Central and North West London NHS Foundation Trust

Inspection report

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Date of inspection visit: 18-19 July, 25 July, 28 July, 1 August, 3 August, 31 August, 11-15 September and 27 September 2023
Date of publication: 22/02/2024

Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We inspected Central and North West London NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

We inspected four of the mental health services provided by the trust. We completed full inspections of the trust's forensic inpatient or secure wards and long-stay or rehabilitation mental health wards for working age adults. We completed a focused inspection of mental health crisis services including health-based places of safety, psychiatric liaison services and some new assessment services. We also carried out a focused inspection of one child and adolescent mental health ward for young people with a learning disability. We chose these core services as we knew there had been some challenges including serious incidents or where the service was more likely to become a closed culture.

The trust provides the following mental health services, which we did not inspect this time:

- Community-based mental health services for adults of working age
- Acute wards for adults of working age and psychiatric intensive care units (PICUs)
- Wards for older people with mental health problems
- Community-based mental health services for older adults
- Specialist community mental health services for children and young people
- Community mental health services for people with learning disabilities or autism
- Wards for people with learning disabilities or autism
- Specialist eating disorder services
- Substance misuse services

The trust also provides the following community health services, which we did not inspect this time:

Our findings

- Community health services for adults
- Community end of life care
- Community health services for children, young people and families
- Sexual health services
- Community health inpatient services
- Community dental services

Our rating of services stayed the same. We rated them as **good** because:

- We rated safe as requires improvement, caring as outstanding, and effective, responsive and well-led as good. We also carried out a well-led inspection and rated the trust as good.
- We rated two out of four of the trust's services that we inspected. Long-stay or rehabilitation wards for working age adults were rated requires improvement and forensic inpatient or secure wards were rated good. We did not rate the other two services as we only partially inspected those services.
- In rating the trust, we took into account the current ratings of the mental health and community health services we did not inspect this time.
- The inspection took place at a time of complexity for the trust board as the decision to have a chair in common across three trusts in North West London had just been made. The board and other senior leaders needed the time to think through the implications including opportunities for more joined up working to better meet the needs of the local population.
- There had been significant changes in the executive leadership team and non-executive directors, these had gone well and provided an opportunity to improve the diversity of the board and introduce people with the breadth of experience needed to support the strategic direction of the trust. Senior leaders demonstrated commitment, enthusiasm and a willingness to innovate to deliver the best services. They were open and honest about recognising and sharing the challenges faced by the trust but also solution focused when looking at how these could be addressed.
- Patient and carer involvement had progressed significantly since the previous well led assessment and was well embedded throughout many areas of the work of the trust. For example, 80% of the 345 active quality improvement projects included people who use services. The trust had an involvement register which had grown and enabled people with lived experience (experts by experience) to join and help deliver this work. At the time of the inspection there were around 100 people on the register. There were many examples of where experts by experience had contributed to the work of the trust. The trust had also made progress with the employment of 134 peer support workers, although they recognised that further work was needed to ensure they received the right support. In October 2022 the trust launched the volunteer to career programme. Since then,156 volunteers had been placed in a variety of settings; 29 new volunteer roles had been created; 25% of volunteers had moved into employment. Whilst some carers recognised the opportunities for more involvement, there were others who still found it hard to engage with services.
- Quality improvement had also become fully embedded in the work of the trust since the last inspection. People working for and associated with the trust talked about how the approach was widely used. This approach was being developed to address areas where the safety of care needed to improve, such as reducing falls and improving

Our findings

pressure ulcer care. Quality improvement projects had resulted in reductions in violence and aggression and in the use of restrictive interventions. A quality improvement approach was used to improve access to services, such as reviewing psychological therapy services and the assessment of young people with attention deficit hyperactivity disorder and autism spectrum disorder.

- The trust made good use of data to inform decision making. They had access to management information and since the previous inspection had made widespread use of integrated performance reporting. There was improved access to 'real time' information and they were working towards automated dashboards. The quality of performance information was good and board members felt they had access to data that was reliable.
- The trust embraced digital technology to improve services. One of the key developments had been the use of e-prescribing which was in place for inpatient services and being extended to home treatment teams. In pharmacy services patients could scan a QR code on their mobile devices which provided access to educational videos on high-risk medicines. Plans were underway to have further automation of human resources processes; increase the number of patients being able to order their prescriptions online; and develop technology to support patients managing their personal health record.
- Partnership working had developed significantly since the previous well led review. Senior divisional leaders were actively participating and leading in the care systems where most trust services were located. The trust had many examples of where it was working in boroughs and neighbourhoods to meet the needs of communities. The trust led and actively participated in provider collaboratives. They also helped deliver national programmes such as the roll out of the Mpox vaccine.
- The trust was committed to supporting staff to 'speak up' and since the previous inspection arrangements for the freedom to speak up guardian had been strengthened. Staff knew how to access this support, the guardian was visible and supported by speak up ambassadors.
- Feedback from the guardian was collated into themes to promote organisational learning. The resources for the speak up function were under review to ensure there was sufficient capacity.
- The trust had further developed equality, diversity and inclusion. The trust had seven staff networks (there were five at the previous well led review). These were the lesbian, gay, bisexual and transgender (LGBT+); Black, Asian and ethnic minority (BAME); carers; women; lived experience of mental health stigma transformation; and disability. All the networks had a non-executive director and executive director sponsor. The staff networks were participating in wider governance arrangements by attending key meetings and having input into policy development. The trust were proud to have remained in the Stonewall list of top 100 employers. There was a recognition that there was still much more to be done and the workforce race equality standards showed ongoing disparity in career progression. However, there was lots of positive feedback about the 21 Century leadership programme where at least 50% of the intake were BAME staff (135 staff so far). The trust was supporting career conversations to look at individual needs. The trust had a stated intention that there would be a representative from a BAME background on recruitment and disciplinary panels. This was monitored but not always achieved, and further training was needed for the representatives.
- We found some good practice in relation to incident reporting, incident investigations and mortality review processes. The trust had a strong reporting culture for incidents. This was reflected in the data for the previous year which showed that 98.2% of all incidents were reported as resulting in no or low harm. The incident investigation reports were completed to a high standard. The trust monitored how long it took to complete investigations and was working to keep the timescales at an appropriate level. The trust looked at themes and this was linked to the quality improvement work on patient safety. The trust had effective and robust governance processes in place to investigate

deaths within the trust and use the learning to make improvements. This included being sighted on the deaths of people using community services. They had found a backlog of action plans which needed to be completed by the divisions and this was being addressed. They also recognised that there could be more shared learning with system partners.

However:

- Overall, we found that whilst there had been significant progress in some areas since the previous inspection there was more to do. The trust leadership was mostly aware of where further input was needed and had plans to continue this work. They were focusing on improving the experience of patients accessing and using their services.
- The escalation and oversight of operational risk needed to be strengthened and work was underway. Our inspection found that an acute ward in Milton Keynes had been experiencing significant challenges when it was inspected in 2020. A follow up inspection in 2023 had found many of the similar challenges. Whilst risks in the service had been escalated there had not been a recognition that following a period of improvement the service had not sustained the changes. Following the latest inspection, the trust had appropriately identified the current level of risk in the service and was making the necessary changes. At the time of the well led assessment the trust was refreshing its processes for the escalation of operational risk so that trust board members could have greater assurance about appropriate levels of oversight by the executive board. The trust had also updated the board assurance framework and there were plans for board members to review this and consider risk appetite.
- The trust had several assurance processes to identify services at risk of developing a closed culture, but these needed to be strengthened further. Our inspection found a rehabilitation service, Westfield House in Epsom, where some institutional practices had developed and where patients were not receiving the support needed to promote their rehabilitation. Among the findings were some restrictive practices that prevented patients from leading a more independent life, a lack of choices and respect of patients' preferences including those associated with eating and drinking and insufficient discharge planning. Following the inspection, the trust closed the service. The trust made good use of data to identify services which were outliers including feedback from complaints and staff concerns. They also had several visits to services including board members, governors, peer visits and in some areas input from Healthwatch. However, this needed further review and strengthening to ensure unacceptable practice was identified.
- The trust was experiencing major pressures on the mental health urgent care pathway. This was a national issue, but our inspection found the experiences of many people accessing these services was poor, for example people waiting for excessive periods of time in acute emergency departments and in health-based places of safety. The trust was working to try and address the challenges within the different systems where they had services. This included work to reduce lengths of stay, improve patient flow and avoid the use of out of area placements. In North West London they had plans to open additional acute mental health beds at Park Royal. They had also opened a mental health crisis assessment service at St Charles Hospital in North Kensington. Other assessment services aligned to acute emergency departments were operating at St Mary's and Hillingdon hospitals. The trust was closely monitoring their performance, and benchmarking, for 12 hour breaches in waiting for a mental health bed. They were performing well in relation to other London trusts but recognised that there was more to do, particularly in partnership with acute providers.
- The trust had a programme of work to improve the physical healthcare of patients with mental health needs, but this had to embed further. Our inspection of the forensic wards looked carefully at this as the patients usually have long term mental health conditions. There had also been a death on the ward where a deterioration in the patients' physical health had not been identified. Here we found that despite measures being taken by the trust to improve physical health monitoring this was not happening thoroughly.
- Further work was needed to embed the trust strategy and align other enabling strategies. The trust had carried out a refresh of its strategy. There were five clear strategic priorities which were easy for people to understand. However,

the strategy was not yet embedded in governance arrangements. For example, board papers were not aligned to strategic priorities. The trust was working to refresh a range of other strategies such as estates and digital. It was not always clear how these pieces of strategic work aligned to each other and the trust governance processes. The work on a clinical strategy was at an early stage.

- Staff supervision had progressed since the last inspection but there was more to do. The staff had developed an online tool so that supervision could be recorded and monitored. However, from focus groups it was evident that staff were often having very different experiences of supervision. We heard about a current quality improvement project looking at how the quality of supervision can be improved this was including updating the policy, auditing supervision practices, and developing training to take this work forward.
- The failure of staff to carry out therapeutic observations appropriately continued to be a recurring theme in serious incidents. Work was underway but there was more to do. The trust was aware of this and was taking steps to make improvements through a task and finish group. This included the pilot of new digital equipment to record observations – although this would not yet work for intermittent observations. Training had been enhanced and observations was covered in staff induction and was an area included in the simulation training being rolled out across the sites by the education team. The trust was trying the use of a badge – so that staff would know when a colleague was carrying out observations. They were also looking at giving staff bum bags containing items which could be used to improve therapeutic interactions such as a pack of playing cards.
- Staff recruitment and retention continued to be the most significant risk for the trust. This led to the use of temporary staff and the associated reduction in consistency of care. Safe staffing was monitored and mostly met, with outliers clearly identified. At the time of the inspection trust vacancies were 9.3% (medical 13% and nursing 18%) – lower than other London trusts. Turnover was 19.2% and high turnover in the first year was an area of particular concern. The trust was trying a number of measures including a 1:1 conversation with each new starter every 30 days to find out if they needed any support. This was an area of ongoing work.

How we carried out the inspection

The teams which carried out the inspections of core services comprised of 11 CQC inspectors, 4 CQC pharmacist inspectors, 3 CQC senior specialists, 6 external specialist advisors and 3 experts by experience who talked with patients and carers in person and on the telephone.

The team which carried out the well-led assessment comprised of 2 external executive reviewers, a financial governance assessor from NHSE, 2 CQC pharmacist inspectors, a Mental Health Act reviewer, 2 CQC inspectors, a CQC operations manager, a CQC senior specialist, and two CQC deputy directors of operations.

The full inspection of forensic inpatient and secure wards involved visits to Java House and Tasman ward both located at the Park Royal site.

The full inspection of the rehabilitation mental health wards included visits to 6 services. In North West London these were Roxbourne Lodge, Roxbourne House and Rosedale Court. In Epsom these were Ascot Villa, Westfield House and The Cottages. Following the inspection the trust closed Westfield House.

The focused inspection of child and adolescent mental health wards for young people aged 13 to 18 with a learning disability involved a visit to Crystal House at the Kingswood Centre in North West London.

Our findings

The focused inspection of crisis services included visits to the health-based places of safety at St Charles and Hillingdon Hospitals; the psychiatric liaison teams at Hillingdon Hospital, Northwick Park Hospital and Milton Keynes Hospital; the mental health crisis assessment services at St Charles and Hillingdon Hospital.

During our inspection of the four core services and the well-led review, the inspection teams:

- reviewed records held by the CQC relating to each service
- spoke with 59 senior leaders during our inspections of services, including board members, divisional directors, service directors, service managers, operation managers, the lead psychologist, matrons, ward managers and lead nurses.
- spoke with 109 other members of staff, including registered nurses, healthcare assistants, forensic social workers, student nurses, consultant psychiatrists, specialist doctors, ward doctors, occupational therapists, pharmacists, advocates, housekeeper and catering staff, ward administrators, a mental health administrator, activity coordinators, a gym instructor, a speech and language therapist, drug and alcohol specialists and staff from the corporate health and safety team.
- interviewed 54 patients and 31 relatives or carers of patients face to face or on the phone
- reviewed 90 patient care and treatment records
- attended meetings on the wards and teams we visited, including 5 staff handover meetings, 2 safety huddle meetings, 2 ward rounds, 2 community meetings, 1 patient planning meeting, observed lunch service on 2 wards and attended a bed management meeting
- carried out observations on 2 occasions using the short observational framework for inspection (SOFI) on the long stay/ reablement wards. This is a tool developed and used by inspection teams to capture the experiences of people who use services who may not be able to express this for themselves.
- looked at a range of policies, procedures and other documents relating to the running of each service.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/ how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Overall feedback from patients on the forensic wards was mostly positive. Patients told us they were listened to and felt safe. All patients reported that they were involved in their care and had access to activities within the service and the community. They told us they were supported to maintain contact with family members. Patients said staff treated them well and that the ward was much calmer and settled.

The relatives and carers of patients with whom we spoke during our inspection of the forensic wards reported that their family members were safe and well looked after. They said they were involved in care programme approach meetings, ward rounds, discharge planning and Mental Health Act tribunals, in accordance with the wishes of their family member. However, all carers told us that they were not always kept updated and communication could be improved.

On the long stay and rehabilitation wards, patients mostly spoke positively about staff attitudes. Staff gave patients emotional support and advice when they needed it. Most patients enjoyed the activities on offer but said there was nothing for them to do at evenings or on weekends. Not all patients felt staff supported them to understand their own care and treatment, and some patients did not have regular one-to-one sessions with their named nurse.

Our findings

Patients' carers were very positive about staff on the rehabilitation wards and the care they provided. However, some carers expressed frustrations with not being invited to ward rounds despite their relatives having consented to their attendance. Most carers did not know how to complain but felt comfortable raising concerns with ward staff.

Young people on the child and adolescent mental health wards told us they felt safe on the ward and were appropriately supported by care staff. One young person told us that "it's good being here, it's good for me to be in a calm place, staff help me".

Feedback from one young person showed that patients had enough to do to keep them stimulated. They told us that they rarely got bored on the ward and enjoyed activities such as boxing, drawing, cooking lessons, using the garden and going on community leave.

We spoke with three carers during our inspection, who were largely positive. A carer told us that their relative had improved whilst at Crystal House, and staff were very welcoming and kept them informed. This was confirmed by a young person who told us that since being at Crystal House "I've learnt to be kinder to myself and to love myself".

In one health-based place of safety, one person gave us positive and complimentary feedback about the staff and told us they found the environment comfortable and accommodating. We also spoke with 4 patients who were former patients of the places of safety and their feedback was mostly positive. They told us they felt safe and cared for and had access to advocacy. One patient told us they did not get a choice of food.

The feedback from patients supported by the psychiatric liaison teams and in the crisis assessment centres was mostly positive. Patients told us they felt safe and found the environment comfortable for their stay. Most patients knew how to feedback or complain. However, 2 patients told us they had not been told how to give feedback. Most patients told us they valued the service and it had been helpful to them in a time of crisis.

Carers across the trust told us that they were pleased with the support they received in their roles. They also said that whilst the trust had many positive initiatives and QI projects, these were sometimes at a higher level and they did not always see the impact on the care of their relatives. For example, they told us about the Triangle of Care concept which the trust has adopted. They reported that they did not always see the application of the Triangle of Care at a more individual level for all patients or feel involved. The Triangle of Care is a partnership between professionals, the person being cared for, and their carers. It sets out how they should work together to support recovery, promote safety and maintain wellbeing.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. 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.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with 7 legal requirements. This action related to four services.

