording of incidents of restraint had improved since our last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training to an appropriate level on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.

However:

- Patients using the seclusion room could, potentially, be seen by other patients through a glass panel. This could compromise their privacy and dignity.
- Records showed that, occasionally, food had been served at a lower than recommended temperature which could compromise the safety of the food.

## Is the service effective?

**Outstanding** ☆ ↑↑

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

- The service provided care and a range of treatment based on national guidance and evidence of its effectiveness. The unit had adopted a therapeutic model of care, the "wellness and recovery action plan" (WRAP), and staff had received training to deliver it.
- Staff supported patients to live healthier lives. The unit had implemented a series of rewards and challenges to motivate patients to achieve and maintain good health.
- Patients had enough food and could access drinks whenever they wanted them. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients' mental and physical health and the effects of any medication prescribed. There were systems in place to identify and respond to any deterioration. This was in line with national guidance.

# Child and adolescent mental health wards

- Patients had holistic up-to-date care plans in place which addressed all their needs and focused on achieving recovery.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, teachers and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They were also trained in consent issues for patients aged under 18.

However:

- Patients were not satisfied with the main meals provided.

## Is the service caring?

Good ● → ←

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well.
- The service had set up a buddy system so patients helped one another to settle in to the unit. New patients received a guided tour of the facilities from their buddy.
- Staff involved patients in decisions about their care and treatment. Patients were routinely invited to care programme approach meetings and ward rounds to express their views on their care plans. There were weekly community meetings where any issues on the unit could be discussed.
- Carers were invited to become involved in care planning and could attend a quarterly carers meeting run by the trust.

## Is the service responsive?

Good ● ↑

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

- The service had clear admission criteria and patients were only admitted when specialist child and adolescent doctors were available to assess their mental and physical health. There was no waiting list.
- Discharge planning was started at the point of admission to minimise any risk of delay when patients were ready to move on.
- The service took account of patients' individual needs. Interpreters and age-appropriate information were available when needed. Patients attended education and could sit for GCSEs. When appropriate, patients were provided with opportunities to participate in activities in the community, such as swimming and cinema visits or day trips.



# Child and adolescent mental health wards

- The service received had received two formal complaints since 1 April 2017 and information about raising complaints was easily available on the unit. The trust's complaints policy and procedures were accessible on the intranet site and staff knew where to find them.

## Is the service well-led?

Good ● → ←

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

- The service had managers with the right skills and abilities to run a secure unit for children and young people. Senior leaders were visible and approachable.
- The service had a vision for what it wanted to achieve and listened to the views of staff, patients, carers and other agencies when making plans to develop the unit.
- Managers promoted a positive culture that supported and valued staff and staff morale was good.
- The service used a systematic approach to continual quality improvement. It was committed to learning lessons from both good and poor practice and making sure all staff were aware of the information gathered.
- The service had effective systems for identifying and managing risks and coping with both the expected and unexpected. Risks were regularly reviewed and captured on the risk register.
- The service engaged well with patients, carers and staff to involve them in the running of the unit.
- The service participated in audits and national quality schemes.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

# Long stay or rehabilitation mental health wards for working age adults

Requires improvement   

## Key facts and figures

West London NHS trust provides two longer term high dependency mental health rehabilitation inpatient wards for men and women at two locations, Glyn Ward and Mott House. The service provides care and treatment for people recovering from long-term complex mental health issues and many of the patients also have physical health needs. Patients using the service come from the boroughs served by the trust.

Glyn Ward is based within Lakeside Mental Health Unit in Hounslow, London and has 22 beds, which were occupied by 20 patients during our visit. All, except two informal patients, were detained under the Mental Health Act 1983.

Mott House is based at St Bernard's Hospital in Ealing, London and has 15 beds. Thirteen patients were being cared for during our visit. Mott House had six patients detained under the Mental Health Act 1983 and had seven informal patients, one patient was on leave.

We inspected both rehabilitation wards to see if they had improved since our last inspection in November 2016.

The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During the inspection visit, the inspection team:

- spoke with one ward manager and one service manager
- spoke with twenty members of staff including doctors, nurses, occupational therapists, activity co-ordinators, a speech and language therapist, a drama therapist, a physical health nurse, a dietitian, a chaplain and healthcare assistants
- spoke with nine patients
- spoke with one peer support patient and one carer involvement worker
- observed two activity groups with patients
- observed two meetings for staff
- reviewed 11 care records
- completed two tours of the ward areas
- reviewed two clinic rooms
- reviewed 32 medication charts
- reviewed six staff files
- reviewed physical health records
- spoke with three carers.

## Summary of this service

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

# Long stay or rehabilitation mental health wards for working age adults

- Whilst improvements had been made and embedded on Mott Ward, further work was still required on Glyn Ward. On Glyn Ward there had been changes in the leadership team and this had impacted on the operation of the ward and communication with staff. At the time of the inspection a new manager had been appointed. On Mott Ward there was some outstanding practice, but the ratings for this ward had been brought down by the performance of Glyn Ward. Senior leaders in the trust were aware of the challenges on Glyn Ward.
- Last time we inspected the service patients did not have access to educational and vocational opportunities to support their recovery. This time they had good access at Mott House, but on Glyn Ward only basic educational and pre-vocational sessions were available to patients.
- While patients at Mott House received structured rehabilitation with identified recovery goals to support the work towards discharge, for patients on Glyn Ward this was less well developed.
- Staff were not regularly receiving supervision on either ward, so staff could not rely on having time with their supervisor to discuss their practice or learning or to raise any issues.
- While the service had made some improvements in ensuring the privacy and dignity of patients since our last inspection, we observed patients receiving routine medical checks in full view of others in the lounge at Glyn Ward, which compromised their privacy.
- Regular team meetings were not happening on Glyn Ward which meant that staff did not have sufficient opportunities to discuss the day-to-day running of the ward.
- Repairs and maintenance were not provided promptly to Glyn Ward. The organisation and cleanliness of the clinic room on Glyn Ward was not up to the standard required and some first aid equipment was past its expiry date.
- The service's inability to recruit and retain sufficient numbers of nursing staff affected the continuity and consistency of the nursing team. It impacted on patients receiving one-to-one time with their named nurse on Glyn Ward.
- Staff on Glyn Ward did not routinely update patients' records when needs or risks changed. There was little evidence of updates between care programme approach meetings, which were six monthly, or following incidents.

However:

- The trust had successfully implemented a range of measures to make sure patients who were admitted for acute care no longer had to sleep on the rehabilitation wards due to the shortage of acute beds. These improvements had been sustained throughout 2018 so there was no longer any impact on the rehabilitation wards.
- There were sufficient therapy staff to support each patient's rehabilitation. Doctors, nurses and other healthcare professionals supported each other to provide care.
- Staff appraisals were being carried out and this was an improvement since our last inspection.
- Doctors' prescribing practice was very thoughtful; minimum effective doses were prescribed and potential side-effects were always taken into account.
- Staff were good at supporting people to calm down when they were distressed so there was little need for physical interventions. There was evidence of positive risk taking.
- Physical healthcare was exemplary, with patients with complex needs receiving specialist care from acute hospitals.
- Patients spoke positively about staff and regular staff knew them well and understood their needs.
- Patients were now much more involved in developing their care plans and understanding their medicines. They were supported to voice their opinions by a peer support worker and in a regular independently run forum. There was evidence that staff made changes in response to patient views.

