

West London Mental Health NHS Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL14	Lakeside Mental Health Unit & Hounslow Community Services	Finch Grosvenor Kestrel Kingfisher	TW7 6AF
RKL79	Hammersmith & Fulham Mental Health Unit and Community Services	Lillie Ravenscourt Avonmore Askew (PICU)	W6 8NF
RKL53	St Bernards and Ealing Community Services	Hope Horizon	UB1 3EU

Summary of findings

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

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We did not re-rate this service.

While good progress had been made in some key areas, we found the following areas that the service needs to improve:

- Some maintenance work in the wards had not been carried out in a timely fashion and some faulty equipment had not been reviewed. There was no system in place at the Hammersmith and Fulham site to identify recurring faults so they could be properly addressed.
- The trust had started environmental work across the wards to address ligature risks and blind spots. However, there was further work outstanding to mitigate a few remaining blind spots and the ligature action plans, while comprehensive, were not always clear about the timescales for this work.
- There were high vacancy rates for nurses at the St Bernard's site.
- While some wards had been reconfigured to reduce the incidence of female patients being secluded on male wards, this work needed to continue. The trust was not able to provide us with accurate data relating to numbers of incidents of seclusion.
- There were gaps in the data supplied to ward managers to help them monitor their ward. In particular, there was a risk that the information they received about incidents of seclusion was not comprehensive. This potentially limited their ability to identify any themes and could prevent them from responding appropriately.
- Some incidents, which should have been reported through the trust reporting system, had not been reported which meant that data provided about the quality of service was sometimes incomplete.
- There was no evidence in the service's risk registers or the minutes of clinical governance meetings that the data accuracy or the lack of incident reporting had been identified or was in the process of being addressed.

- While most staff had a good understanding of safeguarding and their responsibilities to patients at risk on the ward, some staff did not follow the trust's safeguarding policy which required them to record the reason behind any decision to not refer concerns about a patient to the local authority.

However, we found the following areas of good practice:

- The trust had undertaken considerable work to better manage patient flow. This had resolved the issue of patients receiving care on one ward while sleeping on another ward because no beds were available where they were receiving treatment.
- Permanent and contracted agency members of staff were receiving supervision regularly. Staff across the service told us that they felt supported by their managers and that they were able to raise concerns.
- Patients had up to date risk assessments and care plans.
- Records showed physical health screening was carried out regularly with follow up intervention when required.
- The service had started to undertake some quality improvement projects. Members of staff were positive about this.
- The divisional management and local service managers had a good understanding of the acute and PICU services and knew about key risk areas in the services they managed. While work on some areas of risk or concern was not complete, most of the issues we found had been identified internally and work was planned.
- Although there were gaps, ward managers had access to improved information about the ward to support them to manage the service.

Summary of findings

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

Are services safe?

At our last inspection this domain was rated as requires improvement. We did not re-rate at this inspection as we did not look at every aspect of safe.

We found the following areas the trust needs to improve:

- Some minor works and repairs were not carried out in a timely manner and this had an impact on patient care. At Hammersmith and Fulham Mental Health Unit there was not a system in place which provided an overview of maintenance requests so that themes or more significant issues could be identified.
- There were high levels of vacancies for registered nurses, particularly at St Bernard's Hospital site. While we saw that the trust had taken significant action to address nurse recruitment and retention trust wide, this had an impact on the continuity of patient care.
- While each ward had an updated ligature risk management plan, they did not always clearly state when ligature reduction work was taking place.
- The trust policy on safeguarding, which stated that staff should record the reason if they did not refer a patient assault on another patient as a safeguarding concern, was not consistently being followed in Ealing and Hounslow.

However, we found the following areas of good practice:

- Most risk assessments we saw were comprehensive and updated with recent risk information. Staff on the wards had a good understanding of the level of risk and this was discussed in handovers and in regular team meetings.
- The trust had started work on reconfiguring seclusion rooms so that movement between wards when patients needed access to a seclusion room were reduced or eliminated. This work was continuing during our inspection visit.

Are services effective?

At our last inspection this domain was rated as requires improvement. We did not re-rate at this at this inspection as we did not look at every aspect of effective.

We found the following areas of good practice:

- Permanent and contracted agency staff told us that they received regular supervision and felt supported. Staff told us they felt the regular reflective practice groups were helpful.

Summary of findings

- Most staff had access to appraisals.
- Patient involvement in care planning had improved since our previous inspection visit in November 2016.
- Screening, follow up and recording physical health needs had improved since the last inspection visit in November 2016.

However, we found the following areas which the service needs to improve:

- While the involvement of patients in care planning had improved, there were still further steps which could be taken to continue the progress which had been made.
- Clinical psychologist input was low in Hammersmith and Fulham Mental Health Unit and Lakeside Mental Health Unit.