Our findings

Forensic inpatient and secure wards

- The trust must ensure that physical health monitoring is robust and that information about patients' physical healthcare is recorded accurately. NEWS2 records must be completed accurately, and elevated scores must be escalated. VTE assessments must be carried out upon admission, constipation monitoring must be in place for patients on clozapine, patients' blood glucose must be monitored in line with the care plan and any physical health investigations followed up at the ward round. Where decisions have been made not to escalate concerns these should be clearly recorded in patient care plans. Regulation 9(1)(3)(a)(b)

Long stay/rehabilitation mental health wards for working age adults

- The trust must continue to keep under review the provision of mixed sex accommodation across the rehabilitation services. Where sexual safety concerns are identified these must be addressed swiftly. Regulation 12(1)
- The trust must ensure that intermittent observations are carried out at unpredictable times throughout the hour, in line with the trust's policy. Regulation 12(1)
- The trust must ensure that staff check and monitor patients' physical health in line with guidance after the administration of injectable medicines. Regulation 12(1)
- The trust must ensure that a rehabilitation and recovery ethos is effectively integrated into patient care plans and goals, and that patients have the opportunity to develop and practice life skills. Regulation 9(1)(3)
- The trust must ensure that all staff are familiar with safeguarding processes and address them appropriately as per the trust's policy. Regulation 13(1)
- The trust must ensure that the shortcomings and limitations of ward environments, and restrictive practices across the rehabilitation services are kept under regular review, and that shortfalls are addressed where identified. Regulation 15(1)
- The trust must ensure that maintenance issues are addressed across the service in a timely manner. Regulation 15(1)
- The trust must ensure it continues to recruit to vacant psychology posts across the service and an OT post at the Horton site so patients across all wards have consistent access to healthcare and therapies which meet their needs. Regulation 18(1)
- The trust must ensure governance processes operate effectively in relation to quality, risk and performance, and that plans to remedy issues identified by leaders are effective. Regulation 17(1)

Child and Adolescent Mental Health Wards

- The trust must ensure that staff deliver care in line with young people's care plans and risk assessments, particularly specified dysphagia care plans. Regulation 12(1)(2)(a)(b)

Health-based places of safety

- The trust must ensure patients in the health-based place of safety are not held beyond the 24-hour Section 136 detention period with no legal framework for holding them. Regulation 13(1)(2)(5)
- The trust must ensure that staff provide clear information to patients on a regular basis, to meet each patient's need to understand their rights. Regulation 9 (1)(3)(c)(g)
- The trust must ensure that staff are implementing the Mental Capacity Act appropriately. Regulation 11(1)

Our findings

- The trust must ensure that when staff administer medicines to patients in the place of safety, they must record under what legal authority this is being given. Regulation 11(1) (3)

Psychiatric liaison teams

- The trust must ensure that when a person is assessed as requiring an inpatient bed that they are able to access a bed without delay. Regulation 9(1)(3)(a)(b)
- The trust must ensure that staff are recording a patient's mental capacity to consent clearly. Regulation 11(1)

Action the trust SHOULD take to improve

Trust wide

- The trust should continue its work to identify and appropriately escalate operational risk to ensure services needing support and monitoring have this in place.
- The trust should review its assurance processes to ensure services at risk of developing a closed culture are monitored appropriately.
- The trust should continue its work to improve the experiences of patients who have a mental health crisis and reduce the time spent in inappropriate environments.
- The trust should continue their work to identify and address the physical health of patients with mental health needs and ensure new measures are embedded.
- The trust should continue to embed the trust strategy and ensure there is clarity about the enabling strategies and that they are aligned to governance processes.
- The trust should continue its work to ensure staff have access to high quality supervision.
- The trust should continue its work on promoting high quality observations with the aim of reducing the incidents where the failure to carry out observations correctly is a contributory factor.
- The trust should maintain its focus on reducing the turnover of staff in the first year.

Forensic inpatient and secure wards

- The trust should ensure that all staff know and understand the ligature management arrangements on both Tasman ward and Java House.
- The trust should continue to ensure that ward environments are refreshed and ensure there is a programme of redecoration and refurbishment in place for both wards.
- The trust should review the completion of medicines records.
- The trust should include learning from incidents as a standing agenda item for staff team meetings.
- The trust should ensure that patients receive timely and regular updates on concerns that they have raised at community meetings.

Long stay/rehabilitation mental health wards for working age adults

- The trust should ensure all staff know where ligature points are located on the wards they are working on to aid risk management.

Our findings

- The trust should ensure staff follow the trust's clinical risk assessment and risk management policies when admitting patients to the wards, and when new risks are identified during admission.
- The trust should ensure that its target to train all eligible staff in Immediate Life Support (ILS) is reached within its 12 month target.
- The trust should ensure that all food consumed by patients across the rehabilitation services is labelled with expiration dates, and discarded if it is not within this date.
- The trust should ensure that staff monitor and record patients' physical health and vital signs appropriately, including the side effects of medicines and additional monitoring where necessary.
- The trust should ensure arrangements are in place so patients have access to meaningful activities on evenings and weekends.
- The trust should ensure that all the ward environments in the rehabilitation services promote a hopeful and motivational rehabilitation environment.
- The trust should ensure patients feel supported to understand and manage their own care, treatment and/or condition, and that they have access to regular one-to-one sessions with their named nurse.
- The trust should ensure that staff record clear rationales to explain why they have deemed patients to lack capacity.
- The trust should ensure families are carers are invited to ward rounds where appropriate.
- The trust should ensure patients and carers are provided with information about how to make a formal complaint.
- The trust should ensure discharge care plans at the Horton site contain clear goals for how staff and patients will facilitate timely discharge from the wards.
- The trust should ensure all patients have a secure place to store their personal possessions.
- The trust should ensure patients have access to interpreters when this will benefit their treatment outcomes.
- The trust should ensure all patients have access to religious and spiritual material and support that meets their needs.

Child and Adolescent Mental Health Wards

- The trust should ensure that all staff where required are up to date with immediate life support training.
- The trust should consider how it manages risks to young people who are prescribed epilepsy rescue medicines when going on staff escorted leave from the ward.

Health-based places of safety

- The trust should ensure that the number and proportion of prone restraints at St Charles health based place of safety is reduced.
- The trust should review staffing levels at St Charles health based place of safety in response to staff feedback and patient acuity.

Psychiatric liaison teams

- The trust should ensure that patients in the crisis assessment centres do not stay beyond the period stated within the trust's operational policy.

Our findings

- The service at Milton Keynes should continue to work on recruiting a psychology lead for the service.
- The trust should ensure patients are told how to give feedback about the service.
- The trust should ensure that staff are up to date with all mandatory training.

Is this organisation well-led?

Leadership

Since the last well led review there had been significant changes in the board. The trust had appointed a new chair, chief operating officer, chief financial officer, chief strategy and digital officer and chief people officer. There had also been four non-executive directors who had joined the board. These changes had gone well. The chair had previously been a non-executive director. The chief operating officer had previously been a divisional director. This had provided some continuity whilst also introducing board members who were new to the organisation.

The changes in non-executive directors had improved the diversity of the board to better reflect the populations in the areas covered by the trust. The executive directors recognised that they were not sufficiently diverse although work was taking place to promote improved diversity at this level in the future.

The chief executive had remained the national mental health director for NHS England. In dividing her time between these roles, she was very clear about what activities she undertook for the trust that were essential. She was also based at the trust and was available when needed. This arrangement which had been in place at the time of the previous inspection continued to work well.

The non-executive directors had the good range of skills, knowledge and experience. They all had experience as senior leaders in a wide range of public, private and third sector organisations. There was one non-executive director vacancy which was the post vacated by the chair. A second non-executive director was due to leave. At the time of the well led review the decision had been made for the chair to be appointed as chair in common across two other trusts in the local system. The implications of this still needed to be considered and as part of this was the decision about how the non- executive director vacancies would be filled.

The board was observed to work in a unitary manner which was open and where constructive scrutiny took place. Members of the board were mutually respectful, actively listened and were able to ask challenging questions of each other. Throughout the well led interviews members of the board demonstrated a clear understanding of the strategic direction of the trust. Most of the board were passionate about delivering high quality care and treatment for people using the trusts services. A couple of non-executive directors presented in a professional but more dispassionate manner, particularly when talking about examples of where the trust needed to improve.

The board met every two months. Development and workshop sessions took place in the intervening months. A programme of board visits to services took place although there was a variable level of attendance for the non-executive members. Non-executive directors spoke about the value of these visits and how they were able to raise questions and concerns and be assured that issues raised were followed up. Feedback from these visits were provided in part 2 of the board meeting. Executive directors also had a programme of weekly visits to different services.

More recently appointed non-executive directors spoke about their induction. This had been tailored to their individual needs and had supported them to meet key people from the trust and get an understanding of the range of services

delivered with some visits to services. They had been able to access more formal opportunities for learning and development where they felt this would be helpful. All the non-executive directors said they had participated in 1:1s with the previous chair and where they had been in post for a year had completed an appraisal. They anticipated these arrangements would continue with the new chair.

The non-executive directors were aligned to committees of the board, divisions including geographical areas and staff networks. Where possible the non-executive directors attended the divisional operational boards. The executive directors were clear on their portfolios which were kept under review. Some executive directors were asked about their capacity as they had large portfolios but felt these were manageable as they had the right quantity and quality of leaders supporting them to take responsibility for these areas of the trusts work.

The chief executive and executive directors were very experienced. They were able to speak with confidence about succession plans and had people who had received the leadership development to be able to cover for them in an emergency and apply for the roles in the future.

We looked at the Fit and Proper Person Checks (FPPC) that were carried out for the non-executive directors and executive directors. The chief people officer was in the process of developing a new policy document to reflect the most recent NHS England Fit and Proper Person test (FPPT) Framework dated August 2023 for board members. The aim was for the trust's processes to fully reflect the NHS Framework. The plans for this had been presented to the board in September 2023.

Most of the recruitment checks carried out by the trust would have been fulfilled under the current procedure. The checks were in place and included a complete application form with a full history of employment, checks against the insolvency list and other registers such as those held by the Charity Commission, and Company House, employment references and Disclosure and Barring Service (DBS) checks. However, the trust procedure stated that non-executive and executive directors should have an enhanced DBS check. We found that not all non-executive directors had an enhanced DBS check. The Chief People Officer told us that the trust would now work to meet all the requirements for the fit and proper person test as outlined in their local policy, including ensuring that they have an enhanced DBS check. Non- executive and executive directors completed yearly declaration of interests and a register was maintained. The register was updated and presented to the board annually to provide assurance that FPPR were being met.

The trust had strong leadership arrangements in place for the divisions. Each division had a managing director, medical director and director of nursing. Management arrangements were in place for the divisional directors offering them leadership supervision and support. Divisional leadership teams were enthusiastic and committed to improving services. Divisional leaders said the support they received from centralised functions within the trust, such as human resources, finance, pharmacy and information technology was helpful. Divisional teams had close working relationships with the geographical areas they covered. They also led on clinical areas of work which involved bringing together clinicians across the trust to look at services and their associated pathways to promote effective care and treatment.

Allied health professionals and therapists had a lead who was a psychologist and reported to the chief nurse who represented their views at the board. The lead had a very good understanding of the challenges facing professionals and services. For example, he was able to discuss the resourcing and delivery issues for the talking therapy services. Allied health professionals and therapists largely felt appropriately represented and positive about the opportunities available to them from working at the trust. The trust had a social work lead who was the adult safeguarding lead. They reported through the director of quality to the chief nurse.

Our findings

Throughout the well led review we heard from people across the trust about their positive experiences of being able to access leadership development. Senior leaders in the trust had individual development plans linked to their career aspirations. This supported them to access a range of opportunities including mentoring, coaching, experience of work external to the trust, formal training and reflective practice. Leadership development opportunities were available for staff who were aspiring to be managers as well as existing managers. During the inspections, we heard many positive examples from staff who had accessed development opportunities. Specific programmes included the 21 Century Leadership Programme (21CLP) and Management Fundamentals which was accredited by Imperial College London. The 21CLP positively supported aspiring leaders from black and minority ethnic backgrounds to promote a more diverse leadership going forward.

Vision and Strategy

The trust had a clear vision and values which had remained in place since the previous inspection. The vision was 'wellbeing for life for everyone'. This linked to the values of compassion, respect, empowerment and partnership. These had been developed in partnership with people who use services, carers, staff and a wide range of stakeholders. The visions and values of the trust were understood by staff throughout the trust and they could articulate how these related to their work within the organisation and the care delivered to patients.

The trust had carried out a refresh of its strategy which was dated 2022 to 2025. The outline of the strategy had been developed by the board and then there had been collaboration with people who use services and carers, staff and partners. There was a recognition that more work could have taken place with colleagues from the integrated care systems, but they were also at an early point in their development. The intention was to develop this further when the strategy was refreshed again in a couple of years.

The strategic priorities were to focus on excellent care; attract include and retain at all levels; strong local partnerships; simple effective processes; digitally enabled and data driven. These priorities were practical, clear, and easy to understand. The strategy sat alongside an annual operating plan and the focus for the current year was on getting core fundamental standards of care right. This had been given the memorable acronym by the trust of SWEDE - staff, waiting times, environments, documentation, and engagement.

The strategic priorities whilst being well known were not fully embedded in the trust wide governance processes. For example, papers presented to the board did not state which strategic priority they were aligned to. Whilst there were many examples at all levels of the organisation demonstrating how the trust was working towards meeting these priorities, this was not clearly reflected in the trust wide governance meetings to provide assurance the priorities were being met.

The trust was refreshing some of the enabling strategies for example the estates and digital strategy. The well led interviews reflected a lack of clarity about which were the enabling strategies and how these would ensure alignment with the overarching strategy. For example, the trust had a people plan with priorities which clearly aligned to the trust strategy. The progress of these priorities was being closely monitored. More work was needed to review strategies to ensure there was clarity about how they sat together; to promote consistency with the trust strategy and to ensure any deliverables were properly monitored.

The trust recognised that there was a need to formally refresh its clinical strategy in partnership with clinical staff and external stakeholders. This was the responsibility of the chief medical officer who was keen to ensure this was a practical exercise that would bring real benefits for people who use services in terms of identifying the principles and priorities for service improvements and development. There were plans to discuss this work further at a board workshop in October 2023.

Our findings

The trust had made the strategic decision to make 2023 the 'Year of the Child' which meant they focused on children's services with updated reporting to each board. This was leading to some opportunities to share good practice and focused areas for improvement. For example, in June 2023 a pathway was launched on how to approach young people diagnosed with attention deficit hyperactivity disorder and autism spectrum disorder.

The trust had an ongoing programme to promote improvements in its estates. At the time of the well led assessment the trust was about to support the consultation led by the North West London integrated care board on the future of the Gordon Hospital located in Westminster. This hospital which had provided inpatient mental health services had closed during the pandemic as the environment was not safe at that time. The St Pancras site in Camden was also being redeveloped and at the time of this inspection there still needed to be clarity about the future for the continuing care inpatient service located on this site. In response to pressures in the urgent and emergency care pathway for mental health patients the trust had opened the mental health crisis assessment service at St Charles Hospital and assessment services at St Mary's and Hillingdon Hospital to provide a more therapeutic space for patients who would otherwise be in the acute emergency departments. The trust was also opening additional acute mental health beds at Park Royal.

The trust continued to be actively involved in external partnership work to meet the needs of the populations it served. The trust had extended its involvement in the main care systems where the trust services were located. These systems are North-West and North-Central London; Bedford, Luton and Milton Keynes. Senior leaders in the trust were taking leadership roles in the systems. The feedback from the care systems confirmed the trusts engagement and participation in key activities. Examples of this work was the launch of a virtual ward in Milton Keynes with a focus on frailty and respiratory patients. This was developed by the trust in partnership with Milton Keynes hospital and the city council. This has helped to avoid admission to hospital and support earlier discharge. We received feedback from stakeholders about how the trust worked well with partners and was innovative to meet the needs of local populations.

The trust worked to support national health issues. For example, the sexual health teams across Surrey and London had supported the monkey pox vaccination programme. Staff from the trust worked with University College London Hospitals to launch a mobile service to treat vulnerable homeless patients.

The trust led (for eating disorder services) and was actively involved in the provider collaboratives who had responsibility for commissioning specialist mental health services.

There were already many examples of where the trust was working with partners including the third sector to meet the needs of communities and address health inequalities. For example, in North West London the trusts community partnership and engagement team has worked alongside two charities – Chasing the Stigma and Rethink to deliver free training to build resilience on communities. During 2022-23, 604 mental health first aiders were trained. In Brent the trust had been closely involved in the work of Brent Health Matters and examples of joint work included: visiting food factories in Brent during nightshifts, carrying out health promotional activity and health checks; delivering emotional

wellbeing workshops; co-producing materials for Ramadan with faith leads; supporting a partner organisation to apply for funding to employ a Somali speaking community connector. In Westminster the trust funded a mental health practitioner who worked with in-patients who were homeless on admission and not known to another community mental health team.