# Long stay or rehabilitation mental health wards for working age adults

## Is the service safe?

**Requires improvement** ● → ←

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

- Glyn Ward did not always receive a timely response to repairs and maintenance issues. There were three long-standing issues which impacted on the patients, including a bathroom which could not be used.
- Staff on Glyn Ward did not always keep patient risk assessments up-to-date. They were not reliably updated after incidents had occurred which would make it hard for new staff or staff returning from leave to understand current risks.
- There were lapses in the management of infection risks in the Glyn Ward clinic room. A shelf was dirty and some items were stored on the floor.
- The service had a high level of vacancies so it had to rely on bank and agency staff to cover shifts. As a result, patients on Glyn Ward did not receive regular one-to-one time with their named nurse.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. They were skilled at calming down patients in distress. 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.
- The service prescribed, gave and recorded medicines well. Patients received the right medication at the right dose at the right time. Prescribers carefully considered the impact of medicines on patients' health and well-being, including potential side-effects.
- 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 service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service planned for emergencies and staff understood their roles if one should happen.

## Is the service effective?

**Requires improvement** ● → ←

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

- The service did not give patients with similar assessed needs the same access to rehabilitation opportunities, such as education and vocational training. Other activities and therapies were available, but there were limited options for patients on Glyn Ward. Patients on Glyn Ward did not attend the recovery college or participate in work experience.
- Whilst all the patients had a holistic assessment, the patients on Mott Ward had individually developed recovery orientated care plans with clear goals. The care plans and goals on Glyn Ward were not so well developed.
- The service did not provide staff on either ward with regular individual supervision meetings to give them support and guidance in providing effective care and treatment or address professional development needs.

# Long stay or rehabilitation mental health wards for working age adults

However:

- There were sufficient therapy staff to support each patient's rehabilitation. Doctors, nurses and other healthcare professionals supported each other to provide care.
- The service provided good quality physical healthcare and worked with other healthcare providers to make sure patients received specialist care when required.
- Staff had access to information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

## Is the service caring?

Good ● ↑

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

- Staff involved patients in planning their care. Patients and a peer support worker told us they felt much more involved than they had done previously.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and carers were positive too.

However:

- Staff on Glyn Ward compromised patients' privacy and dignity by checking patients' blood pressures and blood glucose levels in the lounge area instead of in a private area. This was routine practice although all other aspects of delivering care took place appropriately.

## Is the service responsive?

Good ● ↑

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

- Staff carefully planned patients' discharges and took account of their individual needs when they did so. Many staff knew the patients very well and were committed to improving their health and well-being. Discharge took place within the appropriate timescales for this model of care, although Mott Ward had shorter lengths of stay than Glynn Ward.
- Staff supported patients to maintain contact with their families and carers.
- The service ensured patients had information on their treatments and it was supplied in a way they could understand.
- Patients were able to follow their religion or culture, for example with appropriate food or attending places of worship. Staff wore rainbow coloured lanyards to show they were comfortable discussing relationships and to support patients who were LGBT+.

# Long stay or rehabilitation mental health wards for working age adults

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

## Is the service well-led?

**Requires improvement** ● → ←

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

- One ward was not functioning as effectively as the other.
- Staff on Glyn Ward did not have sufficient nurse management and leadership support and some were not confident to raise concerns about this.
- Although the service used a systematic approach to continually improve the quality of its services, this was not well-maintained on Glyn Ward. For example, team meetings were rarely held and checks on cleanliness, equipment had not picked up problems in the clinic room and the absence of regular risk assessment updates had not been identified as an issue.
- The service's vision for its rehabilitation services was not well communicated to all staff. This was demonstrated by the variation in the approach to rehabilitation on the different wards. At Mott House there was more structured work towards recovery.

However:

- The service engaged well with senior leaders in the trust.
- A new ward manager was due to start work soon on Glyn Ward.
- Although the service used a systematic approach to continually improve the quality of its services, this was not well-maintained on Glyn Ward. For example, team meetings were rarely held and checks on cleanliness, equipment had not picked up problems in the clinic room and the absence of regular risk assessment updates had not been identified as an issue.
- Work had started to develop the future model of care, the service was working with partner organisations to provide a community rehabilitation service in Ealing.
- Staff could place concerns on a local risk register so that these would be escalated as needed. The areas for improvement identified at the inspection reflected those on the risk register.
- Managers had access to a range of data about the service in an accessible format to help inform their management decisions.
- The service was committed to improving services by learning from when things go well and when they go wrong.
- Mott House had received recognition of its 'excellent' service from external peer reviewers in 2015 and this accreditation was still current.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Wards for older people with mental health problems

Good  

## Key facts and figures

The wards for older people with mental health problems are located in the London boroughs of Hammersmith and Fulham and Ealing. All the wards admit men and women. Although the wards predominantly provide care for older people, there is no lower age limit for people to be admitted to the wards. People with mental and physical health problems are admitted to the wards if their needs can best be met on these wards.

There are three wards for older people with mental health problems within the trust:

**Jubilee Ward** – A 18 bed ward based at the St Bernard's site in Ealing. The ward admits male and female patients with a range of mental health problems for assessment and treatment.

**Meridian Ward** – A 16 bed ward based at Hammersmith and Fulham mental health unit. The ward admits male and female patients with a range of mental health problems for assessment and treatment.

**The Limes** – A 20 bed special care unit for older men and women with dementia and associated behavioural issues. This service is in Ealing and stands alone, it is not based at a hospital site.

This inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We undertook a comprehensive inspection of all of the wards for older people with mental health problems. This was to check on improvements made in the services since our last inspection in November 2016. At that inspection, this service was rated as requires improvement for effective, caring, responsive and well-led. It was rated as good for safe and requires improvement overall.

This inspection was part of a larger inspection of trust services. Before the inspection visit we reviewed information we held about the older people's wards.

During this inspection visit, the inspection team:

- visited each of the wards, looked at the quality of the physical environment, and observed how staff communicated with patients
- spoke with 16 patients and four relatives
- spoke with the ward managers or acting ward managers and modern matrons
- spoke with the clinical director of the cognitive impairment and dementia service (CIDS)
- spoke with 15 other members of staff including registered nurses, healthcare assistants, occupational therapists, student nurses, a consultant psychiatrist, an administrator and a physiotherapy assistant
- looked at 15 patients' care and treatment records
- attended and observed lunch and an exercise group
- attended and observed a ward community meeting and a nursing handover
- carried out a specific check of medicines management on all the wards
- looked at policies, procedures and other documents relating to the running of the services.