Are services responsive to people's needs?

At our last inspection this domain was rated as inadequate, mainly due to poor bed management. We did not re-rate this at this inspection as we did not look at every aspect of responsive.

We found the following areas of good practice:

Significant improvements had been made with the bed management process and patient flow across all the wards. The inpatient wards worked collaboratively with the community teams to facilitate timely patient discharges

Are services well-led?

At our last inspection this domain was rated as requires improvement. We did not re-rate at this inspection as we did not look at every aspect of well-led.

We found the following areas the trust needs to improve:

- Some data was not available at ward manager level, including detailed information about all incidents on their ward. This meant ward managers could not confidently use the data to identify issues.
- We did not have assurance that the information which the trust held on seclusion at Hammersmith and Fulham where patients from Lillie ward (female) were secluded on Askew ward (male) was accurate. This had not been identified on the local risk register or in the divisional action plan.

However we found the following areas of good practice:

- Ward managers had access to a lot of useful information to support them to manage their service.

Summary of findings

- The service managers had oversight of the areas they were responsible for through clear clinical governance processes. This ensured that most key areas of risk were identified and that trust management had sight of the service's areas of strength and weakness.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care ward (PICU) are part of West London Mental Health NHS Trust's local services clinical service unit. Within this, the service is part of the Access and Urgent Care (AUC) service line which includes the crisis teams.

The services are located across three sites.

Hammersmith and Fulham Mental Health Unit

Ravenscourt ward – male assessment ward 22 beds

Avonmore ward – male recovery ward 22 beds

Lillie ward – female assessment ward 16 beds

Askew ward – male psychiatric intensive care ward – 12 beds

St Bernard's Hospital in Ealing

Hope ward – female generic ward 17 beds

Horizon ward – male generic ward 14 beds

Lakeside Mental Health Unit in Hounslow

Kestrel ward – male recovery ward 18 beds

Kingfisher ward – male assessment ward 19 beds

Finch ward – female recovery ward 16 beds

Grosvenor ward – female assessment ward 15 beds

Previously we inspected the wards at St Bernard's Hospital twice between October 2012 and October 2013. We later inspected all the wards as part of our comprehensive inspection in June 2015 and re-inspected all the wards in November 2016.

At the inspection in November 2016, we found that the acute and PICU services were in breach of four regulations under the Health and Social Care Act (Regulated Activity) Regulations 2014 in the following areas:

Regulation 12 Safe care and treatment

Regulation 15 Premises and equipment

Regulation 17 Good governance

Regulation 18 Staffing

At that time the following issues were identified as actions the provider must take to improve the acute and PICU services:

- The trust must ensure that sufficient beds are available for patients on each ward and patients are not admitted to one ward and then sleep on another ward during their admission
- The trust must ensure that at the Hammersmith and Fulham Mental Health Unit and Lakeside Mental Health Unit, seclusion rooms are located so they can be used safely and that patient transfer to seclusion facilities does not compromise the patients' privacy and dignity.
- The trust must ensure that the seclusion room on Finch ward is clean and well-maintained
- The trust must ensure that the new ligature management policy is fully applied and comprehensive ligature audits for each ward and clear actions when the need for further improvements are identified
- The trust must address the risks presented by the blind spots on Kestrel ward
- The trust must ensure that Lillie ward is clean and all the furniture and fittings are well-maintained
- The trust must review the junior doctors out of hours rotas to ensure the workloads are safe.
- The trust must ensure patients' risk assessments are updated following incidents.
- The trust must ensure that action is taken whenever high temperatures are recorded on refrigerators to ensure medication is in an appropriate state to use.
- The trust must ensure that supervision and appraisals are completed and fully recorded. Managers must be able to assess both the competency of all staff and appropriateness of the supervision provided.

Summary of findings

- The trust must ensure that ward managers have sufficient clear and accurate information to monitor the quality of services being delivered.

The following issues were identified as actions the provider should take to improve the acute and PICU services:

- The trust should continue to recruit permanent staff to reduce the use of temporary staff and further improve the consistency of care.
- The trust should ensure clinical equipment is well maintained and calibrated where needed so it provides accurate readings.
- The trust should ensure that care plans for patients on recovery wards focus on recovery and support patients in developing the skills they will need when they are discharged.
- The trust should ensure that steps are taken to mitigate the risks associated with prescribing high dose anti-psychotic medication and patients' physical health is monitored.
- The trust should ensure that patients have access to psychology services.
- The trust should ensure that staff completing national early warning score (NEWS) charts, which collate information about physical health monitoring, have sufficient skills and expertise to respond to deterioration in physical health.
- The trust should ensure that admissions to hospital are a positive experience for patients and that this is reflected in feedback. The trust should also involve patients in decisions about the development and running of the wards.
- The trust should ensure that staff avoid using medical jargon in care plans and treatment. The trust should ensure that staff speak with patients in a way patients can understand.
- The trust should aim to reduce the number of patients being placed outside their local area during an admission.
- The trust should work with partners to continue to reduce the number of discharges that are delayed for non-clinical reasons.
- The trust should ensure that where needed, interpreters are arranged for individual patients.