Our findings

Culture

Throughout the well led review senior leaders reflected on the importance of having a positive and open culture where people can speak up. Staff we heard from repeatedly described the culture as 'supportive', 'caring' and 'compassionate'. Staff commented that they do have the space for learning and development and were supported in their career progression. Senior leaders did reflect that there were parts of the trust where the culture needed to improve and that they were not complacent. Staff talked to us about the pressure they were experiencing to deliver their roles and junior doctors said they were sometimes being told to discharge mental health patients even when they did not feel it was safe to do so.

The NHS staff survey was completed in October and November 2022. The trust's response rate was only 41% against a national median response rate of 50%. The trust reflected that they would like to see a higher response rate. The NHS survey provided the results linked to nine themes. Most of the scores for CNWL were broadly in line with the sector. There were three areas where the scores had significantly reduced from the previous year – 'we are recognised and rewarded'; 'we each have a voice that counts'; and overall 'staff engagement'. The trust scored better than average for 'we are learning'. The trust scored worse than average on 'we work flexibly'.

The previous years staff survey led to action plans focused on four key areas – speaking up; flexible working; career progression and kindness and compassion. The trust had continued to focus on these four areas in the current year to enable the initiatives to embed and start being reflected in the staff survey results.

The staff survey results were available for each division, and they had worked with services to develop action plans. We heard of several initiatives developed in response to the staff survey findings. For example, 42 teams had been supported to set up reflective practice sessions. Another example was the expansion of access to coaching to support career progression which was now co-ordinated by a central team.

The trust had a long-term culture change programme. They had developed a set of behaviours and principles to promote justice, equality, diversity and inclusion. These behaviours and principles were safe, compassionate, accountable, reflective and fair (SCARF). Over 250 staff had been trained and SCARF boards established to oversee this work in the divisions. Examples of work included the training of staff in restorative culture and the development of a civility and respect toolkit.

The results of the workforce race equality standards showed that gradual progress was taking place although there was more to do. The chief people officer reflected that there would need to be an ongoing change in the culture of the organisation with managers being supported to understand and challenge where needed. An equality, diversity and inclusion strategy was being updated.

The trust was still outside the acceptable range with Black, Asian and ethnic minority (BAME) staff three times more likely to go through a disciplinary process. The trust had introduced screening at every stage of disciplinary process – incorporating human factors. An updated procedure incorporating this change in approach was going through the consultation process.

The likelihood for recruiting and appointing white staff to senior roles (higher than band 8a) was outside the recommended 0.8 – 1.25 range and was at 1.35, worse than the national average. The trust wide disparity ratio remained outside the recommended 0.8 – 1.25 range across all bands. (This was the rate at which white staff progress in the organisation from the lower to higher bands compared to BAME staff).

Our findings

The trust breakdown of staff at the time of the inspection was 51% white and 49% from ethnic minorities and for posts as 8A and above – 67% white staff and 33% ethnic minority. This data was being monitored and progress seen. The chief people officer said the main initiative to support career progression was the 21st Century leadership programme where at least 50% of the intake were BAME staff (135 staff so far). The trust was also supporting career conversations to look at individual needs. The trust had a stated intention that there would be a representative from a BAME background on recruitment and disciplinary panels, but this was not adequately monitored, and further training was needed for the representatives.

The trust had seven staff networks. These were the lesbian, gay, bisexual and transgender (LGBT+); Black, Asian and ethnic minority (BAME); carers; women; lived experience of mental health stigma transformation; and disability. All the networks had a non-executive director and executive director sponsor. The staff networks rotated attendance at the executive board and workforce committee. Network chairs were part of a virtual policy group; and the health and wellbeing guardian attended the staff network chairs forum three times a year.

Staff networks were promoted on the trust website and at induction. The Employee Value Proposition was being reviewed to support more staff to join the networks, and communications to staff about the work of each network were becoming more frequent. Priorities for the coming year were in a draft form.

Staff from the BAME network provided positive feedback about the number of opportunities provided by the trust in terms of career progression and leadership development especially the 21st Century leadership programme. Staff commented that the trust have a good way of promoting their leadership programmes for all staff such as in wider staff forums, not just targeting BAME staff. Staff from the BAME staff network forum commented on the positive work that the trust had undertaken in relation to the current WRES data. They also highlighted the work taking place to tackle racial abuse and violence experienced by staff from patients. They recognised the work being done to embed the Patient and Carer Race Equality Framework (PCREF) across the three divisions. They commented positively on the trust's international nurse's recruitment programme and saw this as a success. Recognised the challenges of new staff from different countries adapting the ways of working and culture within the UK. Permanent staff have been supportive with new international nurses.

The trust recognised that more work needed to be done to improve the access, experience and workforce adjustment plans in improved the working experience of staff with disabilities or long-term conditions, such as excessive delays in accessing equipment in line with reasonable adjustments. Data from the 2022-23 Workforce Disability Equality Standard (WDES) showed limited career progression; fear of disclosing disability at interview; bullying and harassment from managers, patients and public; and pressure to come to work when unwell. This indicated a need for more training and support to understand needs. Access to Reasonable Adjustments had been piloted in Diggory division but was open to staff across the Trust.

The priorities for the disability network (DEN+) were the same for 2023-24 as they had been for the previous two years, as there was more work to be done around increasing access, workforce adjustment plans and improving the working experience of staff with disabilities or long-term conditions. A business case to fund Access to Work (ATW) equipment was successful, and a pilot had started. Staff commented that the trust could be more proactive with staff who required reasonable adjustments, such as the delay in obtaining equipment. A disability awareness online training module was being launched.

Our findings

Some examples of positive developments in the last year included the launch of the transgender policy for patients; CNWL ranked in the top 100 Employers in the Stonewall Workplace Equality Index for the eighth year running; an event held to raise awareness of the LEHMIST (Lived Experience) staff network's Time to Talk (Stamp Out Mental Health Stigma) Campaign; celebrations were held to mark LGBT+ History Month in February 2023.

The Freedom to Speak up Guardian (FSUG) arrangements were working well. The FSUG was managed by director of corporate affairs reporting to chief nurse. The current FSUG only worked 3 days a week – and the trust had introduced a 0.5wte deputy on a temporary basis. The FSUG had received 120 direct contacts in the previous year. They analysed the themes and fed these back to local teams, divisions and the board. This included the reason for contact, the staff group and how this was addressed. The highest number of contacts (45 in 2022-23) were in relation to dysfunctional team relationships; the second highest (24 in 2022-23) were in relation to patient safety concerns mostly linked to staff shortages. Contact specifically about discrimination, bullying and harassment was much lower at 5 in 2022-23, but this was hard to separate from the contacts relating to dysfunctional team relationships.

The FTSUG was very accessible in the trust and had visited services where staff had raised concerns. Their details were advertised on posters and on the trust intranet page. They had hosted listening events for staff – 40 took place in 2022-23. Staff were able to confidentially contact the FTSUG and were supported to escalate concerns further when required. This had improved since the last inspection where it was recommended that visibility and access needed more work. The FTSUG was in the process of creating a heat map to identify which services were in contact the most and to identify areas where no contact was made. Visits were given priority in terms of where staff had raised concerns and services that had not been visited before.

Staff gave positive feedback about accessing the FTSUG and described them as visible and approachable within the trust. Trust governors acted as ambassadors for the guardian. The FTSUG was developing a network of staff champions to promote the service to other staff and identify and raise services of concern with them. They planned to provide training and coaching to the staff champions.

The FTSUG had received regular training from the national guardian's office and attended a regional FTSUG forum to share information and good practice with other FTSUGs. There was a clear route of escalation to the chief nurse if they had any urgent concerns.

Although staff could use datix to anonymously report concerns, the trust recognised that there was no formal electronic recording system for recording data for the FTSUG, the trust had planned to improve the capturing of data for this service.

The guardian of safe working hours monitored working conditions for junior doctors. The guardian described the trust as supportive and proactive in trying to resolve issues raised by junior doctors. The guardian produced an annual report which went to the board through the quality committee and included details of exception reports where junior doctors had worked excessive hours. This identified issues such as delays to junior doctors whilst carrying out Mental Health Act assessments. The guardian had oversight of the number of hours that junior doctors worked for the trust using a rota system called 'rota geek'. If excessive hours were worked, the Guardian was able to validate an exception report prepared by the junior doctor and arrange the disbursement of a penalty fine.

The guardian was approachable to staff through attending the junior doctor's forum and formed part of the junior doctor's induction programme. They worked closely with the director for medical education and the clinical medical director for the trust. The guardian was aware of 8 high impact actions during the last year. The guardian was part of a network of guardians to share good practice and discuss common practice issues.

Our findings

Feedback was received from Health Education England about the experiences of trainees working in the trust. At the time of the inspection there were no services which were a particular concern and feedback was largely positive. Where there had been concerns in the past the trust had responded and worked to make improvements. Junior doctors told us that sometimes they did not get their leave approved due to the staffing levels in the team where they were working. They felt the trust could be doing more to make it an attractive place for junior doctors to stay on and work when they complete their training.

The trust had well established arrangements in place to engage and work with trade unions and the union representatives felt these were largely working well. We heard that staff had a variable experience of raising concerns. Some staff felt that whilst the trust held listening events this did not lead to change. Staff who were neuro-diverse also faced barriers to communicating with senior leaders. The unions also highlighted the challenges of staff being able to work flexibly and how this was easier for managers than front line staff and so further work was needed on this.

The recruitment and retention of staff continued to be a significant challenge and a high-level corporate risk. To reflect the level of concern the trust had established a workforce committee as a sub-committee of the board to oversee a corporate people plan. The people plan had four clear strands to attract, retain, include and improve HR processes. Deliverable priorities were monitored through the sub-committee and board.

At the time of the inspection trust vacancies were 9.3% (medical 13% and nursing 18%) – lower than other London trusts; sickness 4.1%; turnover 19.2%a programme of work. Agency spend was 7% with a target of 4.8%.

Safe staffing was monitored closely with bi-annual reports to the board. The levels were mostly met, and outliers identified and at the time of the inspection these were CAMHS inpatient services, St Charles and Health and Justice teams.

A few measures were in place to progress recruitment including international recruitment, project teams focusing on healthcare support workers and allied health professionals, set up recruitment microsite, which was attracting more people, working in partnership at place to target local communities, including a video. The HR team had partnerships with the divisions and were able to develop bespoke recruitment campaigns to meet their needs.

The trust was proud of the apprenticeship schemes they participated in across a range of disciplines. At the time of the inspection there were 160 people in apprenticeship schemes working in the trust.

The trust were focusing on improving retention of staff, especially these within their first year of working for the trust. They were piloting ‘stay conversations’ in Jameson division where there were individual conversations with new recruits at 30, 60 and 90 days to find out how the job is working and if they need any support. This included ensuring they had access to regular supervision and that flexible working had been considered if this would be helpful. In the longer term the focus was on career coaching, talent management and career progression. The trust had been conducting some exit interviews, but these were not felt to be producing particularly helpful insight.

Several areas of work were being put into place to make HR processes easier so that requests could be responded to faster. There had been some success, but more was needed and the trust were looking at how they could make better use of automated processes.

The trust was meeting its overall target for mandatory training at 92%. It had identified the outliers (at the time these were largely in the Jameson division) and was addressing this through targeted work. The trust had a team who went

to wards to carry out simulation training for areas such as physical health emergencies and managing violence and aggression. The trust was working with local system partners to roll out the Oliver McGowan mandatory training on learning disability and autism designed for all staff in health and social care. The online training is available but the face to face training still is not ready to roll out.

The trust had a well-structured induction which introduced new staff to the trust and gave them essential information to start their work. Senior members of staff helped to deliver sessions as part of the induction.

At the last inspection the report said that the trust should ensure that staff had access to regular high-quality supervision. Whilst this inspection found improvements there is more to do to ensure staff more consistently receive high quality supervision. At this inspection we found that staff were receiving regular supervision and this was monitored at a service level. The completion of supervision was not routinely monitored trust wide through the workforce committee although, this was checked through quarterly divisional meetings reporting to the Executive Board, the CQC compliance group by exception and the education and training sub-group who provided reports to the work-force committee. Team managers had an online form for recording the discussions at supervision. The trust had decided not to be prescriptive about what should be covered in supervision. However, staff reported a range of experiences of supervision with some having clinical and managerial and others just focusing on one area. We heard about a current quality improvement project looking at how the quality of supervision can be improved this was including updating the policy, auditing supervision practices and developing training.

The trust monitored the completion of appraisals and at the time of the inspection this was over 90%. Where completion levels needed to improve this was followed up. Staff we spoke with were satisfied with the quality of appraisals and the opportunities to discuss career development opportunities. The General Medical Council fed back that the completion of medical revalidation and was within appropriate levels with no late recommendations in the last 12 months.

The trust was promoting well-being for staff through the divisions. A network of health and well-being champions and mental health ambassadors was available to signpost staff to services. Some well-being initiatives have been well received. For example, the establishment of smart fridges with food for staff who don't have time to leave the service to get something to eat. The chief people officer said that the trust was working towards every person having an individual health and wellbeing plan and they want this to be mainstream.

The trust occupational health service provided support to staff from CNWL and a local acute trust. The workload was carefully mapped so the trust was confident in the capacity of the service. The service offered support for staff with their physical health and access to psychological therapies where appropriate. The trust was leading the North West London occupational health shared service development programme on behalf of the system, looking at how services could be improved and make good use of digital technology.

We heard how there were opportunities in place for staff to celebrate success. This took place in different ways throughout the trust. For example, in the last year the trust thanked staff with a medal ceremony to honour their contribution during the Covid pandemic.

The trust was working to remain compliant with the requirements of the Accessible Information Standard. This involved helping people who have difficulty accessing and understanding information and supporting them to communicate effectively. For example, the trust provided multi-language translation in person and remotely. Easy read literature was available on request. The trusts website had tools to make it more accessible. Patient records included

details of people's communication needs. The trust recognised that there was more to do in making information accessible for people who use services, and work was taking place with experts by experience to develop this further and look at the use of other means of communicating such as making better use of social media. There was also a recognition that many people did not have access to digital technology and that they had to be accommodated.

Governance

The trust board was organised well. They met six times a year. Board workshops or an annual away day took place on the months in between. The board had ongoing plans in place for meetings with the other boards where there was going to be the chair in common. The board meeting was well chaired with good timekeeping and opportunities for members to raise issues and ask questions. Papers were clearly presented. There was an annual work plan to ensure all the areas were covered.

At the last well led review the trust received a recommendation that they ensured items were put appropriately into part two of the board. At this inspection we found the trust was open and transparent about the items for part two and were clear that they only went into this section if they were commercially sensitive or could compromise the privacy of individuals. For example, we heard that there were plans to move papers relating to the future of the Gordon Hospital into part 1 of the meeting once the formal consultation was launched. The board assurance framework was also moving to part 1 once the format was approved.

There were five committees of the board. The quality committee and finance and performance committee met ten times a year. The workforce and audit committees met four times a year. The remuneration committee had one meeting a year and further meetings as and when required. The dates aligned with the board meetings so that they could report back. Non-executive directors were in place to chair the committees and they understood their roles and responsibilities. Non-executive directors also attended other committee meetings, so they got a broader understanding of the trust and promoted consistency of work and sharing of good practice. A recent independent well led assessment felt there was scope for a greater rotation of board members across committees and so this was being arranged.

A few months before this assessment the trust had completed an independent well led review. This review had made several well-led recommendations and the trust had prepared a comprehensive action plan in response.

The three operational divisions continued to describe how they were held to account through the divisional board meetings and supported to identify for themselves when improvements were needed. Where needed a 'deep dive' piece of work could be done. For example, there had been a deep dive into the community health paediatric services in Milton Keynes to understand why they were missing their 18-week treatment target. Divisions had remained largely self-reliant and self-governing entities whilst retaining trust wide oversight, accountability and control. They described a culture of challenging and supportive conversations. The divisional boards reported to the operations board through to the executive board but also actively fed into the committees of the board. In addition, non-executive directors were aligned to divisions and were able to attend the divisional boards.

The trust had access to a wide range of data from its services. They brought together data to support assurance processes. For example, they knew where services had issues with workforce, changes in incidents, increases in complaints etc. They were able to bring this together to identify potential hot spots. The trust also had a few visits taking place to services including board members, governors, peer visits, divisional leadership teams. In some places

Our findings

Healthwatch were visiting services. Our inspection of the rehabilitation service at Westfield House found that institutional practices associated with potential closed cultures were happening. This had not been identified through the oversight of data or from existing visits and has highlighted the need to strengthen assurance processes, especially through external people observing care practices.

The trust had taken part in 11 national audits and one national confidential enquiry. There were 8 trust wide audits in the last year – included controlled drugs; antimicrobial testing; medicines handling; FP10 prescriptions; high dose antipsychotics; bed rails; falls; hand hygiene and lone-working. A wide range of audits were taking place relating to specific services and we found results were used as part of the trust wide governance processes.