# Wards for older people with mental health problems

## Summary of this service

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

- There were significant improvements in the culture of the service and the responsiveness of leaders which had had a positive impact on staff morale and the quality of the service.
- Staff took account of patients' individual needs and preferences and treated patients kindly. They took care to make sure patients understood their care and treatment and brought in independent advocates if they had doubts about the patient's ability to make a decision for themselves.
- The wards were bright and cheerful and, although the ward layouts were not ideal, action had been taken to make the most of the environment and to improve safety.
- Patients received a thorough assessment of their mental and physical health and were monitored for any deterioration. Care plans and risk assessments were in place for all patients.
- Medicines were prescribed appropriately and at the lowest therapeutic dose and prescribers took full account of possible medicine interactions.
- Staff were up-to-date with their mandatory training and were able to access other training opportunities too. They were aware of their responsibilities in relation to the Mental Health Act, the Mental Capacity Act and safeguarding children and adults.
- A range of therapeutic activities was available across the service.
- Families and carers were well-supported by staff and, when appropriate, fully involved in meetings to discuss the patient's care and treatment.
- Patient information was kept securely, but it was accessible to relevant staff members.
- Ward managers could access timely information about the performance of their ward so they could attend to any emerging issues.
- All the staff we spoke with were committed to ongoing improvement of the quality of the services they provided.

However:

- Episodes of restraint were not always recorded, so managers could not effectively monitor its use.
- The service found it hard to recruit registered nurses so there were a significant number of vacancies being covered by bank or agency staff.
- There was not equal access to therapeutic activities across all the wards.

## Is the service safe?

**Requires improvement** ● ↓

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

- Staff did not always record restraint appropriately so managers could not effectively monitor its use. On Meridian Ward some episodes of restraint following patient aggression or agitation were not recorded as incidents.

# Wards for older people with mental health problems

- Recruitment of registered nurses was problematic. The Limes had nine vacancies for registered nurses. Jubilee Ward had five vacancies for registered nurses. The difficulties recruiting registered nurses to The Limes was recorded on The Limes risk register.

However:

- The service had taken action to improve safety. They had installed mirrors or stationed staff to make sure all blind spots in the premises could be observed. Patients had access to an alarm system to summon help.
- On admission to the wards, all patients had a risk assessment which included details of their historical and current risks. On Jubilee Ward, there was an ongoing quality improvement project to reduce patient falls.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- The trust provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service planned for emergencies and staff understood their roles if one should happen.

## Is the service effective?

**Good**  

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

- The service provided patients with a thorough assessment of their mental and physical health before or soon after admission. This was in line with national best practice guidance.
- Staff monitored patients to identify deterioration in their mental and physical health and knew how to escalate any concerns.
- Care plans were in place for all patients we checked. Those on The Limes and Jubilee Ward were person-centred and guided staff.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance annually.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff regularly gave patients drinks to ensure they were hydrated. The dietitian developed care plans for people who needed support with their diet.
- The service as a whole provided a good range of therapeutic activities.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to use the legislation and associated guidance to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff of different kinds worked together as a team to benefit patients. Staff worked collaboratively within a multi-disciplinary team and with other agencies.

However:

# Wards for older people with mental health problems

- Care plans on Meridian Ward were not well developed.
- There was not equal access to therapeutic activities. Patients at The Limes had more opportunity to participate than patients on other wards.
- Whilst systems to ensure staff all had regular supervision had been developed and most staff told us it took place, records did not always confirm they were receiving it at the frequency outlined in the trust policy.

## Is the service caring?

Good ● ↑

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

- Staff cared for patients with compassion. Feedback from patients and carers confirmed that staff treated them well and with kindness. Staff had reported a colleague who did not treat patients well and managers had dealt with this.
- Staff involved patients and those close to them in their care and treatment. They helped patients and their families to understand the patient's health conditions.
- Staff completed assessments which included an understanding of each person's previous lives and interests so they could provide care that met each person's individual needs.
- There were regular carers meetings on two wards and plans to start them on the third ward. The Limes carers' group had developed a sensory garden which benefitted patients.

## Is the service responsive?

Good ● ↑

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

- The trust planned and provided services in a way that met the needs of local people. Only one patient had been placed out of the area during the one year period we looked at.
- The trust had taken action to minimise the risk of delayed discharges and worked with other agencies to prevent this happening.
- The service took account of patients' individual needs. For example, staff found out about their dietary needs and preferences and arranged meals accordingly.
- Work had taken place to improve the environment on all the wards. They were now more 'dementia-friendly'.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However:

- Two of the wards lacked signage that could help some patients to orientate themselves.

# Wards for older people with mental health problems

## Is the service well-led?

Good  

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

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staff and families had confidence in management.
- The trust had a vision for what it wanted to achieve and plans were in place to fully achieve it.
- The culture of the service was much better. There was now a positive culture that supported and valued staff.
- The trust used a systematic approach to continual improvement of the quality of its services. Several quality improvement projects had recently started on the wards
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Ward managers could access information about the performance of their ward.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, quality improvement initiatives and audits.

However:

- Matrons could not directly access performance information about the services they managed.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Mental health crisis services and health-based places of safety

Good  

## Key facts and figures

We visited all the teams that form part of the trust's crisis services as detailed below:

The three crisis, assessment and treatment teams (CATTs) which cover the London Boroughs of Ealing, Hounslow and Hammersmith and Fulham. These CATTs have a role in providing initial assessments for patients referred to secondary mental health services, as well as providing crisis support and brief interventions for periods of up to three months. The service referred to these different functions as tier 1 (crisis support), tier 2 (brief intervention therapy) and tier 3 (initial assessments). These teams also support patients who are being discharged from hospital.

Referrals to these teams come predominantly through the Single Point of Access but may also be received from wards or teams within the trust, including the liaison psychiatry service based at local acute hospitals. The teams also gate-keep all inpatient admissions.

In August 2018 the trust's psychiatric liaison services started to offer 24-hour cover to emergency departments in local acute hospitals (psychiatric liaison services were not included in this inspection). This change enabled the trust's CATTs to be based outside emergency departments at night. Previously patients could only access them at night through the busy emergency department. They were able to respond to urgent referrals at convenient times for the patient or carer. For example, they could undertake home visits at night.

The health-based place of safety is a place where patients experiencing a significant deterioration in their mental health are taken, usually by the police, for an assessment by a team of mental health professionals.

West London NHS Trust provides three locations for health-based places of safety which align with their inpatient beds. There is one health-based place of safety located at Hammersmith and Fulham Mental Health Unit, one at St Bernard's Hospital in the Wolsey Wing and one at Lakeside Mental Health Unit. There are two beds at Lakeside, but at the time of inspection only one was in use due to staffing issues. The suite at St Bernard's Hospital is used for women and the suite at Lakeside is used for men. The suite at Hammersmith and Fulham is used for men and women. At the time of our inspection, the suite at Hammersmith and Fulham was temporarily closed for minor refurbishment. It reopened the week after our inspection visit.

The crisis services and health-based places of safety were last inspected in November 2016, when the overall rating for the service was requires improvement. Safe, responsive and well-led were rated as requires improvement and caring and effective were rated as good. We issued two requirement notices following the 2016 inspection; one in relation to regulation 12 safe care and treatment as patient risk assessments were not always completed robustly in the CATTs, and the other in relation to regulation 17 good governance as the trust did not have governance systems in place to ensure that team managers and the trust's central governance team had oversight of the performance of the CATTs in order to drive improvement.