At this focussed inspection, we followed up on the areas where there had previously been breaches and the areas where we had recommended that the trust should take action. In 2016 the service was rated as requires improvement overall. It required improvement in safe, effective and well-led. It was rated good for caring and inadequate for responsive.

As this is a focussed inspection and is not covering all the areas for each domain we are not re-rating this service.

Our inspection team

An inspector led this inspection. The inspection team also consisted of one CQC inspection manager, four other CQC inspectors, one assistant inspector, three specialist advisors, of whom two were mental health nurses and one was an occupational therapist with mental health

experience and one expert by experience. There were also two CQC staff observing the inspection, one trainee analyst and one member of staff who works in the internal engagement team.

Why we carried out this inspection

This was an unannounced focussed inspection. The focus of the inspection was to check the progress the provider had made in addressing the breaches in regulation identified at a previous inspection in November 2016.

Summary of findings

How we carried out this inspection

Because this was a focussed inspection, we looked at areas where there had been a previous breach of regulations and areas where we had concerns. This meant we looked at specific parts of the service being safe, effective, responsive and well-led. We did not inspect the caring domain as it had previously been rated as 'good'.

Before the inspection visit, we reviewed information which we held about the service through our day to day monitoring work.

During the inspection, the inspection team

- visited ten wards over three locations and looked at the quality of the ward environments including seclusion rooms, where they were located

- spoke with 43 members of staff including doctors, nurses, health care assistants, occupational therapists and psychologists
- spoke with the manager or acting manager of each ward and the service manager based at each location
- spoke with the associate director of the urgent and emergency access service line, the head of urgent and emergency access care and the head of nursing for local services
- spoke with 38 patients and one carer
- checked care records for 30 patients
- observed two handover meetings
- observed one community meeting

Following the inspection visit, we also requested additional information from the trust to help inform our judgement.

What people who use the provider's services say

During our inspection visit, we spoke with 38 patients and one carer across ten wards we visited. Most patients we spoke with were very positive about the support which they received and the input from nursing and medical staff.

While most patients told us that they had copies of their care plan or they knew what was in them, some patients

across the three sites told us that they did not always feel involved in the writing of their care plans. Patients told us they had opportunities to feed back about services at weekly community meetings on each ward, but some patients told us that they did not always feel that these led to change.

Good practice

- The service had made considerable progress in managing beds since our last inspection in November 2016. This had involved a number of initiatives including a 'Red2Green' process to follow up on the productivity of each inpatient day in order to identify potential delays early. The service had also introduced common 'seven day standards' which focused on a patient's path towards discharge from the day of admission. Staff told us that they had noted a significant difference with regard to bed availability and this was evident on the wards and from the data provided to us.
- During this inspection, we saw the impact of some quality improvement projects which had started since our last inspection visit. For example, on Lillie ward in Hammersmith and Fulham Mental Health Unit, staff had initiated a project to look at ways to reduce violence and aggression on the ward. As a result, they had started using safety huddles and reviewing safety crosses regularly to keep on top of potential problems.
- Members of staff were positive about the visibility of management team within the service and generally spoke positively about changes which had taken place since our last inspection visit.
- Although we did not formally inspect the caring domain, we observed care being delivered with

Summary of findings

exceptional kindness and consideration by staff and staff we spoke with talked about patients with respect. Patients were positive about the care which they received from clinical and non-clinical staff across the service.

Areas for improvement

Action the provider **MUST** take to improve

- 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.

Action the provider **SHOULD** take to improve

- 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.

West London Mental Health NHS Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Finch Grosvenor Kestrel Kingfisher	Lakeside Mental Health Unit and Hounslow Community Services
Lillie Ravenscourt Avonmore Askew (PICU)	Hammersmith and Fulham Mental Health Unit and Community Services
Hope Horizon	St Bernard's and Ealing Community Services