The trust had appropriate arrangements in place to undertake the safeguarding responsibilities. The trust had two heads of safeguarding for adult and children's services. Governance was through the trust strategic safeguarding group. Assurance reports were also provided to commissioners and partners in line with local frameworks. External stakeholders provided positive feedback on thew trusts safeguarding work. Safeguarding training compliance for 2022/3 was over 90% in adults and children across all divisions and was monitored on an ongoing basis. Staff could access a range of training options which included e-learning, virtual and face to face sessions. The trust had organised a joint children and adults safeguarding conference in April 2023, which qualified as Level 3 training for staff attending. Staff were also encouraged to utilise partnership and external multi agency training. Prevent training in 2022/23 exceeded the national target of 85%, with CNWL staff at 93% for Prevent basic awareness. Guidance was reviewed and kept up to date. The trust continued to hold an annual domestic abuse conference and the last one was attended by over 600 people including staff and people with lived experience.

There were robust arrangements to ensure that the trust discharged its powers and duties under the provisions of the Mental Health Act 1983 (MHA). The use of the MHA was overseen by the mental health law group (MHLG), which was chaired by the chief nurse who was an executive board member, providing board oversight. This meant there was no non-executive director with responsibility for the MHA. However, the MHLG reported quarterly to the quality committee which was chaired by a non-executive director and provided an annual report to the board. Exception reporting could be made to the board via the quality committee and issues could also be raised via the operations board.

The MHA function was corporate and did not fall under any division, providing a service to staff across all relevant sites. The assistant director of mental health law and corporate safety (ADML), who had been in this role since 2022, led the MHA team and reported via the director of quality to the chief nurse. The MHA administration team consisted of 20 staff, led by a deputy head of mental health law, supported by a mental health law operational lead. There were 4 mental health law locality managers, based at Park Royal, Hillingdon, St Charles Hospital and Milton Keynes, managing MHA administrators and 4 administrators working at these sites. Training and the opportunity to gain relevant qualifications were made available to staff as well as internal promotion pathways and access to conferences and other professional development. Due to the anticipated opening of a new 16-bed ward at Park Royal in March 2024, funding to recruit an additional MHA administrator was being sought.

There was also a mental health law trainer, who was responsible for developing and refreshing e-learning and delivering face to face training and webinars based on identified need and where requested. The trust used a sophisticated electronic training system which reminded staff and managers when training was overdue and created compliance reports. MHA training was mandatory for all mental health nursing staff and health care assistants (approximately 1500 staff) and the compliance rate was 83%. Section 12 MHA approved clinician training in the form of

e-learning and a webinar was made available to doctors and consultant psychiatrists. In the past year additional external training had been bought in following the provision of central funding for training on the anticipated changes to the MHA. The mental health law trainer was also responsible for managing the trust's service level agreements to deliver training to 8 acute hospitals.

There were 19 associate hospital managers (AHMs) in post, with a further 19 having been recruited, following a decline in numbers since the start of the COVID-19 pandemic (when there were 35). Following the recent recruitment, there was a diverse mix in terms of gender, age, ethnicity and service user experience. AHMs were paid an honorarium to attend hearings, training and meetings. All hearings were virtual unless patients requested otherwise. The lead AHM attended the MHLG.

The ADML did not have responsibility for the Mental Capacity Act 2005 which sat with the head of social work and social care, but there was good communication between both. The ADML was responsible for developing and reviewing all MHA policies and procedures, supported by his team. All the MHA records were documented on the trust's electronic record system. The MHA team were also using another system, to create reports, dashboards and reminder and monitoring systems for staff on issues such as section 132 rights. MHA administrators also used tracker spreadsheets in their day to day work and provided ward staff with weekly reminders, as well as undertaking a range of regular audits. The number of unlawful detentions was low (0.4%) compared to the national average. The MHA team were also involved in the development and roll out of a mobile phone application for MHA assessments and in the Pan London MHA Digitisation group which was working towards closer collaboration in a number of areas, such as shared records.

Whilst the trust was taking a number of steps to improve patient flow, access to beds remained a significant challenge, with the consequence that the admission pathway was often blocked. Health-based places of safety, of which there were 3 in the trust, were usually full, leading to breaches of the 36 hour legal limit, police taking patients to emergency departments or using section 136 MHA to move people on from police custody where this was not appropriate. While there were police liaison groups at local level, there was no meeting that both the police and the trust attended at senior level. In addition, the trust did not have section 75 agreements with approved mental health professional (AMHP) services in most boroughs and Hillingdon AMHPs did not have access to the trust's electronic records system.

Issues raised in CQC MHA monitoring visit reports were reported to the MHLG and to the board in the annual report. There was good evidence in the 2022/3 report of action being taken in response to the main themes raised, namely lack of recording of patients' capacity to consent to admission, lack of access to independent mental health advocacy (IMHA) services, lack of patient involvement in care planning and lack of patient understanding of informal rights.

The patient feedback and complaints service monitored compliments and investigated complaints and provided reports to the quality committee which were presented to the overall trust board quarterly. They also provided updates to the bi-monthly divisional board meetings.

The trust was able to analyse data to compare trends from the previous year. The trust had received 394 complaints in 2022-2023 compared with 399 complaints in the previous year of 2021-2022, they had received 4,239 compliments in 2022-2023 compared with 3,475 compliments in 2021-2022. The trust had noted that it had received an increase in concerns with 1,863 received in 2022-2023 compared with 1,799 concerns in 2021-2022, where a complaint was able to be resolved promptly at a local level this was listed as a concern. 88.9% of complaints had been responded to in a timely manner during July 2023, compared with 100% in May 2023. The trust noted that the rate of complaints per 1000 patients was 0.72%, which was less than the year before of 1.10%.

Our findings

Seven complaints had been investigated by the parliamentary ombudsman service, 1 of which was partly upheld and 1 which was upheld. The patient feedback and complaints team were due to receive training from the parliamentary health and ombudsman service on their new national framework for managing complaints when the training becomes available. The trust adhered to the NHS complaints standards 2022 and had worked alongside the parliamentary ombudsmen service to make improvements, such as improving their standard response template for complaints.

The trust had identified that concerns were at the highest number received within the last 2 years and which service in the trust had received the highest number of concerns. The patient feedback and complaints team had commenced a quality improvement project to improve the effectiveness of handling concerns earlier by local teams to stop them escalating into formal complaints. The team identified that there was an increase in complex complaints and reported these fortnightly to the executive team so that they had oversight of these.

The team were able to identify trends, themes and lessons learnt from complaints. For example, the team had identified that a lot of complainants were not happy with the time taken to obtain a written outcome to their complaint. The team had commenced a quality improvement project in 2022 with Jameson division as this division received the highest number of complaints. The team obtained feedback from service users and advocacy groups to understand the reasons why a high number of complaints were reopened and implemented tools to address this, such as a checklist for staff to complete. The team noted that the average days between complaints being opened had increased from 4.75 days to 11.23 days. The trust was able to identify that communication was the main theme stemming from the highest number of complaints in addition to waiting times for accessing certain services within the trust.

We reviewed some randomly selected complaints responses and saw these had been completed to an appropriate standard.

Risk, issues and performance

At the time of the inspection the trust was strengthening its processes for the escalation of operational risk so that trust board members could have greater assurance about appropriate levels of oversight by the executive board.

Services were able to identify and escalate risks using the datix system. Risks were brought together on divisional risk registers. The divisional boards reviewed the risks, agreed risk scorings and had oversight of the action plans. This came together in a divisional risk report. The trust acknowledged that further work was needed to ensure risks were escalated more consistently and received the appropriate level of scrutiny. A programme of work was underway which involved implementing a single risk management and reporting process for all three divisions including changes to the datix system; the introduction of a quarterly divisional risk report to the operations board with a clear escalation route to the executive board with the analysis of themes and oversight of action plans – then going to the audit committee; update risk management guidance and provide training.

At the time of the inspection the divisions reported the following number of risks: Diggory – total 166 open risks including 11 extreme risks; Goodall – total 83 open risks including 3 extreme risks; Jameson – total 47 open risks including 8 extreme risks. However, the trust needed to consider if the right services are getting the oversight required. For example, an inspection of Willow ward in Milton Keynes in 2020 identified serious issues with the operation of the ward. A follow up inspection in 2023 found that many of the same difficulties had remained and further work was needed. During this time an inpatient death had sadly occurred on the ward. We were told that

during this time the ward had improved and then deteriorated again. The trust acknowledged the need for improvement and had taken further action since this date. During this time whilst the operational board were aware of the risks for people using this service they had not received the assurance needed to confirm improvements were being sustained.

During our inspection we heard about risks associated with patient transport systems, for example patients waiting long periods for a transfer. We were pleased to hear the trust was aware of the difficulties and were reviewing the contract.

Medicines optimisation risks were reviewed through the trust governance processes. Any new risks were escalated to the divisions. The implementation of electronic prescribing and medicines administration (EPMA) and associated electronic systems had contributed to improved oversight of medicines use. For example, allergy documentation had increased to 98% from 50% as EPMA prompted staff to complete it. The trust was working towards a patient safety incident response framework for four high risk drugs. As a result of risks in relation to the safe and secure handling of medicines, staff were conducting audits monthly instead of quarterly.

A refreshed board assurance framework (BAF) had been developed and was shared in part two of the September 2023 board. This was working towards consolidating the strategic risks, embedding the strategic priorities and articulating the risk appetite. The board planned to consider this in more detail including risk appetite at a workshop later in the year. The BAF would move to part one of the board. There were nine strategic risks on the refreshed BAF. The two highest risks on the BAF were patient flow which was assigned to the quality committee to oversee; and staffing which was assigned to the workforce committee.

The trust monitored its work through a couple of well-developed scorecards. One focused on quality and the indicators were aligned to the five CQC domains. The second scorecard focused on performance and monitored indicators relating to access, effective treatment, and value for money. The quality scorecard was reviewed at the quality committee and performance scorecard at the finance performance committee. The indicators were a mix of national and trust priorities. The results were benchmarked where this data was available. The results were displayed in run charts so trends could be seen and were also linked to targets. Summary reports were available for each scorecard identifying outliers and the actions being taken. Both scorecards were presented to the board.

The trust had a strong reporting culture for incidents. This was reflected in the data for the previous year which found that 98.2% of all incidents were reported as resulting in no or low harm. Throughout the year, the most prevalent types of incidents reported were pressure ulcers, physical violence, distressed behaviour, self-harm, medication administration and supply and verbal abuse. The trust closely monitored the numbers and types of incidents on the quality scorecard.

In 2022/23, the Trust reported sixty-three incidents onto the NHS Strategic Executive Information System (StEIS). This was a reduction on the previous year where seventy-eight had been reported. Most were jointly categorised as unexpected death (21) and suspected suicide (21).

The trust recognised when there was a need to have an external investigation. At the time of the inspection there was an ongoing independent led panel of enquiry linked to three homicides in the Goodall division.

We reviewed 6 serious incidents not resulting in a death and the quality of incident investigations were of a good standard, with appropriate learning, robust recommendations, with involvement from the service user and family where applicable and identification of immediate learning.

Our findings

The length of time it was taking to complete serious incident investigations had increased over the last year and was an average of 96 days in June 2023. A quality improvement project was in place to work towards reducing this length of time with more people being trained to carry out investigations.

The trust had received an accreditation from the Royal College of Psychiatrists for their serious incident review process. This process included a self-review, a peer review, a publication of the review report to achieve the accreditation. The current accreditation extended to January 2024.

The trust had a variety of ways to support learning from serious incidents alongside the traditional cascade of information through governance meetings to individual wards and teams. This included publishing quarterly newsletters of learning from that were circulated internally and externally to our commissioners and NHSE; holding recommendations workshops following all homicides; using 'clinical message of the week'; holding quarterly learning events for all staff and commissioners – the largest learning event was part of the trust's safety conversation day held in November 2022 and attended by 400 staff. Front line staff talked about the importance of regular safety huddles and debriefing after incidents. The trust recognised the ongoing challenge of ensuring learning from incidents was reaching busy front-line staff and was embedded. Serious incidents had recurring themes which meant there was more to do.

The trust was aiming to fully implement the new NHS England Patient Safety Incident Response Framework (PSIRF) by the end of this year. The trust had a programme board to oversee this work and had so far trained over 800 staff, updated their website to reflect the changes and were in the process of completing the PSIRF policy and procedure.

The trust was rolling out a suicide prevention strategy. The work started in 2021 with the establishment of a steering group who revised the CNWL suicide and self-harm prevention strategy in November 2022. A multi-disciplinary task and finish group was working to ensure that the assessment, management and support for those who have self-harmed was aligned with the recommendations outlined in the revised NICE guidance. The group was also identifying national and local resources and considering risk factors in relation to specific vulnerable groups.

The trust had good oversight and assurance processes for its infection, prevention and control risks. The IPC team were able to articulate the learning from the pandemic and were currently preparing for the winter. The trust assurance processes indicated that all identified risks were addressed apart from in two areas. These were in relation to improving information given to patients and the fitting of FFP3 masks. In both these areas mitigations were in place and work plans were leading to improvements. The IPC committee produced a bi-monthly report which fed up to the board through the quality committee and an annual IPC report to the board, which detailed the low rates of infections. Staff could raise any concerns with IPC trained nurse in each division and each division had its own IPC group, where learning was shared.

Staff employed by the trust were actively encouraged to have their immunisations through the annual flu vaccination video and occupational health.

Improving physical health care remained an annual quality account priority for the trust which meant that progress would be closely monitored and reported in an annual report. This included the identification of deteriorating physical health in mental health services; and recognising the mental health needs of patients using in physical health services. There had been a wide variety of actions including the strengthening of the staffing of the resuscitation team (new nurse consultant); enhancement of staff training using simulation; the trust had developed its own app to monitor physical health. We inspected the forensic inpatient wards where there had been an inpatient death where deteriorating physical health needs had not been identified. Whilst the wards were using the early

warning monitoring system for physical health, concerns were not always being escalated to medical staff in line with trust guidance. Following the incident trust guidance was updated to include a venous thromboembolic (VTE) assessment completed upon admission – but this was not always happening in practice. Some health checks based on individual needs such as blood sugar testing for people with diabetes were not always taking place. Records did not make this clear if the checks had been offered and patients had refused. This showed that whilst improvements had been made, they needed to be embedded further.

The trust had focussed on other areas where there had been regularly reported incidents. This included reducing pressure ulcers and falls. In terms of pressure ulcers, the trust had delivered training to residential care homes in Camden and Hillingdon to support self-management and prevent deterioration. This initiative had led to the development of Podcasts on the SSKIN care bundle and pressure ulcer prevention to inform service users, carers, and multi-agency staff. Risk assessments for pressure care had been standardised to align with national standards including a brief guide which could be used on mental health wards. In terms of reducing falls a quality improvement project had led to an improved assessment / screening; testing different approaches with patients and carers; the creation of a falls dashboard to monitor outcomes although significant reductions in falls had not yet taken place.

The Mental Health Units (Use of Force) Act 2018 (Seni's Law) had been in force since 31 March 2022. Significant work had taken place to ensure the trust was compliant with the requirements of the Act; these included appointing a responsible person to oversee the work to monitor and to reduce the use of all restrictive interventions. The Prevention and Therapeutic Management of Violence and Aggression Policy (Use of Force Policy) had undergone its first annual review. A co-produced information leaflet for patients and their families on the use of force was available in wards and the external trust website, including in easy read format. The trust had training services that were certified by Bild Association of Certified Training as compliant with the Restraint Reduction Network Training Standards. The quality committee reviewed data and found disproportionate use of restrictive practices at Park Royal site with people who are BAME. Work was ongoing to understand and reduce this. During 2022/23, there were 1,903 restraints reported across the trust, a reduction by 19% from the previous year. The trust benchmarked itself against other trusts and was performing well. The trust reviewed CCTV footage after incidents and on a random basis. The trust had taken part in a trial of staff using body cameras, but staff had reported these were uncomfortable to wear and difficult to use – they were considering trying again.

The trust closely monitored and tried to reduce the use of seclusion and long-term segregation. The incidents of seclusion were also monitored in the health-based places of safety. There were seven seclusion rooms across the trust. Work had taken place to strengthen seclusion reviews and ensure they were covered in safety huddles. They were also trying to improve the experience of those who were subjected to seclusion across acute and PICU wards. A dedicated extra care facility had opened on Nile PICU at St Charles in November 2022. The inspection heard how an episode of long-term segregation at the Kingswood learning disability service had been addressed and the patient was receiving much less restrictive care.

There had been a sad death in a health based place of safety room at St Charles where staff had not sufficiently engaged and monitored the patient and had relied on Oxehealth (a patient monitoring system) which at the time was switched off. The trust had ensured that staff understood that the use of Oxehealth did not replace the need to carry out checks on patients.