Our inspection of mental health crisis services and health-based places of safety took place between 17 and 20 September 2018 and was announced (staff knew we were coming). The trust received 48 hours' notice of our inspection in line with CQC guidance in relation to inspections of community-based services to ensure that staff were present during our inspection.

Before our inspection, we reviewed information we held about the trust and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

# Mental health crisis services and health-based places of safety

- spoke with the managers of each home treatment team and the managers who had responsibility for each of the health-based places of safety
- spoke with 26 members of staff including nurses, consultant psychiatrists and support workers
- spoke with the clinical director for access and urgent care and the deputy director of local services
- looked at the quality of the environment at each location
- reviewed 40 care and treatment records
- spoke with 9 patients and 2 carers either face to face or via telephone calls.
- observed five handover meetings
- observed two multidisciplinary team meetings including one clinical improvement group (CIG meeting)
- observed two reviews of patient care and one assessment of a patient, with the patients' consent.

## Summary of this service

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

- Care professionals in the trusts single point of access worked closely with the health based places of safety and crisis assessment and treatment teams to ensure patients had access to services in a timely manner. For example, the health-based places of safety were open to young people under the age of 18, as well as adults and they did not turn away people who presented as intoxicated. Also the CATTs were now operating 24 hours a day.
- The crisis services worked closely with other stakeholders including the police, local authority AMHP leads and psychiatric liaison teams to review services and address challenges in joint working.
- Staff monitored patients' physical health needs and ensured that any issues identified were addressed appropriately. Each CATT had specific physical health clinics to ensure that basic checks could be carried out and this information was recorded. In the health-based places of safety, each patient had a physical health check on admission and their physical health was monitored while they were awaiting an assessment. This was an improvement since our last inspection.
- Staff in the CATTs offered a range of brief interventions and support groups which enabled them to provide care and treatment to a wide range of people. This was in line with recommendations in national guidance.
- Staff teams were highly motivated and morale was strong in the teams we visited. Staff were positive about the support they received from managers and felt they were supported to develop, personally and professionally by the trust.

However:

- In the health based places of safety, staff had not ensured that key information relating to the operation of the service was effectively captured and that other systems were working well. For example, data was not being collected accurately, such as the time the patient arrived (and therefore their length of stay) or when the service was closed due to staff shortages. Other essential records such as physical health observations and a record of patients being told

# Mental health crisis services and health-based places of safety

their rights were not stored consistently in each service. Environmental audits and ligature risk assessments had not been completed and this was not identified until the inspection visit although this was addressed immediately. Incidents had been reported but were assigned to wards rather than the health based places of safety themselves which hindered oversight by managers and potentially, learning.

- In the crisis assessment and treatment teams (CATTs) staff did not always keep appropriate records of patients' care and treatment. Risk assessment documentation in Hounslow and Hammersmith and Fulham CATTs did not reflect the current patient risk. Some care planning documentation in all the CATTs had not been completed comprehensively to reflect the care that was being provided to patients.
- Medication in the CATTs was not consistently reconciled which meant that medical and nursing staff in the teams did not always liaise with GPs and inpatient wards to ensure that the prescriptions and the medicines received by patients were consistent. As a result there were errors on a few prescription charts.

## Is the service safe?

**Requires improvement** ● → ←

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

- In the CATTs, although staff were aware of patients' risks, and the patients we spoke with told us their care needs had been discussed with them, the recorded risk assessments were not always up to date. Nor were they were stored consistently in the electronic patient record system. Staff worked a shift system and several people could be involved in supporting a patient, which meant the need for updated recorded risk assessments to be available and stored in the same place in the care records was important. We found some improvement in staff awareness of risk since our 2016 inspection, but the recording of risk needed further work.
- Staff in the CATTs did not follow good practice in medicines management as medicines reconciliation was not carried out effectively and accurately. The meant that the prescription charts for some patients did not fully represent the medicines which they had in their homes. While this had not caused any patient harm, the processes were not in place to ensure there was good oversight of the medicines prescribed to each patient.
- At the time of the inspection, incidents that took place in the health based place of safety were being reported through the wards and so these incidents and the learning from them could not be clearly identified to the correct service. However, the trust said they were addressing this shortly after the inspection.
- Key information relating to the operation of the health-based places of safety was not effectively captured. Essential records such as physical health observations and a record of patients being told their rights were not stored consistently in teams.
- Environmental audits and ligature risk assessments for the health-based places of safety had not been completed, although this was addressed immediately we pointed it out.

However:

- The work environments, including the team bases for the CATTs and the health-based places of safety were clean, well-equipped, adequately furnished, well-maintained and fit for purpose. There were sufficient meeting rooms for patients who attended the CATTs and staff had an understanding of the environmental risks. Staff were aware of and used the trust and local lone-working procedures.



# Mental health crisis services and health-based places of safety

- The CATTs were staffed sufficiently to provide a safe service, although having recently increased their hours of operation were still recruiting permanent staff and using significant numbers of bank staff. The health based places of safety were also adequately staffed but staff came from the wards and there was not a dedicated team of staff for the service.
- Staff knew how to report incidents. Staff recognised incidents and reported them appropriately. Managers investigated incidents and ensured that lessons learnt were shared through the service and through the trust. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were able to learn from incidents through clinical governance meetings in their teams.
- The start time for the detention of patients who were waiting for assessments in the health-based places of safety was not accurately recorded when the detention had started in another service. This meant statutory checks may not be carried out at the correct time. The trust amended this immediately when we made them aware of the issue during the inspection visit.

## Is the service effective?

Good ● → ←

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

- Staff assessed and monitored the physical health of patients who were admitted to the health-based places of safety. This information was recorded and patients were provided with appropriate support to meet their physical health needs. In the CATTs, staff recorded and monitored patients' physical health. They also liaised with GPs to ensure that key information was shared. This was improvement from the inspection in 2016.
- Staff provided a range of treatment and care for patients based on national guidance. Patients in the CATTs had access to a range of treatments and support including psychological therapies and medication. Staff worked with other organisations in the community to signpost patients to additional sources of support.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to enhance their skills. This had a positive impact on morale within the team and more skilled staff ensured better patient care.
- Staff had received a training on the Mental Health Act and were able to use this appropriately across the services.

## 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' dignity and privacy and supported them with their individual needs. Most patients we spoke with were positive about the care and treatment they had received
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the services. Patients confirmed they had been involved in making these decisions. The service had developed a crisis care forum which included people who used services and carers to ensure there were opportunities for feedback on the service. Plans for service development were also presented to the forum.

# Mental health crisis services and health-based places of safety

## Is the service responsive?

Good ● ↑

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

- People could access the services when they needed it. Patients who needed support in a crisis were referred to the CATTs in a timely manner from the trust's single point of access which was accessible 24 hours a day, 7 days a week, 365 days a year. Care professionals at the single point of access monitored patients while they were waiting to be seen. The health-based places of safety were open to young people under the age of 18, as well as adults and they did not turn away people who presented as intoxicated.
- The services were accessible to all who needed them and took into account patients' individual needs. Health-based places of safety were accessible for patients with mobility impairments. Accessible rooms were available in the CATT bases.
- The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with all staff. Staff had a good understanding of the complaints processes and were able to explain changes that had taken place following complaints.