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Safety of the ward layout

- At our previous inspection in November 2016, we found that some environmental risks, such as blind spots on some of the acute wards, had not been adequately addressed. At this inspection, we found improvements. We saw that mirrors had been added in some wards to reduce blind spots, for example, they had been installed on Kestrel ward where we had specifically identified concerns at the last inspection. We saw that the trust was continuing to work on addressing identified blind spots, but on Hope ward, mirrors had been ordered two months prior to the inspection, but had not been installed. There was a risk that this delay could impact on patient safety.
- At our previous inspection in November 2016, we found that a few ligature anchor points on some wards, including Avonmore and Ravenscourt, had not been clearly identified on the relevant ligature risk assessment documentation which meant that risk levels were underestimated. At this inspection, we found every ward had a ligature risk assessment which was up to date. In a few cases we found a gap, for example, the balcony on Finch ward which staff described as high risk. This was rectified during our inspection visit. The ligature risk assessments incorporated plans for work on outstanding areas and detailed how the risk areas were mitigated. Staff on the wards were aware of the key risk areas where they worked. However, some ligature risk assessments and management plans did not include timescales for actions to be taken. For example, on Grosvenor ward at Lakeside we saw that the work needed was listed, but the planned date of completion was not.
- As well as a ligature risk assessment document, wards had risk heat maps which identified the key areas of risk visually and were easy to interpret. On Avonmore ward

at Hammersmith and Fulham, the ward manager had collated information, including photographs, for the key risk areas and staff had signed to confirm that they were aware of the ligature risks on the ward.

Maintenance, cleanliness and infection control

- Staff, across the wards at all sites, told us that repairs were not consistently undertaken in a timely manner. For example, we saw that issues which had been logged for maintenance in September on Hope ward at St Bernard's Hospital had not been completed at the time of our inspection in January 2018. These were predominantly minor cosmetic issues, such as holes in the wall and skirting boards coming away, but they impacted on the general appearance of the ward.
- Some staff across all sites told us that delays to repairs impacted on the quality of care they provided. At Hammersmith and Fulham Mental Health Unit, there was no effective system in place to manage and monitor minor repairs. Staff on the wards completed requests in a log book which remained on the ward and when work was completed, this book was updated. At Lakeside and St Bernard's we were told by staff that repairs information was collated centrally in the service and that a weekly call took place with the maintenance leads in order to follow up issues which were outstanding so there was a more effective process in place. This had not yet started in Hammersmith and Fulham.
- At our last inspection in November 2016, we found some areas of Lillie ward and Finch ward were not clean and well-maintained. This had been addressed by the time of this inspection and all the wards we visited were clean and well-presented.

Seclusion rooms

- At our last inspection in November 2016, we found that the seclusion room on Finch ward was poorly maintained. At this inspection, the seclusion room on Finch ward had been decommissioned. All the seclusion rooms we saw were in good order and were clean and well-maintained.

Are services safe?

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

- At our last inspection in November 2016, we saw that when some patients needed access to a seclusion room they had to be escorted to a seclusion room on a different ward at a time when they were most distressed. This included female patients being moved to seclusion rooms on a male ward at Hammersmith and Fulham as there was no seclusion room on the female ward at this location. We saw that while this continued to take place, the trust was in the process of making more significant environmental changes so the issue could be addressed. Since the last inspection in November 2016, Finch ward at Lakeside Mental Health Unit had become a female ward, so the seclusion room on the female Grosvenor ward was more accessible. Further planned changes were awaiting extensive building work in the wards.

Clinic room and equipment

- At our last inspection in November 2016, we found that action was not consistently taken in response to high readings on the fridges in the clinic rooms. At this inspection, we found that in Hammersmith and Fulham on Lillie ward and on Ravenscourt ward, there were some readings where, over a 24 hour period, the maximum temperature of the fridge was higher than the recommended 8°C.
- We saw staff had the opportunity to log any concerns about the temperature and record the action taken, but it was not always clear what actually happened as a result. Staff at Hammersmith and Fulham Mental Health Unit told us the thermometers were not consistently reliable. However, reports had not been made through the trust's incident reporting system so that the pharmacy team could address the ongoing problem. After our inspection, the trust introduced additional checks on the fridge temperatures, particularly at Hammersmith and Fulham Mental Health Unit.
- At our last inspection in November 2016, we found that some blood glucose monitoring equipment was not routinely calibrated on Horizon and Grosvenor wards. On this inspection, we found blood sugar monitoring equipment was calibrated regularly and this was recorded. However, on Hope ward, where there were two blood glucose monitoring meters, the checks for one of them had been recorded on a paper hand towel. This was inappropriate and could lead to the record being lost. However, staff were clear about how and when they should monitor and check this equipment.