The trust monitored sexual safety incidents. The chief nurse was the lead for sexual safety. The trust had participated in the national sexual safety collaborative. They had a few quality improvement projects to reduce sexual safety. The

inspection of rehabilitation services found at Westfield House in Epsom that men were entering a female flat to access meals which was compromising their privacy and dignity. The trust were aware of the poor environment and since the inspection have closed Westfield House while continuing the provide mental health rehabilitation services at the Horton site in Epsom.

The failure of staff to carry out therapeutic observations appropriately continued to be a recurring theme in serious incidents. The trust was aware of this and was taking steps to make improvements through a task and finish group. This included the pilot of new digital equipment to record observations – although this would not yet work for intermittent observations. Training had been enhanced and observations was covered in staff induction and was an area included in the simulation training being rolled out across the sites by the education team. The trust was trying the use of a badge – so that staff would know when a colleague was carrying out observations. They were also looking at giving staff bum bags containing items which could be used to improve therapeutic interactions such as a pack of playing cards.

The inspection reviewed a few randomly selected staff recruitment records. These showed that there was a robust system to complete recruitment checks and these had continued to take place as required since the previous inspection.

The trust had emergency planning and business continuity plans in place. At the last assessment the trust was 85% compliant with the business continuity plans. Since then, training exercises had been completed. The next assessment was starting in September 2023 – focusing on areas including preparing for the Notting Hill Carnival and a potential cyber-attack.

The trust had an estates strategy which was in the process of being refreshed. They continued to provide the estates and facilities function through a wholly owned subsidiary. It ensured that money raised was available to re-invest. The subsidiary board was chaired by a non-executive director. There was a 5 year capital programme refreshed each year.

The capital bids were prioritised based on health and safety and the chief nurse and chief medical officer support the decision-making process.

This year's capital highlights will be developing a new ward at Park Royal to open by end of financial year, significant roof repairs, upgrading the seclusion rooms, fire door replacement. They had a list of leases and when they were ending so they could plan in terms of services needing to move.

The trust operated a maintenance help desk. They offered a hybrid inhouse model. There were clear escalation processes, so they knew which work to prioritise.

The trust had systems in place through the fire safety group to oversee the maintenance of fire safety. The estates team arranged for annual fire safety risk assessments and servicing of fire safety equipment. They visited wards to advise about what they should do in the event of a fire. Bedrooms are now fire-retardant boxes – doors provide protection for 30 minutes and walls an hour. They reviewed any fire related incidents.

There were no significant concerns about financial risk for the trust. No Use of Resources review was undertaken as part of the 2023 inspection. External auditors KPMG had given an unqualified opinion on the 2022-23 accounts. Internal auditors RSM had given the Trust reasonable assurance about the operation of internal controls.

Our findings

At the time of the inspection, the trust was expecting to receive income of £710mn to provide commissioned and contracted services. It estimated that about 50% of its income related to the care of patients who lived outside NW London. It planned and told us that it was on track at the time of the inspection, to deliver a break-even financial position for the year 2023-24. It assessed its underlying financial deficit at £12mn as per 2023/24 plan and was working through its plans to mitigate this risk.

In addition, the trust planned to invest £16.5mn in its estates, equipment and digital infrastructure. Under many of its contracts it occupied premises owned by other trusts and NHS PropCo and was using its capital resources allocated by the NW London ICS to maintain those buildings. Estates and facilities services were delivered by Quality Trusted Solutions LLP ("QTS") whose registered partners were the trust and CNWL Holdings Limited. The trust benefitted directly from any profit generated by the LLP.

The chief financial officer had recently joined the trust and previously had had experience mainly in acute hospitals. The chair of the audit committee was a qualified accountant with significant experience on audit committees; the chair of the finance committee was also chair of the subsidiary QTS LLP.

The trust had strong track record of managing its finances in line with agreed plans. The plan required the trust to deliver savings from transformation, improved productivity, and reduced waste of £28.6mn in the current financial year. At the time of the inspection, the trust was expecting to deliver its agreed break-even plan, albeit with non- recurrent support. The trust assessed its underlying deficit as £12mn.

As part of the inspection, we noted that whilst the trust's capital allocation was received from the NW London Integrated Care Board, it was required to maintain leased buildings and incur capital expenditure to support the care of patients who were the responsibility of other integrated care systems. The trust told us that it had raised this matter with NHS London.

The trust maintained costing systems that allowed it to assess whether contract values matched the expenditure incurred. It told us it planned to share this information (drawn from the patient-level information costing system) with the finance and performance committee in October 2023 to inform a refresh of the board's financial risk appetite and its commercial strategy going forward.

Engagement

Patient and carer involvement had progressed significantly since the previous well led assessment and was well embedded throughout many areas of the work of the trust. For example, 80% of the 345 active quality improvement projects included people who use services.

A patient, carer and public involvement strategy was in place and was being refreshed with new key priorities at the time of the inspection. A patient involvement forum oversaw this work and the monitoring of the progress with the priorities. Much of the work took place within the divisions with geographical areas having service user representatives who attended local patient involvement groups and fed back to the forum.

The trust had a patient and carer involvement team who advised on involving patients and carers in groups, activities, local communities, recruitment and staff training, review of trust policies and production of information given to patients and carers. The trust had an involvement register which had grown and enabled people with lived experience (experts by experience) to join and help deliver this work. At the time of the inspection there were around 100 people on the register.

Our findings

There were many examples of where experts by experience had contributed to the work of the trust. For example, they had helped establish a new project promoting shared decision making in medication; had actively contributed to the Open Dialogue work via the steering group and some experts by experience had also been trained alongside clinical staff in delivering Open Dialogue; had advised the trust on its strategies including the new supporting transgender service users policy; had attended peer reviews and local inspections of wards; had taken part in a short film about the importance of staff supervision. The trust involved experts by experience in many of their key working groups, for example they were involved in the development of the trusts suicide prevention strategy which included designing a badge to encourage people to speak out if they were struggling. There were many examples of where experts by experience were helping to train staff and over 15 clinical teams received bespoke involvement training.

The trust had started to develop advanced lived experience practitioner roles who were working with the involvement team to help advance coproduction across the trust. For example, the gambling clinic had established a new monthly forum where service users, friends, family and staff shared experiences and worked together to make decisions about how the service can be further developed and promoted.

The trust held a successful patient involvement conference and a carers conference. This had received support from the now trust chair.

People who used services and carers were involved in several ways in the trust governance processes. The trust board meeting always started with a patient or carer story. In Westminster, experts by experience attended senior management team and care quality meetings to ensure the patient and carer voice was well represented. Feedback from patients and staff confirmed that this was helping to promote a culture of coproduction. The trust was looking at how this might be further developed across the trust.

The trust had also made progress with the employment of 134 peer support workers, although they recognised that further work was needed to ensure they received the right support.

In October 2022 the trust launched the volunteer to career programme (VtC). Since then, 156 volunteers had been placed in a variety of settings; 29 new volunteer roles had been created; 25% of volunteers had moved into employment.

The trust monitored the completion and themes from friends and family tests. Overall the completion of the tests were low in line with other trusts. The feedback was largely positive. The trust also used the findings from other surveys. For example, the community mental health annual survey showed that patients were not always aware of the available employment support. This had led to community mental health teams signposting patients to opportunities such as volunteering roles with the trust. The trust was looking at ways to obtain feedback using digital technology. For example, they were considering having posters with QR codes where patients could scan the code and provide instant feedback.

Since the past inspection the trust had continued to make progress in their work with carers. Training had been delivered to over 1000 staff carer awareness. Carers champions were in place across the trust. Across the divisions there were carers support groups; carer surgeries so they can meet with staff; education sessions on specific topics. Carer peer support workers were now in place in a couple of services including eating disorders and older people's services.

The trust had recently achieved its second Triangle of Care star, which was a national initiative for NHS trusts to improve how they support and involve carers, such as involving them in decisions made within the trust and

signposting them to unpaid carer support services. The trust had achieved their second star for their community mental health teams through their implementation of their carers dashboard on their electronic patient record system (which ensured carer details were consistently recorded), welcome packs, leaflets for carers and carer champions.

We spoke to carers during the inspection. Whilst they valued opportunities to be involved in working with the trust, they reflected that some carers were still having a poor experience of liaising with clinical teams especially when the person they were supporting was experiencing a deterioration in their mental health. They had a few examples of this for people receiving community mental health services. They felt able to raise concerns but did not feel they were always being adequately addressed. They also said that there were variations in how the Triangle of Care was implemented across the trust and that in some areas the arrangements for carer involvement were much more advanced than others.

Governors continued to feel engaged in the work of the trust and were well supported. Confidence was expressed in the skills and experience of the lead governor. There were around 30 governors from a mix of geographical areas, staff, people who use services and carers. Governors were offered a training session to support them to understand their role and then ongoing opportunities for learning throughout the year. They had quarterly council of governors' meetings which were attended by the chair and several of the non-executive directors. Governors regularly attended the board to observe. The governors did not attend the committees of the board apart from the nominations committee for non-executive directors, which was chaired by the lead governor.

The governors when asked did not express a strong wish to have more time with the non-executive directors to fulfil their role of holding them to account. Governors were able to visit services, although most of this had taken place remotely during the pandemic and was taking time to return to in-person visits. The governors felt the work they had recently undertaken to replace the chair had been carefully considered and thorough. They also reflected on their other opportunities for being involved such as joining sessions to refresh the trust strategy.

The trust had over 15,000 members. They received a newsletter and were invited to join events such as the Governors Annual General Meeting.

Information management

The trust was refreshing the digital strategy which was an enabling strategy for the overall trust strategy. The independent well led review had recommended that there could be greater clarity on the trust's future digital transformation and that oversight of digital work should have greater scrutiny in the board committees. The trust had identified how this would be addressed and when this would be discussed.

The trust had invested significant funds into the digital infrastructure. They closely monitored the stability of their main systems and platforms to ensure they remained available for staff to use. Over the past year this had remained over the target of 99.95%. Throughout the trust most of the records were digital and there was only limited use of paper records.

Staff told us that they mostly felt they had the right equipment and could access support when needed. The trust had bought its IT support back in house and monitored staff satisfaction. In the past year the monthly staff satisfaction had varied between 96% and 86%. The trust monitored feedback to consider how it could increase satisfaction. We

heard how technology could be made more accessible for staff with a range of disabilities. We did observe variations in individual confidence using digital technology. For example, some trainees said they did not get enough support to use some IT systems and did not have time to read guides. Staff told us that at a few sites the Wi-Fi connection was not reliable, and we were told that solutions were being found for this.

The trust was keen to develop digital solutions to improve services. One of the key developments had been the use of e- prescribing which was in place for inpatient services and being extended to home treatment teams. In pharmacy services patients could scan a QR code on their mobile devices which provided access to educational videos on high-risk medicines. Plans were to spend £3.7m on capital to promote the digital work of the trust in 2023/4. Areas of ongoing work included the automation of HR processes; improving Wi-Fi access for patients; increasing patients being able to order their prescriptions online; technology to support patients managing their personal health record. A range of different digital technology was being incorporated for individual services including school nursing and specialist dental services.

The trust was focused on cyber security and were continuously monitoring and responding to cyber security risks. They were ensuring their software was kept updated and using the safest browser.

The trust had systems in place to oversee information governance through a programme board. The trust had completed the information governance toolkit and had an action plan in place. In 2022/23, there were 236 information governance incidents, 28 incidents less than the previous year. Of these 98.5% of which were assessed as low risk or minimal harm and no incidents had needed to be reported to the information commissioner. The most frequent category of breaches was information disclosed in error – either via email, post or verbal disclosures which was 52% of all incidents. The trust monitor the completion of information governance training.

The trust made good use of data to inform decision making. They had access to management information and made widespread use of integrated performance reporting. There was improved access to 'real time' information and they were working towards automated dashboards. The quality of performance information was good and board members felt they had access to the right data that was reliable.

Continuous improvement and innovation

There had been significant progress in the use of a quality improvement (QI) approach since the last well led assessment. The trust had focused on embedding quality improvement within the trust and created a culture of empowering staff to have the freedom to create their own quality improvement projects within the trust.

CNWL has been partnered with the Institute for Healthcare Improvement since 2017. The trust had 234 live QI projects with 86% having expert by experience involvement and had trained 3,200 staff, with each division having a QI lead. The trust had a QI team consisting of 8 staff, working to embed the work across the trust.

The trust created their improvement academy in 2022. The academy had created cards with QR codes for people to easily access their improvement academy website, which had information on current QI projects, how to access training and development, resources and support and project posters and the latest improvement academy newsletter. The trust offered bronze, silver and gold QI training to staff and offered a 6-month improvement coach development programme. The trust had achieved a continuous professional development accreditation for their level 1 bronze bitesize QI training and offered this to external strategic partners.

Many of the quality improvement projects were was closely aligned to the trust priorities and improving patient safety. For example, reducing restrictive practices, pressure ulcers and reducing falls. The trust held an annual safety

conference to identify approaches to improve the safety within their services such as holding safety conversations. Staff produced about 120 posters presenting their QI initiatives. For example, Nile ward (PICU ward) had produced a poster to evidence a reduction in violence and aggression incidents and a 30% reduction in the number of assaults per week on patients and staff, through a number of improvements that they had made to the ward, such as introducing a patient feedback board, gardening sessions and upgrading the gym equipment for patients to use. The trust rolled out a reducing violence and aggression project across 10 inpatient wards, which linked to the trust's violence reduction strategy, and this led to a 60% reduction in violence and aggression incidents.

QI methodology had also been used to look at other trust priorities such as improving access to services. For example, they worked closely with the therapy leads to address the long waiting lists for service users to access psychology.

The QI teams held clinics to support staff with their possible quality improvement ideas and initiatives. They also held a series of 'spreadathon events', to share learning from different successful quality improvement projects across similar services within the divisions who would benefit from the same intervention. For example, Collingham Child and Family Centre, Lavender Walk and Crystal House joined together in their aims of reducing violence and improving psychological safety. The trust had held 3 successful 'spreadathon events' so far.

The trust had some well-developed research and development but there was scope to give this greater visibility and further expand the internally led studies. The research and development director worked one day a week for the trust reporting to the chief medical officer. His role was to facilitate research activities across the trust. A research and development strategy group met quarterly, chaired by the chief medical officer and attended by clinicians and academics. The trust had long standing research links with Imperial College London with a number of staff working between the trust and university. There were also links with University College London particularly in relation to research on sexual health. The trust was supported by an organisation called Noclor which provided research and development management across several North London NHS trusts.

The trust had a research and development strategy although this was now five years old and would benefit from being refreshed. This had a few priorities which were ongoing. It promoted research through the provision of a starter grant scheme which had been operating for 4-5 years providing up to £10k for new research studies. For example, it has led to a research study in offender care services looking at the support given to fathers from BAME backgrounds in their parenting role. The strategy also developed the capacity in the trust for undertaking research. Staff could apply for grants to access courses to develop their research skills. About 20 staff from a range of professional backgrounds had accessed these grants over the last 4-5 years. The strategy also promoted the sharing of research and this had led to a seminar series which took place remotely for people to present their research. Research was also shared through other trust communications but it was recognised that this could be strengthened and the content on the trust website updated.

Research and development took place through two approaches. The first was the trusts participation in national clinical research. Trust research champions helped to recruit patients to studies. The second was research led by the trust where clinicians and academics worked together. Examples of this were research on sexual health, particularly in relation to the prevention and treatment of HIV; care of older people and the delivery of virtual care. It was recognised that there was scope to broaden the areas of research led by a wider range of professionals.

There were well established processes in place to approve new research projects and to ensure the ethics had been considered and the methodology approved. People who use services participated in this work.

Our findings

The trust recognised the need to focus on equality, diversity and inclusion in future research work, with studies focusing on the needs of communities. A workshop had taken place in July 2023 attended by around 50 people to look at how this could be taken forward.

The trust had established external partnerships with quality improvement research fellows from a local university.

The trust promoted continuous improvement through the accreditation of many services. They had continued to support mental health services to be accredited and members of the relevant quality networks through the Royal College of Psychiatrists' Centre for Quality Improvement. The Camden early years' service had completed the UNICEF UK baby friendly stage 2 accreditation.

The trust was nominated for and won several awards for which it was rightly proud. In the past year these had included:

September 2023 – National Preceptorship Interim Quality Mark – trust recognised as offering high quality preceptorship for newly qualified clinicians

September 2023 – trust recruitment team shortlisted for three categories in the London healthcare support worker awards 2023

August 2023 – trust received a bronze award under the defence employer recognition scheme as an employer who supports people who have served in the armed forces

August 2023 – trust volunteer service shortlisted for national Helpforce champion awards 2023 which recognises the contribution of volunteering in the health and care sector

June 2023 – trust awarded menopause friendly accreditation.