However:

- While staff told us that the health-based places of safety were rarely closed to patients, the trust had not collected data about the frequency of closure.

## Is the service well-led?

Good ● ↑

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

- The service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were positive about the teams they worked in and the support they received from their managers. They told us that they were comfortable raising concerns and felt supported to provide good care.
- The CATTs had collected, analysed, managed and used information well to support their activities. Managers had access to relevant information to monitor their team performance and to encourage improvement.
- The service had engaged well with patients, staff and the local community to plan and manage appropriate services and collaborated with partner organisations effectively.
- Staff in Hounslow CATT were encouraged to develop quality improvement projects and to pilot new initiatives. For example, the Pets in Practice initiative where a member of staff brought their dog into work regularly and this had a positive impact on team morale.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

# Mental health crisis services and health-based places of safety

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Forensic inpatient or secure wards

**Outstanding** ☆ ↑↑

## Key facts and figures

West London NHS Trust provides low secure and medium secure forensic mental health services for men and women at St Bernard's Hospital. The service consists of three directorates from four buildings on the site. These are men's medium secure, men's low secure and community and women's service.

Thames Lodge is a new building which opened in 2016 and has five men's medium secure wards. The Orchard is the women's service and provides low secure, medium secure and enhanced medium secure (known as WEMSS – women's enhanced medium secure services) wards. The Orchard opened in 2007. The Tony Hillis wing houses men's medium secure and low secure wards for men. Butler House is a standalone men's low secure rehabilitation unit on the grounds of St Bernard's Hospital.

The West London Forensic Service covers eight boroughs in north-west London – Ealing, Hammersmith and Fulham, Kensington and Chelsea, Harrow, Hillingdon, Westminster, Brent and Hounslow.

West London Forensic Service was last inspected in November 2016. The overall rating for the service was requires improvement. The service was rated good for caring and well-led and requires improvement for safe, effective and responsive. We issued five requirement notices following the 2016 inspection; one in relation to regulation 9, person-centred care, one in relation to regulation 12, safe care and treatment, one in relation to regulation 13, safeguarding service users from abuse and improper treatment, one for regulation 15, premises and equipment and one for regulation 18, staffing.

At this inspection, we found the service to have significantly improved since our last inspection visit.

Our inspection of forensic inpatient services took place between 24 and 28 September 2018 and was announced (staff knew we were coming). The trust received one week's notice of our inspection in line with CQC guidance to ensure that security could be managed during our inspection as we were visiting so many wards concurrently.

We visited the following wards during our inspection visit:

Tony Hillis Wing

Avebury ward – 16 bed men's medium secure ward

Barron ward - 17 bed men's low secure rehabilitation ward

Bevan ward - 18 bed men's medium secure rehabilitation ward

Solaris ward – 16 bed men's low secure rehabilitation ward

Tennyson ward – 8 bed men's low secure rehabilitation ward

Thames Lodge

Berry ward – 18 bed men's medium secure high dependency ward

Brent ward – 17 bed men's medium secure admissions ward

Falcon ward – 17 bed men's medium secure admissions ward

The Orchard

Aurora ward – 10 bed women's medium secure admission ward

# Forensic inpatient or secure wards

Damson ward – 5 bed women’s medium secure rehabilitation ward

Garnet ward – 10 bed women’s medium secure rehabilitation ward

Pearl ward – 15 bed women’s low secure ward

Melrose ward – 10 bed women’s enhanced medium secure ward

Parkland ward – 10 bed women’s enhanced medium secure ward

Butler House is a separate standalone ward which is a 12 bed men’s rehabilitation/step down ward for patients working towards discharge.

Before our inspection we reviewed information we held about the trust and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

- spoke with ward managers or acting ward managers for each of the wards we visited
- spoke with 105 other members of staff including nurses, health care facilitators, occupational therapists, consultant forensic psychiatrists, doctors in training, forensic and clinical psychologists, social workers and general practitioners.
- Spoke with the clinical director, service director, heads of service and the executive director for forensic and high secure services.
- spoke with 90 patients
- spoke with 3 carers
- checked 71 clinical records including care plans and risk assessments.
- checked 33 medication charts
- attended two patient forums (one for male patients and one for female patients)
- attended one staff forum
- attended one carers’ event
- attended four clinical team meetings
- attended 6 community meetings
- attended one ward manager’s meeting
- observed 4 nursing handovers
- attended one reducing restrictive practice meeting.

We also requested additional information from the trust following our inspection visit.

## Summary of this service

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

# Forensic inpatient or secure wards

- Leadership within the service was highly effective. Leaders at all levels were supportive of staff and visible within the service. They supported each other to deliver the best possible service for all patients. Staff were supported to develop their leadership skills through a range of creative training, coaching and mentoring opportunities. This service had greatly improved since its inadequate rating at our first comprehensive inspection in 2015 and this confirmed that leaders had good skills and knowledge.
- There was a strong ethos around patient involvement and it was integral to the way the service was provided. Patients were at the heart of any decision making about the way the service was delivered and in respect of their own care and treatment. We heard examples of changes that had taken place as a direct result of patient feedback.
- Patients were inspired to have hope in their recovery by staff members and recovery and involvement (HOPE) workers. The service was focused on rehabilitation, with patients offered extensive opportunities for vocational training, education and personal development. Staff were committed to this approach. Patients told us that this was important to them and helped them progress through towards discharge.
- The service provided individual care which reflected the holistic needs of patients. This meant that as well as needs relating to physical and mental health being assessed, monitored and reviewed, the patients' social, cultural and spiritual needs were well met.
- Staff had an excellent understanding of patients' needs and this enabled them to take positive risks to aid patients' recovery. For example, one ward escorted all its patients to a leaving party for one patient in the hospital café. The patients concerned said they appreciated the trust put in them and it encouraged them in their recovery.
- The service had safely reduced the use of restrictive practices. De-escalation techniques were used well; rapid tranquillisation of patients had only been required on eight occasions in one year. There were fewer blanket restrictions in place and both patients and staff were better informed about those that were in place and the reasons for them. For example, previously, in the Tony Hillis wing, there had been a 'one-size fits all' approach to searches on return from unescorted leave, even though the wing accommodated both medium and low secure wards. Now patients on the low secure wards received searches in keeping with that level of security.
- Patients had access to a full range of physical healthcare professionals at the on-site primary healthcare centre, which included a fully equipped dental surgery. Patients could be seen on the ward if they could not visit the centre so no one was disadvantaged. Patients were supported to make healthy lifestyle choices, such as using the gym facilities and selecting healthy snacks.
- Plans were well underway to move some wards in the least suitable building to a newly refurbished building and to make sure those wards that remained behind also had improved facilities. Repairs and maintenance had not been put on hold in the interim period and were taking place throughout our inspection.