Safe staffing

Nursing staff

- At our last inspection in November 2016, we found that there were significant vacancy rates for nursing staff, particularly at Lakeside where there had been a 44% nurse vacancy rate. At this inspection, we found that the vacancy rate for registered nurses was at 32% across all the acute sites. This was highest on Horizon ward which had a vacancy rate of 63% and next was Hope ward with a vacancy rate of 46%. Whereas the overall vacancy rate for nurses at the Lakeside site had reduced to 34%, the rate at St Bernard's was significant at 54%. Since the last inspection, there had been a period when the future of the acute wards at St Bernard's was uncertain and this had led to a high turnover of staff. The service was aware of the specific difficulties in staffing at St Bernard's and was seeking to address local factors. Where possible, agency staff had been booked on contracts to cover the vacancies.
- Staff at St Bernard's told us that the high vacancy rates for nurses meant morale was low at times. Three members of staff at St Bernard's told us that activities could not always be facilitated. We saw that in the three months between October 2017 and December 2017, 21 nursing shifts and six health care assistant shifts had not been filled. However, staff worked hard to ensure that any impact on the delivery of care was minimised. Five out of the six patients we spoke with on Hope ward at St Bernard's mentioned to us that they had noticed a lack of consistency in staffing or that some activities had been cancelled due to shortages in staffing. Some staff at St Bernard's and on Kingfisher ward at Lakeside told us that shortages in staffing meant that nursing staff could not always attend ward rounds. This sometimes meant that the staff who knew the patients best were not present. At Hammersmith and Fulham, on Lillie ward, we saw that an assistant practitioner had been assigned to attend each ward round, thereby ensuring nursing information could be shared with the multi-disciplinary team.

Are services safe?

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- Senior managers in the trust were working to further develop the trust recruitment strategy, specifically focusing on Ealing and Hounslow services at St Bernard's and Lakeside respectively. There were a number of initiatives which had started, including working with the Capital Nurse programme which enabled newly qualified nurses in London to gain a range of experience with additional support from mentors. The trust had also developed a broader recruitment and retention strategy which was inclusive of the inpatient wards that we visited.

Medical staff

- At our previous inspection in November 2016, we found that junior doctors, particularly those based at St Bernard's in Ealing, covered a very large workload. At this inspection, we saw that changes had been made to the rota at St Bernard's to ensure that there was additional medical input, including out of hours cover. However, some staff told us that more experienced doctors had, at times, to cover the junior doctor rota at night due to a lack of availability; this could impact the availability of doctors during the day. We saw that the trust were aware of this issue and were looking at plans to remedy it, including undertaking additional medical recruitment.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We asked the trust for information relating to the use of restrictive practices across the wards we visited. The information provided to us stated that January 2017 and December 2017 the use of seclusion varied significantly between wards. For example, for the 12 month period, seclusion had been used four times on Avonmore ward and four times on Ravenscourt ward. Neither of these wards had their own seclusion room. During this period Ravenscourt was an assessment ward and Avonmore was a recovery ward. The highest numbers of seclusions took place on Hope ward, a female generic ward, where there had been 65 incidents of seclusion in 12 months and on Kingfisher, a male assessment ward, where there had been 85 incidents of seclusion in 12 months both of which have a seclusion room. The male PICU, Askew ward, at Hammersmith and Fulham Mental Health unit had 45 incidents of seclusion over 12 months and this ward

also has a seclusion room. However, after the inspection, the trust acknowledged that they could not be assured that the seclusion data provided to us was accurate. They told us that they would take immediate action on this as a priority.

- Between January 2017 and December 2017, the ward with the lowest numbers of restraint, according to the data which was provided to us by the trust, was Avonmore, a men's recovery ward at Hammersmith and Fulham Mental Health Unit. There had been 15 incidents of restraint, of which 26% were in the prone position, but there had been no recorded use of restraint on this ward since September 2017. On Finch, a female recovery ward at Lakeside, there had been 23 incidents of restraint, of which 30% were in the prone position. The highest levels of restraint were on Kingfisher, a male assessment ward at Lakeside, which had 85 incidents of restraint, of which 49% were in the prone position, and Grosvenor, a female assessment ward, which had 74 incidents of restraint, of which 42% were in the prone position. Askew ward, the male PICU at Hammersmith and Fulham Mental Health Unit, recorded 65 incidents of restraint of which 33% were in the prone position.
- At our previous inspection in November 2016, we saw that while risk assessments were generally completed and up to date, on some wards, including Finch, Kestrel and Avonmore, staff had not updated risk assessments comprehensively following significant incidents. At this inspection we found that this was not the case and that risk assessments were regularly updated and reflected the current risk areas relating to individual patients.
- Ward managers or senior nurses on the wards reviewed and audited risk assessments regularly to ensure that they were up to date.

Management of patient risk

- We observed one handover on Horizon ward and saw that patient risk was identified and discussed extensively. At St Bernard's staff recorded handovers electronically so that information could be recorded and shared more easily. At Hammersmith and Fulham Mental Health Unit, the staff had morning meetings, called huddles, which involved all staff on the ward. It

Are services safe?

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was a standing meeting so that it took place quickly. All plans and key risks were discussed so that all staff were aware of them and any areas of concern could be shared.