June 2023 – Milton Keynes paediatric service; North Central London sexual health service; North Central London urgent community response team - all shortlisted for HSJ patient safety award

April 2023 – trust shortlisted for HSJ digital awards

March 2023 – two nurses from addiction services won infection prevention nurse of the year at British Journal of Nursing Awards

March 2023 – CEO listed in top 50 CEOs in HSJ

December 2022 – CAMHS psychiatrist runner up for digital innovation at Royal College of Psychiatry conference
December 2022 – trust received award from Drive Forward Foundation for supporting care leavers

The trust had effective and robust governance processes in place to investigate deaths within the trust and use the learning to make improvements. This included being cited on the deaths of people using community services. The findings including themes were escalated appropriately to the quality committee and board. The board appropriately

commissioned an external review where the death was serious enough to require external scrutiny. For homicides, non- executive directors were trained to lead panels. The trust organised quarterly learning events and produced a monthly newsletter to promote learning. The trust recognised that they could do more to share learning with other providers and system partners.

The trust's clinical mortality review group met every two months to review deaths and was chaired by the trust's chief medical officer. Members of this group reviewed the initial management reviews (72-hour reports) for all patient deaths. Specific data on deaths from self-harm were also reviewed. Divisional teams also reviewed and signed off every initial management review (72-hour report) for serious incidents and immediate learning was discussed and recorded.

We reviewed a sample (6) of initial management reviews relating to deaths and serious untoward incident reports. The trust used the CESDI grading model to attribute a score from 0-3 from no suboptimal care identified to suboptimal care identified which could have reasonably had an outcome on the death. We agreed with all the gradings apart from one where we felt that different care (linked to the person being referred to addiction services) might have made a difference to the outcome.

The content and quality of investigation reports using a root cause analysis were of a good standard, they were focused on the person, there was clear involvement of the family, there was immediate identified learning.

The trust identified that there was a backlog of action plans being not signed off as completed at a divisional level (by the divisional director) in a timely manner. They had conducted an audit of the completion rates and had agreed with the local integrated care board that there needed to be more oversight and scrutiny of this process in future. They had also implemented a quality improvement project to address this, resulting in a 30% reduction in delays to producing reports, but recognised that this needed to be further improved.

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 ↓ Feb 2024	Good ➔➔ Feb 2024	Outstanding ➔➔ Feb 2024	Good ➔➔ Feb 2024	Good ➔➔ Feb 2024	Good ➔➔ Feb 2024

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
Mental health	Requires Improvement	Good	Good	Good	Good	Good
Community	Good	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement ↓ Feb 2024	Good →← Feb 2024	Outstanding →← Feb 2024	Good →← Feb 2024	Good →← Feb 2024	Good →← Feb 2024

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.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Child and adolescent mental health wards	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health crisis services and health-based places of safety	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Community mental health services for people with a learning disability or autism	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Wards for people with a learning disability or autism	Good Jun 2017	Outstanding Jun 2017	Outstanding Jun 2017	Outstanding Jun 2017	Outstanding Jun 2017	Outstanding Jun 2017
Community-based mental health services for older people	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Good →← Feb 2024	Requires Improvement →← Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024
Community-based mental health services of adults of working age	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Forensic inpatient or secure wards	Requires Improvement ↓ Feb 2024	Good →← Feb 2024	Good →← Feb 2024	Good →← Feb 2024	Good →← Feb 2024	Good →← Feb 2024
Wards for older people with mental health problems	Good Jun 2019	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Overall	Requires Improvement	Good	Good	Good	Good	Good

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.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Community end of life care	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Community dental services	Good Jun 2015	Good Jun 2015	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Community health inpatient services	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Community health services for children and young people	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Overall	Good	Good	Outstanding	Good	Good	Good

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.

Mental health crisis services and health-based places of safety

Inspected but not rated

Is the service safe?

Inspected but not rated

Health-based places of safety

Safe and clean environments

Clinical premises where patients received care were safe, clean, well equipped, well furnished and well maintained. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

We inspected the environments of the health-based places of safety at the Hillingdon Hospital site (Riverside Centre) and St Charles Hospital. Staff completed and regularly updated thorough risk assessments of all areas and removed or mitigated any risks they identified.

Patient areas were clean, well maintained, well-furnished and fit for purpose. Staff cleaned and checked the rooms after each patient was discharged. All rooms were of a good size with external windows providing natural light. However, not all rooms had ensuite toilets. At the Riverside Centre the place of safety had 2 rooms for patients, and these did not have ensuite bathrooms. At St Charles Hospital there were 4 rooms for patients. Two of these had ensuite facilities; the other 2 rooms used an external bathroom within the service.

At the time of inspection, the service at the Riverside Centre was about to open a new place of safety. The new place of safety was larger and less cramped and would have ensuite rooms for 3 patients. This was to be opened in August 2023.

Safe staffing

Although the service had enough staff, who received appropriate training to keep people safe from avoidable harm, St Charles Hospital had a high vacancy rate for nurses and staff had raised concerns regarding staffing levels and increasing patient acuity. Staff gave patients the time and support they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe at both sites. At the Riverside Centre there was 1 registered nurse and 1 health care assistant assigned to the service during the day and night shifts. If there was a need this could be increased to 2 registered nurses assigned to the shift. At St Charles Hospital there was 1 registered nurse and 2 health care assistants assigned to the service during the day and night shifts for up to 3 patients. If there were 4 patients, there would be 2 registered nurses and 1 health care assistant assigned for the shift. At both services, a team manager supported staff during the day and a unit co-ordinator at night.

The service had staff vacancies. At St Charles Hospital, 45% of nursing posts were vacant with 2 staff due in October 2023. Staff meeting minutes from August and September 2023 showed that staff had raised concerns regarding staffing levels and patient acuity. Senior staff reported that this had been escalated and the trust lead was asking for external guidance on appropriate staffing levels.

Mental health crisis services and health-based places of safety

Medical staff

Both of the services had enough medical staff. The places of safety had a consultant assigned to the service. Out-of- hours cover was provided by the hospital on-site duty doctor supported by on call registrar and consultant psychiatrist.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. This included training in observation and engagement, intermediate life support, dementia level 1, autism and learning disability and physical health.

Managers monitored completion of mandatory training and alerted staff when they needed to update their training. Staff at St Charles place of safety had an overall compliance rate of 94% with all mandatory training. Staff at the Riverside Centre had 99% compliance with mandatory training in the last 12 months.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. At the place of safety, staff reviewed any information held on the electronic patient record as soon as they received a referral from the police. This enabled staff to complete an initial risk profile. When patients arrived at the service, staff completed a comprehensive risk assessment.

Staff used a recognised risk assessment tool. When patients were admitted to the place of safety, staff completed a risk assessment on a standard form and recorded this on the electronic patient record.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. At the place of safety, if patients presented with any physical health concerns which required urgent attention, staff will request the London Ambulance Service for the patient to be transferred to an emergency department of a general hospital to receive medical assistance.

Use of restrictive interventions

Restrictive interventions were used when needed. A high proportion of restraints at St Charles health based place of safety were in the prone position. Prone restraint is more likely to put patients at risk of harm.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. At the Riverside Centre, staff told us there had been 3 instances where staff had used rapid tranquilisation and 5 physical restraints since January 2023. In one of these the patient had been restrained in the prone position. At St Charles Hospital health based place of safety there had been 36 patient restraints from April to September 2023. Information provided by the trust for the St Charles Hospital place of safety recorded that in August 2023 there were 14 incidents of restraint, 7 of which were in the prone position, representing half of all restraints that month. In the same month there were 9 incidents where rapid tranquilisation by injection was used. There had been 24 incidents involving intramuscular rapid tranquilisation from April to September 2023.

Staff at the place of safety followed National Institute of Health and Care Excellence (NICE) guidance during the first hour after the administration of rapid tranquilisation. Staff observed and recorded patients' vital signs appropriately.

Mental health crisis services and health-based places of safety

When a patient was placed in seclusion at the place of safety, staff kept clear records and followed best practice guidelines under the Mental Health Act code of practice. The facilities at the place of safety met the requirements for seclusion rooms set out in national guidance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff received and kept up to date with their safeguarding training. All staff undertook mandatory safeguarding level 3 training for adults and children. The trust had a safeguarding lead in place.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. At both health-based places of safety, staff recorded all their notes on the electronic patient record.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed trust systems and processes when safely prescribing, administering, recording and storing medicines. Staff had their medicine administration competency assessed to ensure they were safe to administer medicines. At both health-based places of safety, staff stored standard medicines, and those the patient brought with them, in a locked medicine cupboard in the clinic room. The service could access other medicines from the hospital wards if necessary.

Track record on safety

In March 2023, a patient died at the St Charles health-based place of safety after tying a ligature. The health-based places of safety at Hillingdon had a good track record on safety.

Reporting incidents and learning from when things go wrong

Both places of safety 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.

Staff knew what incidents to report and how to report them. The most common incident reported at both places of safety was a breach of the permitted period of detention (24 hours). At the Riverside Centre, staff provided the patient with a letter to apologise for delays in finding a suitable inpatient bed.

In March 2023 there was a serious incident at the place of safety at St Charles Hospital. A patient died after tying a ligature in the place of safety. Following the incident, the staff at the service refreshed their observation and therapeutic engagement training.

Staff reported serious incidents clearly and in line with trust policy. Staff recorded all incidents on the trust's electronic incident reporting system.

Mental health crisis services and health-based places of safety

Managers debriefed and supported staff after any serious incident. Staff discussed incidents at reflective practice sessions and monthly team meetings.

Psychiatric Liaison Teams

Safe and clean environments

Although the main clinical assessment rooms where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. One alternative room, used when the main assessment room was occupied, required repairs and cleaning. The crisis assessment centres were clean and well-maintained.

We inspected the psychiatric liaison services at Hillingdon Hospital, Northwick Park Hospital and Milton Keynes Hospital. The 3 teams all had access to an assessment room for 'high risk' patients in the emergency department. Staff completed environmental risk assessments for all these rooms.

The assessment rooms were well maintained, appropriately furnished, and suitable for purpose. They were all ligature free, had at least 1 door that opened outwards, had an alarm system and CCTV, an observation panel, and appropriate furniture that could not be used to cause harm. All services had access to alternative rooms to use if the assessment rooms were not available. The alternative rooms at Hillingdon Hospital and Milton Keynes Hospital were situated away from the main assessment room. The alternative room at Hillingdon Hospital had damage to the wall from a previous patient that had not been fixed or cleaned. The alternative room at Northwick Park Hospital was not ligature free. The risk was mitigated by ensuring a staff member always accompanied patients.

The 3 crisis assessment centres we inspected were clean and well maintained. We observed staff following infection control guidelines.

Safe staffing

The service had enough staff to deliver the service model. Staff across all teams received appropriate training to keep people safe from avoidable harm. The number of patients seen within the emergency department or by the psychiatric liaison services, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing staff to keep patients safe and deliver the service model. The services at Hillingdon Hospital and Northwick Park Hospital delivered an enhanced 24 service model and the service at Milton Keynes Hospital delivered the core 24 model. The service at Hillingdon Hospital, for example, had 9 band 6 nurses and 4 band 7 nurses, which meant its staffing was in line with National Institute for health and care excellence guidance.

The services at Hillingdon Hospital and Northwick Park Hospital had a first responder team, which was a team of band 6 nurses that provided further assessment of patients in the emergency department and at the crisis assessment centres. The services at Nortwick Park Hospital and Milton Keynes Hospital had implemented a band 5 development nurse posts to assist with retention of staff.

The service did not employ non-registered nursing staff. Staff covered the urgent and emergency care department and the rest of the general wards in the hospitals. The services did not accept referrals of young people under 17 years old, these were referred to the child and adolescent mental health service.

The service had some nursing staff vacancies. The service at Hillingdon Hospital had no vacancies. At Northwick Park Hospital there was a 32% vacancy rate for nurses, 5.8 band 6 nurses and 2.8 band 7 nurses.

The services did not use agency staff due to the specialist nature of the service and there was minimal bank staff usage across the 3 services.

Medical staff

The service had enough medical staff and were able to cover sickness and absence. Service staff could access support from a psychiatrist quickly when they needed to. The service at Hillingdon Hospital had 1 full time consultant who was an older adult specialist, 2 part time consultants and 3 junior doctors. At Northwick Park, the service had 3 consultants and 3 junior doctors; and at Milton Keynes Hospital, the service had 1 full time consultant, 1 part time older adults' consultant and 2 junior doctors.

Medical staff were available office hours Monday to Friday and staff could access out-of-hours medical staff when needed.

Mandatory training

The mandatory training programme was comprehensive to meet the needs of patients and staff.

The team leads at the service at Hillingdon Hospital and Northwick Park Hospital were informed of training expiring for team members a few weeks in advance but did not have access to the overall training dashboard. The manager at Northwick Park Hospital kept their own performance data to keep track of staff training compliance. All staff at Northwick Park Hospital had training compliance between 70% and 90%. All staff at the service at Milton Keynes Hospital were above the 90% service target.

There were mandatory training shortfalls in some areas. For example, 6 staff (25%) at Northwick Park Hospital psychiatric liaison team had not completed NEWS2 training (NEWS2 is a way of identifying and measuring aa deterioration in a patient's physical health). Seven staff (29%) had not completed both online and face to face training in life support and 6 staff (25%) had not completed risk assessment and safety training.

Managers alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. Staff responded promptly to sudden deterioration in a patient's mental health. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed face-to-face risk assessments for each patient on referral, using a recognised tool, and reviewed these at least daily. We reviewed 30 patient care records and a timely risk assessment had been completed on each record. Staff at the service at Northwick Park Hospital had access to the patient records of the trust that managed the emergency department and could include this in the patient's risk history.

Management of patient risk

Staff regularly monitored patients with mental health problems on the wards and in the urgent and emergency care departments and waiting areas for changes in their level of risk and responded when risk increased.

Staff followed clear personal safety protocols.

Mental health crisis services and health-based places of safety

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received and kept up-to-date with training on how to recognise and report abuse, appropriate for their role. Staff completed level 3 adults safeguarding training and level 3 children's safeguarding training. The service at Milton Keynes Hospital had implemented quarterly group peer safeguarding supervision facilitated by the trust's children's safeguarding lead.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a safeguarding lead in place. All staff we spoke with were aware of the process and who to contact.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The services used electronic care records. The services at Milton Keynes Hospital and Northwick Park Hospital had access to both the mental health trust and the acute hospital electronic care records.

When patients transferred to and from other services there were no delays in staff accessing their records. Care records were stored securely.

Track record on safety

The service had a good track record on safety.

There had been 36 incidents in the Hillingdon Hospital psychiatric liaison service in the last 12 months, none of these had been serious incidents.

A patient had died in July 2022 shortly after being seen by the psychiatric liaison team at Hillingdon Hospital and leaving the department. The incident was investigated, and learning identified.

Reporting incidents and learning from when things go wrong

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.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with trust policy.

Managers debriefed and supported staff, including staff from the emergency department, after any serious incident.

Mental health crisis services and health-based places of safety

Managers investigated incidents thoroughly. This included the managers from the psychiatric liaison teams, emergency department and the wards. Incidents were discussed at joint serious incident governance meetings.

Staff received feedback from investigations of incidents at team debriefs, team meetings and through supervision. There was evidence that changes had been made in response to feedback. For example, there was an incident last year where a patient was sent home but was detained under section 136 of the Mental Health Act. As a result of this incident, the service had implemented a new induction checklist that included areas to discuss with a new member of staff such as the s136 process, working with the partner agencies, and responding to referrals from the emergency department.

Is the service effective?

Inspected but not rated

Health-based places of safety

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected patients' assessed needs and were personalised.

Staff completed a comprehensive mental health assessment of each patient. Most patients were seen promptly by a triage doctor to assess whether the patient had a mental disorder and whether a further assessment for admission under the Mental Health Act 1983 was required.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Staff at the place of safety completed a physical health check as part of the core assessment.

Best practice in treatment and care

Staff used recognised rating scales to assess and record severity and outcomes. Staff in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff completed audits including of patients staying more than 24 hours in the place of safety, environmental checks, risk assessments and care plans.

Quality improvement initiatives included designing a welcome pack to the service and implementing an additional daily safety huddle to discuss patient risks.

Skilled staff to deliver care

Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers at both places of safety gave each new member of staff a full induction to the service before they started work. This included a tour of the ward, how to manage the patients and reviewing the policies.