However:

- Although all shifts were covered and recruitment and retention had improved, there were insufficient permanent nursing staff to ensure proper continuity of care for all patients.
- Some records of seclusion were not comprehensive and did not record all the observations which had taken place to show staff were following the Mental Health Act Code of Practice.
- A few patients in the women's service may not have had all their physical healthcare needs met as on one ward diabetes care plans were not in place for four patients with the condition.

# Forensic inpatient or secure wards

## Is the service safe?

Good  

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

- Staff achieved a good balance between maintaining safety and providing the least restrictive environment. This was a significant improvement since our last inspection. The service was actively involved in a restrictive interventions reduction programme in partnership with patients; de-escalation techniques were frequently used and rapid tranquillisation rarely used.
- Staff had developed and implemented care and treatment plans, including positive behaviour support plans, which followed best practice. Staff and patients told us that the ethos of the service was one which encouraged individualised planning around risk and restrictions.
- The wards 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. We were given examples of changes made following learning from incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service was using a recognised tool to monitor any deterioration in patients' physical health and work was taking place to make sure it was embedded in the daily practice of the wards as the service had identified that issues were sometimes not escalated appropriately.

However:

- Wards on the older Victorian Tony Hillis wing required constant repair and the layout of the building was not appropriate for the delivery of modern health care. Plans were in place to replace or refurbish the old wards.
- Some seclusion records did not consistently show checks had been carried out in line with the Mental Health Act Code of Practice. Sometimes the reason for changing the seclusion conditions was not clear in the patient notes.
- The service did not have enough nursing staff employed in permanent posts. Although the service had improved its recruitment and retention and shifts were always filled by bank or agency staff, there was a risk that the lack of permanent nursing staff on the wards had an impact on the consistency of care. There were also insufficient social workers to provide a full social work service.

## Is the service effective?

Good  

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

- Staff assessed the physical and mental health of all patients on admission and continued to monitor and review their health. The service used a holistic approach to assessing, planning and delivering individual care and treatment for patients which was strongly recovery-focused.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Innovative evidence-based interventions were used to support the delivery of high quality care. Advice and support was sought from external specialists when necessary.



# Forensic inpatient or secure wards

- Staff had good access to training to consolidate or enhance their specialist skills and knowledge. We received very good feedback from staff about training in positive behaviour support which was complemented by ongoing work on the wards to embed this approach.
- Staff ensured patients had excellent access to physical healthcare, including access to specialists when needed. There was a dedicated primary healthcare centre on-site with access to GPs, practice nurses and a dental suite. The team made ward visits when required. For example, to patients in seclusion. Ward staff received bespoke training and support to ensure patients' physical healthcare needs were met.
- The service had access to the full range of specialists required to meet the individual needs of patients. This included medical and nursing staff, but also clinical and forensic psychologists, occupational therapists, pharmacists, social workers, speech and language therapists, dietitians, art, drama and music therapists and peer workers.
- The occupational therapy team provided a wide range of vocational packages which focussed strongly on recovery and meaningful occupation. These programmes were tailored to individual patient need and included links with the local community which were growing. For example, a local business was interested in opening a branch on-site, having been impressed with patients' work and staff support at one of their local branches. There were also education programmes which enabled patients to gain many skills and supported them to access accredited qualifications.
- Staff received regular supervision and reflective practice sessions. On some wards, patients and staff had joint reflective practice groups as well. Staff had opportunities to develop personally and professionally and the trust supported a wide range of educational and developmental opportunities for staff.

However:

- While all staff had received training in understanding and using the Mental Capacity Act, some staff were not confident in this area and told us they needed more support.
- Some risks which were identified may not have been managed effectively. We found four patients with diabetes without relevant care plans in place on one ward.

## Is the service caring?

**Outstanding**  

Our rating of caring improved. We rated it as outstanding because:

- Staff cared for patients with compassion and kindness. They supported patients to understand and manage their care and treatment. Feedback from patients and those close to them was consistently positive. Patients told us that staff went the extra mile to support them.
- Staff involved patients and those close to them in decisions about their care and treatment. Coproduction involving patients was deeply embedded in the culture of the service and patients were involved in day-to-day decisions and consulted about proposed changes to the service.
- Patients were empowered as partners in care and they were supported to realise their potential. They told us they were encouraged by the hope staff had for their recovery.
- Recovery and involvement (HOPE) workers and service user consultants were used extensively across the service. Many of them said they had been inspired by others who had been in the role before them and they tried to inspire other patients in their turn. Patients told us this was indeed happening.

# Forensic inpatient or secure wards

- HOPE workers were encouraged to develop in their roles. They had been supported to visit another trust which was outstanding for patient involvement, so they could compare and contrast experiences.
- Staff understood the individual needs of each patient. This was reflected in care planning and risk management; it was evident in all staff / patient interactions.
- Staff knew how to motivate patients; we heard from patients how conversations with individual clinicians, competitions, awards, celebratory events and similar had made them re-think how they engaged with their treatment.
- Patients worked with the practice development team to produce a regular magazine; it was informative, inspiring and well presented. The magazine was used to showcase achievements and display patients' art work, poetry and writing skills. They had also co-produced a booklet about self-harm which was informative and insightful for both patients and professionals.
- Staff informed and involved families and carers appropriately. Carers champions on each ward encouraged and supported their colleagues to do this. Carers had regular opportunities to meet each other and attend events at the service.

## Is the service responsive?

Good ● ↑

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

- The service planned and provided services in a way that met the needs of patients. The service offered a range of person-centred services that took into account patients' cultural, religious, spiritual and linguistic needs.
- The service was inclusive and celebrated events such as black history month. Staff who were happy to be approached to discuss issues related to being lesbian, bisexual, gay or transgender (LGBT+) self-identified with rainbow lanyards and rainbow wristbands were being made available for patients at their request.
- The service emphasised recovery and rehabilitation throughout all the wards and there were clear pathways and a diverse range of facilities for patients to access which promoted this.
- The service had exceeded the annual target set for it to bring patients back from other areas. This meant these patients were now provided with care and treatment near to their home.
- Staff liaised well with services that provided aftercare to ensure patients moved on to appropriate settings. They supported patients during referrals and transfers. Regular carers events were held.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. Staff were able to give us examples of changes that had been made.
- Progress had been made within the service in respect of delayed discharges and the trust was working with clinical commissioning groups and other bodies to address the external barriers that remained.

## Is the service well-led?

Outstanding ☆ ↑

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

# Forensic inpatient or secure wards

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were very positive about the senior leadership team within the service and across the trust. They said they felt supported. There had been an enormous improvement in the culture of the forensic service since our last inspection.
- There were robust governance systems in place across the service with effective systems in place for identifying risks and clear plans to eliminate or reduce them. When we came across a matter requiring further attention we found there were already arrangements in place to address it.
- Leaders actively involved patients in improving the service at all levels. They made sure patients received support to participate in or chair meetings and were debriefed afterwards.
- Success and good practice was recognised throughout the service through certificates and awards for both staff and patients which were very much valued.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. The service was part of a new models of care project across North London forensic services and worked with other local trusts to learn from best practice elsewhere.
- Managers had access to information about the performance of the part of the service they were responsible for so they could respond as required. The information available had just been improved and managers were being trained to become familiar with the new system.
- The service was committed to learning, continuous improvement and innovation. Staff had excellent opportunities to develop their skills and knowledge, including around quality improvement. There were a number of innovative projects and programmes underway.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

# Community-based mental health services of adults of working age

Requires improvement   

## Key facts and figures

West London NHS Trust provides community based mental health services for adults of working age throughout the London boroughs of Hammersmith and Fulham, Hounslow and Ealing. Some adults in receipt of the services may be subject to conditions under the Mental Health Act 1983.