- We saw that on Lillie ward, the staff team had worked on a discrete quality improvement project focusing on reduction of violence and aggression on the ward. Staff were proud of this work and reported they had won an internal award for it.
- Staff were aware of recent incidents and told us that information about incidents, including learning from incidents, was discussed at team meetings and also in supervision. Where there had been a serious incident, information and learning was also shared by email. In October a significant incident with potential learning across the service had taken place and had featured on the front page of the trust intranet site to ensure that all staff knew about it.
- At Lakeside, the local acute NHS trust had withdrawn from an arrangement to provide emergency cover to the mental health wards. Some staff, including medical staff at Lakeside, raised concerns about this and the impact that it had on patient care. Alternative arrangements involved calling emergency services, even though the mental health wards at Lakeside are based on the same site as the acute hospital trust. Staff at Lakeside knew the protocol had changed and that they were no longer able to call direct to the acute hospital for assistance in a medical emergency.

Safeguarding

- Staff we spoke with told us that they had an understanding of safeguarding both adults and children and had accessed training through the trust. Some members of staff across all sites were able to give us examples of where they would report safeguarding concerns and some told us about times when they had

raised concerns with their managers. However, across the three sites, we saw that the trust safeguarding policy, particularly in respect to patients who assault other patients on the wards, was not being consistently applied.

- The trust policy states that when staff make a decision not to refer a safeguarding concern to the local authority, the reason should be clearly identified in the patient's records. We found that this was not consistently happening. For example, on Hope ward, we reviewed eight incidents of patients who assaulted other patients between July 2017 and December 2017. One incident was reported as a safeguarding concern. The seven other incidents were not flagged as safeguarding concerns and there were no details recorded to explain why. We also found two reports on Finch ward which did not include the reason for the non-referral. This meant it was difficult to be sure proper consideration had been given to the patient's wellbeing when the decision was made.
- Safeguarding information and data was not routinely discussed at local performance meetings or divisional management meetings. This meant that potential data inconsistencies were unchallenged and safeguarding data was not interrogated at a local or divisional level to ensure a consistent approach across services. For example, on Lillie ward in Hammersmith and Fulham, one set of minutes from the clinical improvement group meeting stated that there had been three safeguarding concerns over the previous month (December 2017) but the data received from the trust referred to one safeguarding concern having been reported. The trust were aware that the processes around safeguarding were an area for which they needed additional assurance as their internal governance procedures had identified the gap.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- At our last inspection in November 2016, some care plans did not evidence clear involvement from patients and the language used was not accessible. The trust had undertaken significant work on the quality of care plans and related areas which were important to patients during their inpatient admissions. During this inspection, we saw improvements had been made in relation to people's involvement in care planning but further work was required to make sure all care plans were completed to a good standard and reflected patients' views. Most of the patients we spoke with told us that they were aware of the content of their care plans and that they had been discussed with them. This was confirmed, for example at St Bernard's, where the six records we checked showed evidence of patient involvement in care planning. However, some care plans still contained acronyms and medical jargon so staff needed to remain vigilant about use of language. Staff told us they explained the language used to patients when they discussed care planning with them so that it would not have a significant impact on their understanding.
- Ward managers across the three sites audited care plans weekly and these audits were collated by managers for the site. This made sure that care plans were regularly updated. Most care plans we saw were up to date.

Best practice in treatment and care

- At our last inspection in November 2016, we found that patients at Lakeside Mental Health Unit, who were prescribed high dose anti-psychotic medication, did not receive routine physical health checks and staff we spoke with were unaware of the additional risks related to high dose prescribing of anti-psychotics. During this visit, we did not find any patients that were prescribed anti-psychotic medication above the British National Formulary (BNF) recommended limits. However, we saw that the service had a cohesive protocol in place so that when this happened additional physical health checks were undertaken. Most staff were aware of this.
- At our previous inspection in November 2016, we found that staff on Ravenscourt ward in Hammersmith and Fulham had not consistently recorded and completed

regular physical health checks using the National Early Warning Score (NEWS); a protocol used to record information and escalate concerns about any deteriorating physical health of patients in mental health wards. At this inspection, we found that staff across all the sites were regularly recording (manually and electronically) physical health checks and using the NEWS. Members of staff were aware of the need to escalate physical health concerns and the deterioration of physical health was discussed during ward rounds, in safety huddles and at handovers. Staff across all the sites were able to give us examples of situations when the scores had led to a patient being escalated to see a doctor. Staff had a good understanding of best practice for screening and intervening when patients had physical health needs. The method of scoring NEWS and information about when a response should be triggered was displayed clearly on all the wards.