Mental health crisis services and health-based places of safety

Managers at both places of safety supported staff through regular, constructive appraisals of their work. Staff at the place of safety said they had regular managerial and clinical supervision with their manager, group supervision with their colleagues and an annual appraisal. Staff said they found these sessions helpful.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff at both health-based places of safety held regular team meetings.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff at both health-based places of safety had monthly team meeting to review performance data on the service and discuss incidents and development.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. At the start of each shift, staff at both health-based places of safety held a handover meeting to discuss patients held within the facility. Staff provided a discharge summary for the service that the patient was being transferred to.

Teams had effective working relationships with other teams in the organisation. Staff at health-based places of safety worked closely with bed managers, crisis teams, community mental health teams and acute admission wards.

Teams had effective working relationships with external teams and organisations. The team leader of the place of safety attended a monthly meeting with other services involved in conveying patients to a place of safety. This included representatives from the police and approved mental health professionals.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Many patients were kept in the place of safety for more than 24 hours, the permitted period of detention. Staff did not always inform patients about a change to their Mental Health Act 1983 status and record when and what they told them.

Staff usually explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We reviewed 12 patient care records across both places of safety. Of these, 10 patients were held at the place of safety for beyond the permitted period of detention. We found the main reason for this was patients were waiting to be admitted to an inpatient bed, and the average wait time was 2 to 3 days for an inpatient bed. The service would request a 12 hour extension of the detention period if the patient's condition would prevent completion of the assessment by the end of the 24 hour period. The service wrote an apology letter to patients in the place of safety once the 24-hour period expired, but this did not explicitly state the patients had been unlawfully deprived of their liberty.

Staff explained to patients about how the Mental Health Act applied to their situation when they arrived at the place of safety. However, in the 3 records we reviewed at St Charles Hospital place of safety, we did not find any evidence to show that staff informed the patient of the change in their status when the permitted period of detention had elapsed.

Mental health crisis services and health-based places of safety

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and the associated Code of Practice. Staff at both places of safety could access support in relation to the Mental Health Act from approved mental health professionals (AMHPs) and an on-call consultant psychiatrist. The AMHP service at both places of safety was located onsite. We did not find delays in patients accessing medical recommendations in relation to their detention, or the AMHP service, which coordinated the assessment of patients for detention.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Mental Health Administrators were based on the same site as both of the places of safety. Staff could contact them whenever they needed to.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff could access policies and guidance through the trust's intranet.

Good practice in applying the Mental Capacity Act

Staff did not always assess and record capacity to consent clearly for patients who might have impaired mental capacity.

Although staff received and kept up to date with training in the Mental Capacity Act, and there was a clear policy in place, this was not always followed.

Staff did not always assess and record capacity to consent clearly on admission and each time a patient needed to make an important decision. We reviewed 12 patient care records across both places of safety. When the patient was deemed to lack capacity to understand that they must stay in the place of safety for longer that the 24-hour permitted period of detention, staff had recorded that they considered it to be in the patient's best interests to remain. However, the Mental Capacity Act 2005 does not confer any power to deprive a patient of their liberty in these instances.

When medicines were given to patients in the place of safety, staff did not always record under what legal authority this was being given. Patients detained under section 136 powers cannot be treated under the Mental Health Act; medicines can be given either by the patient giving valid consent or as a best interests' decision under the Mental Capacity Act. The entries we saw in records where patients in the place of safety were given medicines, did not state the legal basis for this decision.

Psychiatric Liaison Teams

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the liaison psychiatry service team worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

The psychiatric liaison team who worked mainly in the emergency department ensured that patients attending the department received a mental health assessment and were referred to other services as appropriate or admitted and plans of care put in place. We reviewed 30 care records of people referred to the service and the crisis assessment centres.

Staff within the 3 psychiatric liaison teams developed and updated care plans when patients' needs changed. We observed this occurring at the daily handover meeting and on accompanying staff to visit a patient.

Staff worked to develop individual plans of care which they reviewed regularly through multidisciplinary discussion and updated as needed. Staff detailed regular contact with patients and any families or carers in patient records.

The team at Northwick Park Hospital had implemented a trauma informed approach and used a stabilisation manual to support this. This manual included 10 workbooks and staff chose which were most appropriate for the patient. Staff told us this has had a positive impact on patients.

The service at Milton Keynes Hospital had good follow up of care in the community if a patient had been discharged home. The team offered outpatient appointments to provide signposting and referrals to community services. This was initially implemented to address a wait for psychology services, but staff identified this helped in maintaining mental health in the community and this service was retained.

Best practice in treatment and care

Staff used recognised rating scales to assess outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff delivered care in line with best practice and national guidance from the National Institute of Health and Care Excellence and the Royal College of Psychiatrists.

The services undertook audits such as risk and assessment audits. Managers shared results of the audits with the team and used these to make improvements to the services.

The services at Northwick Park Hospital and Milton Keynes Hospital used the Clinical Global Impression Improvement Scale (CGI-I) to measure outcomes for patients. Managers used this to monitor performance of the services. The service at Hillingdon Hospital used a different system that allowed the service to see other hospital's data to benchmark against.

The psychiatric liaison services at Hillingdon Hospital and Northwick Park Hospital were accredited under Psychiatric Liaison Accreditation Network (PLAN). The service at Milton Keynes Hospital had begun this accreditation process but had not been in a place to meet the standards. The service planned to reapply in the next 12 months.

Skilled staff to deliver care

The psychiatric liaison service included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a range of specialists to meet the needs of the patients on the wards and attending the emergency department. Each team had a drug and alcohol specialist, an older adults specialist and a psychologist. The service at Milton Keynes had a vacancy for a band 7 drug and alcohol specialist and for their lead psychologist. Each team had access to learning disabilities specialists, and the perinatal team.

The acute trusts provided security staff in the emergency department to support staff.

The service at Northwick Park Hospital had a drug and alcohol specialist worker. The service had recently submitted a business case for additional alcohol specialist roles as there was a need for this.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Managers gave each new member of staff a full induction to the service before they started work. The service at Hillingdon Hospital had updated their induction checklist following learning from an incident in 2022 at the service. The induction at all the services included understanding the referrals process, systems access and shadowing other services.

Managers supported staff through regular, constructive clinical supervision and appraisals of their work. At the time of inspection the service at Hillingdon Hospital provided clinical and managerial supervision every 8 weeks and a yearly appraisal, and 100% of staff were up to date with these. The service at Northwick Park provided combined managerial and clinical supervision, and 95% of staff were up to date with supervision and 90% of staff were up to date with their yearly appraisal. The service at Milton Keynes provided combined managerial and clinical supervision every 8 weeks, and 100% of staff were up to date with these. There was 1 staff member that had not had their appraisal and there was a plan for the manager to complete this.

Managers made sure staff attended regular team meetings or gave information about the discussions to those they could not attend. Each of the 3 psychiatric liaison teams and 3 crisis assessment centres we inspected held regular team meetings. The service at Hillingdon Hospital provided monthly reflective practice sessions with the psychologist.

Managers identified any developmental training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Each of the 3 services we inspected offered their staff the 5-day liaison psychiatry training course provided by South London and Maudsley NHS Trust. The service at Hillingdon Hospital offered staff a 3-day cognitive behavioural therapy course.

Managers made sure staff received any specialist training for their role. Each of the 3 teams we inspected had implemented training on learning disabilities and autism. The service at Milton Keynes Hospital had the autism reality experience bus come to provide training by giving non-autistic people an experience of the sensory processing difficulties faced by people on the autism spectrum.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

The 3 psychiatric liaison services we inspected were composed of medical staff, registered mental health nurses with specialisms in drugs and alcohol, older adults and physical health, clinical psychologists and administration staff. Staff attended daily multidisciplinary allocation meetings that reviewed the referrals. Additionally, there were 2 daily handover meetings in the afternoon and evening to update and handover patient assessments. We observed one of these handover meetings and found this to be comprehensive and professional. Staff shared clear information about patients and any changes in their care.

The psychiatric liaison service had effective working relationships with other teams in the organisation. The service at the Riverside Centre had an evening meeting with the home treatment teams, junior doctors, speciality registrars and

consultants to discuss who was available out of hours. Also present was the bed manager who acts as the coordinator of the HBPoS suite. The purpose of the meeting is to collectively discuss the patient flow across the site and to escalate any issues or concerns and any support needed for the night shift staff members who are on duty on a particular evening.

The psychiatric liaison service had very effective working relationships with external teams and organisations. Staff attended multidisciplinary meetings in the acute trust, safeguarding meetings, and meetings with the single point of access. The service at Hillingdon Hospital held monthly high intensity user meetings to review frequent attenders, patients with complex needs who would often attend the emergency department. This meeting involved the ambulance service, police, the acute trust and community mental health teams. The psychiatric liaison team also chaired a meeting with the police every third week. The service at Milton Keynes attended monthly care quality and innovation meetings with the other crisis teams.

The psychiatric liaison services provided teaching to the ward staff of the acute trusts. Staff at all 3 services provided Mental Health Act, Mental capacity Act and mental health awareness training. The service at Hillingdon Hosoital provided teaching every third week to the emergency department staff.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. However staff did not always implement the Mental Health Act appropriately.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. We reviewed 30 care records of people referred to the psychiatry liaison service and the crisis assessment centres. We mostly found good recording of the legal status of the patient and staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes.

However, on 1 record from the crisis assessment centre in Northwick Park Hospital we found staff had recorded that if the patient tried to leave, they were to be detained under the Mental Health Act for assessment. We spoke with the manager about this, and they said this would not be the process and should not have been recorded.

At the crisis assessment centre in St Charles Hospital, we found on 1 record the patient had 'used their escorted leave' although they were not subject to the Mental Health Act. The centre's operational policy stated they could take patients with 2 medical recommendations for detention and that patients were not to stay longer than 24 hours. However, on 2 records we found patients had stayed longer than 24 hours while waiting for a bed without lawful detention under the Mental Health Act.

The crisis assessment centres at Hillingdon Hospital and Northwick Park Hospital did not take patient with 2 medical recommendations for detention.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Mental health crisis services and health-based places of safety

Patients had easy access to information about independent mental health advocacy.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed capacity for patients who might have impaired mental capacity. However, on 4 occasions we identified that staff did not record a patient's capacity to consent.

Staff received training in the Mental Capacity Act. There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients.

Staff assessed and recorded patients' capacity to consent on most occasions that a patient needed to make an important decision. We reviewed 30 care records of people referred to the psychiatric liaison service and the crisis assessment centres. We found good recording of capacity assessments in the majority of cases. However, on 2 records from the crisis assessment centre in Northwick Park Hospital and 2 from the crisis assessment centre at St Charles Hospital we found staff had not recorded a patient's capacity to consent clearly or at all. This meant it was not clear whether the patients concerned had given appropriate consent to stay at these centres.

Is the service caring?

Inspected but not rated

Health-based places of safety

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 1 patient at the place of safety at St Charles Hospital. The patient told us the staff were kind and treated them well, and they found the environment comfortable and accommodating. We also spoke with 4 former patients.

Their feedback was mostly positive. Patients told us they felt safe and the staff treated them well. One patient would have preferred a choice of food. Patients were provided with access to advocacy and forms to give feedback about the service.

Staff were discreet, respectful, and responsive when caring for patients. At both health-based places of safety, staff talked about the importance of good patient care. They sought to achieve this through listening to, and engaging with, patients.

Staff gave patients help, emotional support and advice when they needed it. They spent time with patients, talking to them about how they felt. They offered patients encouragement and reassurance.

Staff directed patients to other services and supported them to access those services if they needed help. At both places of safety, staff referred patients to the crisis team or the community mental health team when they were not admitted to hospital.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers when they could. Staff at the place of safety contacted patients' families and involved them in decision making when this was possible and appropriate.

There were phones at the places of safety that patients could use to contact families and carers. Families and carers could visit and bring permissible items for the patient with their consent. At the Riverside Centre, the service held monthly face-to-face carers' meetings.

Psychiatric Liaison Teams

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 8 former patients of the psychiatric liaison teams and crisis assessment centres. Their feedback was mostly positive. Patients told us they felt safe and found the crisis assessment centres comfortable for their stay. Most patients told us they valued the service and it had been helpful to them in a time of crisis.

We observed staff and patient interactions in the assessment rooms in the emergency department. We saw that staff were discreet, respectful, and responsive.

Staff understood and respected the individual needs of each patient. Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff in the liaison psychiatric teams involved patients in care planning and risk assessment and sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed. Staff informed and involved families and carers appropriately.

Involvement of patients

We spoke with 8 former patients of the psychiatric liaison teams and crisis assessment centres.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. One patient told us they were not told they were speaking with a consultant and so were not able to ask about their health plans.

Mental health crisis services and health-based places of safety

Patients could give feedback on the service and their treatment and staff supported them to do this. Most patients knew how to feedback or complain. However, 2 patients told us they had not been told how to do this. Staff provided patients with feedback forms but all services told us they did not have a high response rate.

Staff made sure patients could access advocacy services.

Is the service responsive?

Inspected but not rated

Health-based places of safety

Access and discharge

The health-based place of safety was available 24-hours a day. The referral criteria did not exclude patients who would have benefitted from care. Staff assessed people promptly. However, patients were frequently held in the place of safety for longer than the permitted period of detention.

The service had clear criteria to describe which patients they would offer services to. The place of safety accepted referrals for patients aged 18 or over. Patients younger than 18 who required a place of safety were usually taken to the emergency department of local hospitals. The Riverside Centre could take patients as young as 15 years old. If they admitted a person under 18, they would not admit an adult patient to the other room. The service did not accept patients when there were concerns about their physical health. The police took these patients to an emergency department of an acute hospital for medical assessment before taking them to the place of safety.

The trust did not always discharge patients from the place of safety within the 24-hour permitted period of detention. We reviewed 12 patient care records across the 2 places of safety and found the 24-hour detention period was breached for 10 patients. Managers and staff explained that delays were caused by a lack of availability of inpatient beds and wider system pressures. The trust told us that the average length of time patients spent in the St Charles health based place of safety was 57 hours. The longest stay over the same period was 8 days and was due a lack of inpatient bed available. Thirty per cent of patients were discharged from the place of safety, with the remaining patients admitted to an inpatient ward. The trust report that the average length of stay was reducing.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The facilities differed between the 2 places of safety we inspected. At the Riverside Centre, the current place of safety was cramped and did not have ensuite bathrooms in the rooms. However, a new place of safety was due to open in August 2023. The 3 bedrooms in the new health-based place of safety were bigger and had ensuite facilities. Staff offered patients showers on the wards nearby and trips to the on-site garden.

At St Charles Hospital, the service had a full range of rooms and equipment to support treatment and care. The service provided large rooms for patients with ensuite facilities and natural light. The service used closed-circuit television (CCTV) to monitoring patients in their bedrooms. The rooms had privacy screens near the bathroom to protect patients' privacy. If a patient was in the privacy screened area staff would check on them to ensure their safety.

Mental health crisis services and health-based places of safety

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make reasonable adjustments for people with disabilities and those with communication or other specific needs. At both health-based places of safety, managers ensured staff and patients could get hold of interpreters (including British Sign Language interpreters) when needed. Staff supported patients with cultural and spiritual activities. Staff supported patients to access religious texts and offered visits from faith representatives.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Managers investigated complaints and identified themes. Managers and staff at both health-based places of safety told us the main theme of complaints was patients complaining about the length of stay. The St Charles place of safety had received one complaint since January 2023 and this related to waiting times. At the Riverside Centre the team had received 2 complaints in the last 12 months.

The service also received compliments for the staff, approved mental health practitioner (AMHP's) and police officers. Managers shared feedback from complaints with staff and learning was used to improve the service.

Psychiatric Liaison Teams

Access and discharge

The psychiatric liaison services we inspected were available 24 hours a day and were easy to access and the referral process was clear. Some patients had long waits to access mental health beds.

The 3 psychiatric liaison services we inspected had skilled staff available to assess patients 24-hours a day seven days a week. The services had specialist nurses who attended the emergency department to assess and treat patients attending the department and were also able to support the hospital staff for the patients on the general wards.

However, performance data from the services showed there were often delays in patients being admitted to mental health beds. Length of stay for service users waiting for beds in the Harrow mental health emergency centre (Northwick Park Hospital) was highlighted as high risk on the liaison psychiatry risk register. The risk controls in place focused on regular bed management calls. Managers from the service escalated delays for a bed to the trust's bed management central system. Managers met 3 times a day to review patients waiting for beds and availability of beds. The chief operating officer for the trust attended the morning meeting to monitor patient flow.

The trust had recently opened crisis assessment centres at some of their hospitals. We inspected 3 of these at Hillingdon Hospital, St Charles Hospital and Northwick Park Hospital. The centres allowed time for staff to complete an assessment, start treatment quickly, and ensure patients that did not need admission were directed to other services or sources of support. They were not meant to be for patients assessed as requiring admission to an inpatient bed.