Teams visited:

- The single point of access (SPA), also known as the 24/7 helpline, is a telephone based service that manages all adult mental health referrals to the trust, as well as providing telephone support to patients and carers.
- The early intervention service (EIS) provides specific support and treatment for patients experiencing a first episode of psychosis. Teams provide a service to people between the ages of 18 and 35 years, over a three-year period.
- The recovery teams support patients who have complex mental health and social care needs. They provide patients with longer term support. The recovery teams are 'ageless' services, which means they are not restricted to supporting patients of working age. However, the trust has separate cognitive impairment teams within the community which support and treat older adults with dementia and associated cognitive conditions. The recovery teams referred patients into three clinical pathways: psychosis, personality disorder, and complex depression, anxiety and trauma.

CQC previously inspected this core service in November 2016, and issued an overall rating of requires improvement.

This inspection was announced (staff knew we were coming) the week before the inspection to ensure that everyone we needed to talk to was available. It was part of a wider trust inspection.

The team that inspected the service comprised six CQC inspectors, two CQC inspection managers, a CQC assistant inspector, a CQC pharmacist and two specialist professional advisers, one of whom was a nurse and the other a social worker.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited eight services and looked at the quality of the environment
- spoke with eight patients and six carers who were using the service
- observed two patient appointments, with the patients' consent
- spoke with nine team managers
- spoke with the service manager for the recovery teams and early intervention services, head of planned and primary care services, and the director of clinical services.
- spoke with 81 other staff members including administrative staff, psychiatrists, nurses, clinical psychologists, social workers, occupational therapists, peer support workers, and non-registered nurses
- attended and observed six team meetings

# Community-based mental health services of adults of working age

- attended and observed five risk management or 'zoning' meetings
- observed one depot clinic meeting
- reviewed at 53 treatment records
- looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- Services needed to improve access and waiting times. The recovery teams did not assess all referrals promptly. They did not meet the 28-day trust target to see the patient for their initial assessment from the day of their referral. Some patients had to wait for a long time for transfers between teams. Ealing West Recovery Team needed to have a better system for monitoring the safety of patients on their waiting list.
- Some teams had staffing challenges due to high vacancies and high staff turnover. This meant that many staff in the teams affected had more patients on their caseload than recommended by national guidance. In Ealing Early Intervention Service there were not enough care coordinators for all the patients within the service.
- Staff did not always manage medicines safely. At Ealing West Recovery Team, we found out-of-date medicine kept with in-date medicines. This increased the possibility that a patient may be given an out of date medicine.
- Some teams did not assess and plan how to manage patients' risks robustly. Patients' risk assessments and care plans were not reliably updated following changes in circumstances or incidents. These documents were not regularly audited to check they were person-centred, accurate and up-to-date. Staff in the Ealing West Recovery Team also did not fully address risk in their 'zoning meeting'.

However:

- Senior and team managers across the teams had a good understanding of their teams and the challenges they faced. Senior managers had already implemented support and intervention plans for the two teams where we found the most concerns during our inspection. This demonstrated managers understood the risks associated with their teams and had acted to eliminate them or reduce them.
- Despite the pressures faced by the teams, managers and staff worked well together to ensure patients received good care and treatment. There was an open culture and morale was generally good. The provider regularly recognised staff success within the service.
- Staff had the necessary training to ensure they could deliver their role safely and effectively. Staff followed good lone working practice, which enhanced their safety when meeting patients. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff recognised incidents and reported them appropriately.
- Staff demonstrated excellent working relationships with other teams, both internal and external to the trust, which ensured seamless and holistic care for patients. Staff offered interventions aimed at improving patients' social networks, education and employment.
- Staff used technology to support patients effectively and avoid missed appointments, such as by sending text appointment reminders.
- Staff demonstrated good practice when using the Mental Health Act and the Mental Capacity Act.

# Community-based mental health services of adults of working age

- Staff involved patients and, when appropriate, carers in decisions about care. They had implemented a way of working collaboratively with patients and carers. Teams supported patients, families and carers to understand their mental health and to develop strategies for dealing with its impact.
- Patients told us that they could contact the service easily if they felt unwell or had any questions about their treatment.
- Staff planned for patients discharge from services well. Teams had been involved in quality improvement projects, which aimed to improve the patient discharge pathway.
- Patients knew how to complain or raise concerns. Information about how to complain was on display in the patient waiting room in the service we visited.
- Managers had better access to data to help them monitor the performance of their teams. A new 'dashboard' had just been made available and the trust was rolling out training to support managers to get the best from it.
- The teams had made good progress with addressing the recommendations made in the November 2016 inspection. This included access to psychological therapies, and staff receiving regular appraisals and supervision.
- Improvements had also been made in the delivery of physical healthcare, but teams still needed to do more work to embed physical healthcare in their day-to-day practice.

## Is the service safe?

**Requires improvement** ● ↓

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

- The Ealing Early Intervention Service (EIS) did not have sufficient staff to deliver consistent care in accordance with guidance. Care co-ordinators had high caseloads (between 26-28), which was not in line with the nationally recommended maximum of 15. There were 42 patients awaiting allocation of a care co-ordinator. The team could not ensure consistent care or the full recommended package of care was provided for patients presenting with first episode psychosis. Senior managers were aware of this issue and had implemented a support and intervention plan the week before our inspection. Staff at the other EIS we visited also had high caseloads.
- The Ealing West Recovery Team had caseloads between 35-40, and the Hammersmith and Fulham Recovery Team ranged between 15-30. However, staff at Ealing East and Hounslow East and West recovery teams had manageable caseloads, averaging 25 patients.
- The Ealing West Recovery Team managed the referrals waiting list poorly. At the time of the inspection, there were 51 unopened emails in the team's referral inbox, which meant staff had not yet screened them for risk. Staff did not monitor referrals regularly and did not have a clear system to manage patients on the waiting list. The team had recently appointed a band seven nurse to support the referral and assessment of patients by the team.
- Staff did not always manage medicines safely. At Ealing West Recovery Team, we found out-of-date medicine (Risperidone) kept with in-date medicines. The out-of-date medicine was not stored appropriately or clearly labelled. This increased the possibility that a patient may be given an out of date medicine.
- Some teams did not assess and plan how to manage patients' risks robustly. The Hounslow West and Ealing West recovery teams did not always update patients' risk assessments following changes in circumstances or incidents.