- We saw that staff audited physical health records weekly so any concerns could be addressed in a timely manner.
- At our previous inspection in November 2016, we noted that access to psychological therapies and input from a clinical psychologist was limited at Hammersmith and Fulham and Lakeside to one psychologist for all the acute wards on site. This meant that patients had limited access to psychology-led groups or individual therapy. This was the same during this inspection; psychology provision had not changed. Some staff at Hammersmith and Fulham Mental Health Unit and Lakeside Mental Health Unit told us that, in their judgement, the psychology provision was insufficient on the wards. At the time of our inspection, there was a consultation taking place to look at the reconfiguration of psychology input to inpatient services. The proposal we saw recommended an increase in clinical psychology for the acute wards.

Skilled staff to deliver care

- At our previous inspection in November 2016, we found that staff were not consistently accessing supervision and ward managers did not always have information to assure themselves of the quality of supervision provided by ward colleagues. At this inspection, we found that recording of supervision did not always keep up with the supervision which happened on the ward. For example, we saw that the supervision rates between January 2017 and December 2017 across all the wards

Are services effective?

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

was at 57%, with the highest rates on Ravenscourt ward (78%) and the lowest on Grosvenor ward (24%). However, when we spoke with permanent staff and agency staff who were on longer term contracts, they told us that they had access to regular supervision and they felt supported and able to raise concerns regarding clinical practice. Staff on all the wards also had access to facilitated reflective practice groups which they also told us were helpful. These were available to all staff in the multi-disciplinary teams on the ward. We found the recording of supervision did not reflect the work happening in practice. Ward managers used a template for supervision which flagged key areas such as performance, development and support so that these areas could be discussed regularly with staff. Staff also

spoke to us positively about informal support within the teams in which they worked, particularly nursing staff. Most staff we spoke with were very positive about the support that they received from their immediate managers.

- Regular bank staff did not always receive the same level of supervision and support. When we raised this with the trust they immediately took steps to improve their offer to bank staff and ensure that all staff working on the wards had access to supervision.
- Across the wards, we saw that staff had been appraised. Overall the number of appraisals completed in the year to January 2018 was 88%, with Hope ward and Grosvenor ward each reaching 100%.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- At our last inspection in November 2016 we found occupancy rates on all the wards were high. This meant that patients had to be placed with private providers outside their local or that patients, particularly on Horizon ward, had been sleeping on the rehabilitation ward at the same site because there had not been an acute bed space available for them. At this inspection we found this was no longer the case and the wards were running on an 85% occupancy rate at the time of the inspection. The service had worked hard to reduce patients' lengths of stay and delayed discharges to ensure that beds were available for other patients when they needed them.
- The trust had undertaken a thematic review of patients with the longest lengths of stay across the service to analyse the reasons for this. A number of specific recommendations arose from this piece of work and the work on the acute inpatient pathway was continuing to make sure beds were available when and where patients needed them. The clinical service unit which managed the acute wards for adults of working age and the psychiatric intensive care unit made the reduction of the length of inpatient stays a priority, ensuring that discharges were considered from the date of admission and beds were local to patients who needed them.
- We saw that for the four months prior to the inspection, no patient had been moved to sleep on a different ward due to bed pressures and for seven months, no patient had slept out on a rehabilitation ward.
- The service had implemented seven day standards to assist with this. This was an initiative which was agreed with the community teams to ensure that care coordinators were involved within the first week of all inpatient admissions. This meant that as much as possible was already in place to support the patient in the community as soon as they were medically fit for discharge and that where there were any potential delays, such as those which may relate to housing, these could be identified early in the admission.

Bed management

- Since our last inspection, the trust had incorporated new ways to look at discharge management. This included using a Red2Green system. Red2Green is a visual approach to bed management which has been used in acute hospitals and some mental health trusts. The trust used this approach to focus on bed flow and ensure that daily discussions took place on wards about each patients' progress towards discharge. They adapted material which had been used in acute trusts to meet the needs of a mental health service. This approach had started in Hammersmith and Fulham and had rolled out across the trust.
- Bed management meetings took place weekly at each site, they had been adapted to embrace the Red2Green process. A wide range of professionals attended, including care coordinators or representatives from community teams, as well as staff from housing support organisations and the local authority. Each inpatient day was determined to be a 'green' day if action had been taken towards discharge and, if no action was taken, this was classed as a 'red' day. It helped to maintain the momentum around discharge planning. As well as these weekly meetings, there were also daily calls or huddles between the senior management team so they were aware of any issues that impacted on discharges. This led to more rapid problem solving with input from local community teams, including the crisis team.
- The system that the service had put into place allowed ward teams to see the granular details of their own barriers to discharge in a visual form in terms of days which progressed care and treatment as well as 'hidden' days which did not. This enabled a more detailed transparency allowing ward teams to escalate situations which may delay discharge very easily and quickly. This information could also be aggregated across each borough or throughout the service to quickly identify trends.
- Staff told us that when patients were on weekend leave, their beds were not used for new admissions. Therefore they had access to a bed on the same ward on their return from leave.
- Other work had taken place to develop a team to monitor and review out of area placements and to work with local services around clinical engagement. Through

Are services responsive to people's needs?