# Community-based mental health services of adults of working age

Staff in the Ealing West Recovery Team also did not demonstrate they knew patients' risks and had plans to address them in the team's 'zoning meeting'. Staff in this meeting did not follow a structured format to robustly discuss risk. Staff in the Hounslow West Recovery Team held effective risk 'zoning' meetings to ensure staff knew how to support patients. Staff in the other teams assessed and managed risks for patients well.

However:

- Staff followed safe procedures when lone working. At the inspection in November 2016, some staff did not use the lone working devices that had been provided. During this inspection, there was an improvement. The trust had issued all staff new lanyard personal alarms that had a tracker and we observed staff using them.
- 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 service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.

## Is the service effective?

Good  

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

- Staff assessed the physical and mental health of all patients. They developed individual care plans that met needs identified during assessment. Staff considered patients' employment, education, housing, relationships and financial needs.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged patients to live healthier lives.
- Staff used technology to support patients effectively. For example, with patients' consent, staff sent text reminders to patients prior to appointments, and activities such as the walking group.
- Staff from different disciplines worked together as a team to benefit patients. The teams had effective working relationships with other teams within the trust, and external organisations.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- The trust had improved how staff supported patients with their physical health needs. At the last inspection in November 2016, staff did not monitor and record patients' physical health consistently. During this inspection, there had been substantial progress in most of the teams. Teams had received physical health training, had introduced patient physical health clinics, good liaison with GPs and district nursing, and the trust had implemented a physical health section in patients' electronic records to record key physical health information. However, further work was required in some teams to ensure improvements were embedded and the monitoring and recording of patient's physical health was robust.
- The service ensured staff received appraisals. At the last inspection in November 2016, there were low rates of appraisal. During this inspection, this was no longer an issue, and 95% of staff had received an appraisal.



# Community-based mental health services of adults of working age

- Staff received regular monthly management supervision from their line manager. This had improved from the last inspection in November 2016, when staff in one of the teams did not receive one to one supervision.

At the last inspection, in November 2016, mental health support workers in the single point of access (SPA) team had received no formal training for carrying out their duties, especially responding to crisis calls at night time, prior to commencing their roles. There was a risk there were ill equipped to deal with very difficult situations. During this inspection, this was no longer an issue. Training and induction was in place and staff said this was sufficient for their role.

However:

- Staff in the Hounslow East and West and Ealing West recovery teams did not always update care plans following changes in circumstance. In Hounslow East and West recovery teams, the quality the quality of care plans across the teams varied. Most were not person- centred and did not identify goals for recovery.

## Is the service caring?

**Good** ● → ←

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

- Patients were supported, treated with dignity and respect, and were involved as partners in their care. Patients attended care review meetings and reported that they could give their views.
- We spoke to eight patients who said staff treated them well and behaved appropriately towards them. However, one patient from the Ealing West Recovery Team said they could not always get hold of their care-coordinator and did not feel adequately supported.
- Staff supported patients to understand and manage their care, treatment or condition.
- Staff were sensitive to the diverse cultural needs of patients, and considered a patient's history and presentation to match them to an appropriate care co-ordinator.
- Patients were involved in staff recruitment panels.
- Teams provided patients, families and carers with the tools needed to support ongoing care and recovery. For example, there was a monthly carers forum where carers could learn about different topics such as medication and personality disorders. Carers fed back that they found them helpful.
- Teams had recently introduced the triangle of care model, which is a working collaboration, or "therapeutic alliance" between the patient, professional and carer that promotes safety, supports recovery and sustains well-being.

## Is the service responsive?

**Requires improvement** ● → ←

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

- The recovery teams did not assess all referrals promptly. They did not meet the 28-day trust target to see the patient for their initial assessment from the day of their referral. In the last year 812 patients had waited longer than 28 days to be assessed by the teams. Ealing West Recovery Team had the highest average waiting time of 85 days, but this was an issue in all the teams.

# Community-based mental health services of adults of working age

- Some patients had to wait for a long time for transfers between teams. Hammersmith and Fulham Early Intervention Service (EIS) patients ready for the recovery team were not able to transfer in a timely manner to the Hammersmith and Fulham Recovery Team. At the time of inspection, there were ten patients awaiting transfer. Three of the ten patients had been waiting approximately two years. There was pressure for the recovery team to prioritise people on their waiting list who did not already have contact with services. EIS staff continued to deliver good support and treatment to the ten patients waiting to transfer.
- At Hammersmith and Fulham Early Intervention Service, care plans were not provided in an accessible format for patients.

However:

- Patients could access recommended psychological therapies quickly. At the last inspection in November 2016, patients in the recovery teams could not to access psychological therapies in a timely manner. At this inspection, we found the trust had made significant improvements, and no patients waited more than four weeks to be seen.
- The trust had reduced the number of patients that did not attend (DNA) appointments. At the last inspection in November 2016, the trust had high levels of DNA. At this inspection, improvements had been made. Staff followed the trust's DNA policy. Staff contacted DNA patients by telephone, wrote letters to them and their referrer or contacted their GP. They did home visits if they felt that the risks to the individual were high.
- Staff planned for patients discharge from services well. Teams discussed discharges regularly in team meetings and supervision. The teams could discharge patients to a service called primary care plus, which was a service for those who needed extra support over and above what was available from their GP.
- Patients could access advice and support easily. Patients told us that they could contact the service easily by telephone if they felt unwell or had any questions about their treatment and their care coordinator or duty worker would get back to them.
- Patients knew how to complain or raise concerns. Information about how to complain was on display in the patient waiting room in the service we visited.

## Is the service well-led?

Good  

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

- Senior and team managers across the teams had a good understanding of their team and the challenges they faced. Senior managers had already implemented support and intervention plans for the two teams (Ealing West Recovery Team and Ealing Early Intervention Service) where we found the most concerns during our inspection. This demonstrated managers understood the risks associated with their teams and had acted to eliminate them or reduce them.
- All teams had clear governance processes in place, to make sure staff delivered a good service and the environment was safe and clean. They enabled senior and team managers to identify and deal with problems.
- Despite some of the issues faced by the teams, managers and staff worked well together to ensure patients received good care and treatment. They reported an open culture within the team where they felt proud of the work they did. Teams described morale as good, but said it could fluctuate according to work pressures such as caseloads and capacity demands.
- The provider recognised staff success within the service, through staff awards and employee of the month.

# Community-based mental health services of adults of working age

- Teams were committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Hounslow East and West and Ealing East recovery teams were involved in quality improvement projects, which aimed to improve the patient discharge pathway.
- Managers had better access to data to help them monitor the performance of their teams. A new 'dashboard' had just been made available and the trust was rolling out training to support managers to get the best from it. At the time of this inspection some managers had yet to get to grips with it.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

# Our inspection team

Jane Ray, Head of Hospitals Inspections - Mental Health, led this inspection. An executive reviewer, Sheena Cumiskey, Chief Executive, Cheshire and Wirral Partnership NHS Foundation Trust, supported our inspection of well-led for the trust overall.

The team included 18 inspectors, five inspection managers, one analytics manager, two policy officers, four mental health act reviewers, one inspection planning coordinator, three pharmacists, including a specialist pharmacist adviser, 12 other specialist advisers and two experts 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.