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

the process of engagement, targets were set for the services around, for example, admissions and discharges each week, so any potential outliers could be monitored.

Meeting the needs of all people who use the service

- At our last inspection in November 2016, we found that, on occasion, an interpreter had not been arranged when a patient had required one. At this inspection, staff had a good understanding of when and how to book interpreters for patients and for carers, when necessary. We heard about examples of interpreters being used and saw that this had improved.

Are services well-led?

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

Our findings

Governance

- At our last inspection in November 2016, we saw that some ward managers did not have extensive access to information about their ward's performance. At this inspection we saw that some progress had been made. Ward managers were able to access basic information directly from the trust intranet relating to staff training, supervision and incidents which occurred on the wards. All ward managers ensured there were regular audits in areas such as care planning and risk assessment and the outcomes of these audits were collated centrally.
- Following our inspection visit, we queried some information provided to us in relation to numbers of seclusions at Hammersmith and Fulham Mental Health Unit. In response to this request, the trust confirmed with us that due to the systems which had been used, they could not confirm the accuracy of the data provided. They provided us with an assurance that this would be actioned as a priority. The issue of data quality was raised at the previous inspection in November 2016, but this had not been addressed as part of the divisional action plan, the local risk registers or the contents of the minutes of the senior management meeting for the division. This demonstrated a weakness in the trust's governance processes.
- Most wards had regular clinical improvement group (CIG) meetings where areas of clinical governance were discussed. Ward managers, service managers based at each of the three sites and the relevant modern matrons also had monthly quality meetings which looked at the data amassed at ward level before it was fed back to the board. This process of information transfer from ward to board and back to the ward was in place but more work was needed. For example, some ward managers were not able to access sufficient detail about all incidents, to aid their understanding of developing themes. On Lillie ward, the staff team had worked on a specific project to reduce restrictive practices by looking at themes and types of incident. They demonstrated the value of access to detailed information at ward level, as a result, the ward manager had good oversight of the current needs, risks and strengths of their patient group and how this matched with the staff group.

Leadership

- Staff were generally positive about their management, both locally and within the trust. Staff at the three sites told us that members of the trust executive team were visible and they felt they could raise concerns if they had them. One member of staff at Hammersmith and Fulham told us that they felt the senior management team had really listened to them when changing the number of beds on Ravenscourt and Avonmore wards and that this had been positive. One member of staff at St Bernard's told us that the pace of change had been very fast and, sometimes, it felt like constant change, which was not always consistently positive.

Management of risk, issues and performance

- All ward managers received monthly updates on the performance of their service which was used to inform the ward clinical improvement group. These were in the form of a spreadsheet called a quality improvement map which listed key performance areas for each ward and service in the trust.
- Staff across the service were committed to patient involvement. All wards had community meetings which were recorded so that issues which were raised could be followed up. We observed one community meeting and saw that issues were raised, addressed and recorded. There were 'you said, we did' boards on the wards and staff gave out feedback cards to collect comments.
- Staff at the Hammersmith and Fulham Mental Health Unit, had not consistently followed the trust policy and recorded as incidents the occasions when the maximum fridge temperature was over 8°C for more than one consecutive day. Therefore, the problem continued because it was not properly addressed.

Learning, continuous improvement and innovation

- Since our last inspection in November 2016, the service had continued to embed some quality improvement work in day to day practice. Staff spoke positively about the initiatives and the opportunities for training. We saw some projects had progressed and led to positive outcomes for patients, as well as improved engagement with staff.
- On Lillie ward in Hammersmith and Fulham, as well as their quality improvement project, we saw examples of positive behavioural support plans which were detailed

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and helpful to both staff and patients in identifying potential triggers for further deterioration in the patient's mental state. We met a member of staff who had been promoted through the trust into a new role which had been developed on the ward and they told us that they had been supported to develop by the trust.

- The trust was undertaking a significant piece of work to develop a set of standards, co-produced with a local service user group, setting out what all patients should expect when admitted to a ward within the trust's local services. This piece of work was ongoing at the time of our inspection but we saw the initial standards had been drafted.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

The trust was not ensuring care and treatment was provided to service users in a safe way.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The trust had not ensured that all premises and equipment used by the service provider was properly maintained.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust had not ensured there were a sufficient amount of suitably qualified staff deployed to carry on the regulated activity.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The trust did not have systems in place to effectively prevent the abuse of service users.

Regulated activity

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

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

The trust did not have systems in place to assess, monitor and improve the quality of services provided in the carrying on of a regulated activity.