However, 5 records from the centre at St Charles Hospital showed patients had been assessed as needing an inpatient bed and were waiting 2 to 7 days for a bed.

The centre at Northwick Park was reducing admissions to inpatient beds for patients. Since it had opened, 14 of the 157 patients were admitted to an inpatient bed.

Staff mostly saw referrals to the psychiatric liaison team within the trust target time. The services had an emergency pathway where patients were seen and initially assessed within an hour and their stay at the emergency department was no longer than 12 hours, an urgent pathway where patients from the inpatient wards were seen within an hour and assessed within 24 hours, and a routine pathway where patients were assessed within 48 hours.

The referral to assessment times were in line with the Royal College of Psychiatry and National Institute for Health and Clinical Excellence (NICE) quality standards. The performance targets were monitored in monthly performance reports and each service had different local targets. At Hillingdon Hospital the target was 95%, at Northwick Park Hospital the target was 90% and at Milton Keynes Hospital the target was 80%.

Over the 6 months prior to our inspection the psychiatric liaison services compliance for the emergency pathway was 94% for Hillingdon Hospital, 85% for Northwick Park Hospital and 94% for Milton Keynes Hospital. The psychiatric liaison services compliance for the urgent pathway was 93% for Hillingdon Hospital, 64% for Northwick Park Hospital and 79% for Milton Keynes Hospital.

Managers at Northwick Park Hospital had identified a need for additional alcohol specialist roles as approximately one third of their referrals were alcohol related. They had recently submitted a business case for this to reduce waiting times. Managers at Milton Keynes Hospital had band 6 nurse vacancies during this 6-month period, which had negatively affected waiting times. They had now filled those vacancies and the routine referral response time in July 2023 was the highest in the 6-month period at 76%.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of assessment rooms supported patients' treatment, privacy and dignity.

The assessment rooms at the 3 psychiatric liaison services we inspected supported patient care. They were appropriately furnished, ligature free and had ensuite toilets.

The facilities varied across the 3 crisis assessment centres we inspected. The crisis assessment centres at Hillingdon Hospital, St Charles Hospital and Northwick Park Hospital did not all have ensuite rooms. The rooms did not have beds, but fully reclining couches that folded out into flat beds with blankets, sheets and pillows if the patient wanted to lie down. These assessment centres were not intended for long stay, but we found patients at each centre were sometimes staying several nights and would need a bed to sleep in but only had access to a fold out couch.

Meeting the needs of all people who use the service

The liaison psychiatry service met the needs of all patients, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Mental health crisis services and health-based places of safety

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The liaison psychiatry managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

Managers investigated complaints and shared feedback from complaints with staff. The service at Hillingdon Hospital had not received any formal complaints in the previous 12 months. At Northwick Park the team had received one complaint and at Milton Keynes Hospital they had received 3 complaints. The services tried to resolve any complaints at the informal stage.

The service used compliments to learn, celebrate success and improve the quality of care. We saw a complimentary email from the police regarding the Hillingdon Hospital psychiatric liaison team. We saw compliments displayed on the notice board at Milton Keynes Hospital.

Is the service well-led?

Inspected but not rated

Health-based places of safety

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The managers at both places of safety had the skills, knowledge and experience to perform their roles. The manager at the Riverside Centre had previously been the manager on an inpatient acute mental health ward. The manager at St Charles Hospital had held the role for many years. Both managers knew the main risks and concerns at the service and worked with other teams to manage them.

Registered nurses at the place of safety were all experienced and had previously worked on acute admission wards, psychiatric intensive care units and psychiatric liaison teams.

Staff at the places of safety said that senior managers visited the service frequently. They knew the senior managers well.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff at both health-based places of safety said that the trust was a good place to work. Staff said that the trust had supported their professional development.

Mental health crisis services and health-based places of safety

Staff felt they were valued by their managers and felt that their contribution to the service was recognised.

The manager at the Riverside Centre had just completed their masters in practice education. The trust supported with paid study days. The manager was also enrolled into the trust's leadership course taking place in September 2023.

The trust planned to introduce a rotation scheme that enabled nurses to work in different areas of the trust in order to broaden their experience.

The services provided programmes to support nurses develop skills. Secondments were offered to all staff. Staff told us nurses at band 7 were encouraged to undertake development opportunities into management roles.

Staff felt they could raise concerns without fear. The trust had a freedom to speak up guardian who regularly visited the places of safety and shared their contact details with the staff.

Governance

Governance processes were in place at team level. Senior managers were aware of performance concerns particularly in relation to breaches of the permitted time of detention, but the concerns were ongoing.

At the places of safety, staff held clinical governance meetings to review performance data relating to the service. Managers had access to performance data which included data about the number of admissions, the discharge pathway, the number of breaches of the permitted time of detention, assessment times and incidents. To address this, managers attended regular bed management calls. In addition, there was wider work across the trust to try and improve the flow of patients through the pathway.

We identified concerns in the other key questions in relation the recoding of capacity and consent and keeping patients fully informed in regard to their legal status.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe care and mitigate and manage risks.

The places of safety had risk registers where risks to the service were monitored. Managers were aware of the risks and were working to mitigate them. Patients waiting to be admitted to an inpatient bed was identified as the primary risk across both places of safety and the trust. Patients waiting for beds were escalated to the Central Flow Hub (CFH), and meetings with the CFH were attended daily by the chief operating officer for the trust.

Information management

Teams had access to the information they needed to provide safe and effective care.

Patient care records were recorded on electronic systems. The service notified the Care Quality Commission of notifiable incidents. The managers had access to information to support them with their management roles.

Engagement

Staff engaged actively with other health and social care partners to ensure that an integrated health and care system was provided to meet the needs of the local population. Managers of the service worked actively with partner agencies to ensure that people received help when they experienced a mental health crisis.

Mental health crisis services and health-based places of safety

The team leaders at the place of safety met each month with managers from partner agencies including the police, ambulance service, emergency department and local authority.

Learning, continuous improvement and innovation

Staff were committed to learning and continuous improvement of the service.

Staff at the place of safety were involved in quality improvement projects to improve the service. For example, the service held a co-production workshop to develop a welcome pack to the service for patients.

Psychiatric Liaison Teams

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Each of the 3 liaison psychiatry services had service managers and team managers who were based onsite. Managers had the required skills, knowledge and experience in managing mental health crisis patients.

Staff spoke highly of the senior leaders and managers in the service. Staff told us that the managers and senior leaders were approachable and supportive.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with were positive about working for the trust and described a supportive culture.

Career development was supported. Staff said managers supported them in identifying professional development opportunities. For example, the manager of the Milton Keynes Hospital service had undertaken the chief nurse fellowship programme in 2021.

The services provided other leadership training, such as programmes to clinically develop nurses through the band levels. The offered opportunities for nurses to undertake advanced clinical practitioner courses.

Staff felt able to raise concerns without fear of retribution. Staff said they would feel comfortable in raising any concerns with their colleagues and managers. They felt their views and options would be listened to. Staff knew how to use the whistle-blowing process.

Governance

Governance processes were in place at team level and risk was managed. Senior leaders were aware of the issues leading to longer than expected stays in some crisis centres due to a lack of mental health beds.

Governance issues were discussed at the team business meeting and meetings with the acute trusts.

Lines of accountability for escalation of governance issues from the psychiatric liaison team were through the mental health and acute trusts' governance structures. Patients waiting for beds were escalated to the Central Flow Hub (CFH), and meetings with the CFH were attended daily by the chief operating officer for the trust.

Mental health crisis services and health-based places of safety

Governance was also monitored at senior manager meetings held with the acute trust, the police and ambulance services, and community mental health teams.

The services had appropriate operating procedures and local agreements to provide training and guidance to staff of the acute trusts.

Management of risk, issues and performance

Teams had access to the information they needed to mitigate and manage risks.

The services had risk registers to monitor risks. Managers were aware of the risks and were working to mitigate them. Patients waiting for an inpatient bed was identified as a high risk across the trust. Senior leaders met daily to discuss patients waiting, and the availability of beds, with the Central Flow Hub, which managed the bed flow.

Managers at the service at Hillingdon Hospital had identified that the psychiatric liaison nurse roles at their service should be a band 7 role and this would provide incentives for staff to stay. Managers at the service at Northwick Pak Hospital had identified the need for more alcohol specialist roles to reduce referral to assessment waiting times.

Managers at the service in Milton Keynes Hospital had identified the psychology lead vacancy as a high risk to the service.

The service measured its compliance against an agreed set of key performance indicators and managerial staff were able to monitor their progress regularly and report in their monthly performance report.

Information management

Teams had access to the information they needed to provide safe and effective care.

Patient care records were recorded on electronic systems. The service understood the need to notify the Care Quality Commission of notifiable incidents. The managers had access to information to support them with their management roles.

Engagement

Staff engaged actively with other local health and social care partners and others to ensure that an integrated health and care system was provided to meet the needs of the local population.

There were effective, multi-agency arrangements to agree and monitor the governance of the psychiatric liaison services. Managers of the services worked actively with partner agencies including the police, ambulance service, primary care and local acute medical services to ensure that people received help and support in the general hospital inpatient setting.

Learning, continuous improvement and innovation

Staff were committed to learning and continuous improvement of the service. Two of the services were accredited nationally.

Staff from the psychiatric liaison services provided education sessions to staff from the acute trusts in formal teaching sessions. They were regular contributors on the acute trusts' doctors' induction programme.

Mental health crisis services and health-based places of safety

The service at Milton Keynes Hospital was undertaking a study with the National Institute for Health Research to identify more appropriate ways to manage self-harm in patients. The service was also was working collaboratively with the safeguarding children's team to create a local operating procedure for cases that require further review.

The psychiatric liaison services at Hillingdon Hospital and Northwick Park Hospital were accredited under Psychiatric Liaison Accreditation Network (PLAN), and the service at Milton Keynes Hospital was planning to apply in the next year.

The service at Northwick Park Hospital was undertaking a quality improvement project in the management and treatment of delirium. The team shared weekly publications with the team.

Forensic inpatient or secure wards

Good ➔➔

Is the service safe?

Requires Improvement ➔

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

Safe and clean care environments

All wards were safe, clean, well equipped and fit for purpose. However, furnishings and décor were not always well maintained. Staff understanding of ligature management was mixed.

Safety of the ward layout

The trust had completed ligature risk assessments for both wards. For Tasman ward the risk assessment had been completed at trust level with a local management plan that staff on the ward followed.

On Java House, which is an open step-down rehabilitation unit, the local risk management plan had been completed by the ward manager and a member of the health and safety team. At the time of the inspection the risk assessment had a review date for September 2023. Following the inspection the trust reported that the risk assessment for Java House was incorrect and submitted a risk assessment dated 21 July 2023 which had been completed in line with the trust ligature policy for open rehabilitation wards.

Staff awareness of ligature management was mixed. One member of staff on Java House had never seen the ligature risk assessment, on Tasman ward a member of staff did not know where the ligature cutters were kept. There was a list of ligature points on the notice board in the Tasman nurse office. Staff told us this list was used for bank and agency staff working on the ward. The service induction and competency booklet for new staff did not include any information on environmental ligature risks. Staff were trained in using ligature cutters as part of immediate life support training.

Staff reported that they mitigated ligature risks by using observation, engagement and individual risk management plans. Risk assessments were carried out for patients who were at risk of self-harm.

The trust took immediate action to review ligature risk assessments and management plans on both wards and to ensure all staff were informed about the location of the ligature cutters.

The ligature risk assessments were reviewed by the ligature management group (LMG) where discussions took place on outstanding risks and plans how to manage these, this included finance and estate solutions.

Staff carried out a health and safety check of the ward environments each hour on each shift

Staff could not observe patients in all parts of the wards. The layout of the wards did not allow for clear lines of sight in every area. Where there were blind spots, these risks were mitigated by convex mirrors to improve visibility, staff observations, engagement with patients and understanding of relational security through knowledge of individual patients.

Closed circuit television (CCTV) was in place in the corridors and communal areas and recorded any activity taking place.

Staff had easy access to alarms. All staff carried individual alarms. Patients on Tasman ward had access to the nurse call system. Java House did not have a nurse call system that patients could use. Most of the patients on Java House had a physical health condition. This had not been identified as a risk by the service and was not on the service risk register.

The trust took immediate action to address this within the inspection period and purchased portable alarms for all patients to use.

Fire safety arrangements were in place. Staff completed fire safety training as part of their role. A fire risk assessment and tabletop fire drill exercise had been carried out for the service in July 2023. Where required, staff completed personal emergency evacuation plan (PEEP) for patients who had mobility difficulties.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, safe and fit for purpose. Work was planned to refurbish the ward environment on Tasman ward. The work was being undertaken in stages to minimise the impact on patients and maintain a safe environment. Work had already taken place to redecorate the bedrooms, replace mattresses and flooring on Tasman ward. Patients had access to a new hot and cold drinks dispenser and new gym equipment had been installed. However, some furnishings were not well maintained and there were signs of wear and tear, for example, on Tasman ward paint on the high walls and ceilings in the corridor areas was peeling and the ceiling vents in the shower rooms were discoloured with what looked like mould.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff were seen cleaning high touch areas throughout the day.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment (PPE) including aprons, masks, gloves, and hand sanitiser was readily available. Infection control audits were undertaken on each ward including regular hand washing audits. Audit findings and actions were discussed in handover and staff meetings if any issues were identified.

Staff accessed infection control training. All wards had training compliance of 85% and above.
Staff could seek support from the infection prevention control lead within the service.

Seclusion room

There was a seclusion room on Tasman ward. This allowed for clear observation and two-way communication and had toilet facilities and a clock visible to patients. The seclusion room was in a corridor where patient bedrooms were located. Staff reported that seclusion was rarely used for patients in the service. However, it was used by the adjacent psychiatric intensive care unit and acute wards.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. Blood glucose testing kits were being calibrated appropriately. We saw records to confirm that medical equipment was portable appliance tested to ensure suitability for use. Staff recorded the temperature of the clinic rooms and the medicines fridges to ensure that all medicines were being stored appropriately.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe and to provide the right care and treatment. Staffing levels across each ward were reviewed daily within the service. Staffing numbers were displayed on each ward in the communal areas so patients could see them. The ward manager reported that staffing was inter-changeable between Tasman ward and Java House to allow flexibility of staffing between the two wards.

The service had reducing vacancy rates. The service had vacancies for one ward manager and four registered nurses. The service was actively recruiting into vacant posts, this included undertaking recruitment overseas. All four registered nurse vacancies had been recruited into.

From 01/07/2022 to 30/06/2023 there were 1238 shifts covered by Bank Staff (16%). 579 shifts were covered by Agency Staff (7%). The ward manager reported the service no longer used agency staff. Bank staff were used to cover staff sickness and occasions when patients required longer periods of escorted leave.

Managers limited their use of bank and agency staff and requested staff familiar with the service. 69% of the bank shifts were covered by substantive staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff we spoke with confirmed they had received an induction when they started work on the ward.

From 01/07/2022 to 30/06/2023, 19 shifts were not covered by bank or agency staff.

The service had moderate turnover rates. The average staff turnover on Tasman ward for the last 12 months was 19%. Whilst this was above the trust target rate of 15%, the trust reported that several secondments and promotions had taken place within the team. The average staff turnover on Java House for the last 12 months was 0%.

Managers supported staff who needed time off for ill health.

Levels of sickness were low. The average sickness rate on Tasman ward for the last 12 months was 2.46% and on Java House the sickness rate was 0.15%, which was below the trust target of 3%.

The ward manager could adjust staffing levels according to the needs of the patients. For example, managers could increase the number of staff on the ward when a patient required enhanced observations, hospital appointments or pre- booked activities in the community.

Patients had regular one to one sessions with their named nurse. Patients' records showed that nurses had regular individual time with patients.

Forensic inpatient or secure wards

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. There were sufficient staff to support patients to take their escorted leave, although staff said this was challenging at times. Patients told us that leave was regularly delayed or cancelled. However, trust data showed that only one episode of leave had been cancelled in the last three months.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others, for example, handover meetings took place between shifts, site and ward safety huddles were held daily. Staff told us they used these meetings to discuss any incidents that had occurred and update patient risk information.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. An out-of- hours on-call rota system operated within the trust. The duty doctor could access the on-call consultant psychiatrist for advice in an emergency.

Mandatory training

Staff had completed and mostly kept up to date with their mandatory training to ensure they had the appropriate knowledge and skills to carry out their roles safely. Overall compliance for Tasman ward was at 93% and Java House at 91%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with said they felt confident carrying out their role and applied training to their practice. They were fully supported to carry out any additional required training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed most risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, physical health monitoring arrangements were not robust.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool. Risk assessments were reviewed regularly, including after any incident. The psychology department took a lead in patient risk assessments and used a range of evidence-based tools such as Structured Assessment of Protective Factors (SAPROF), short term assessment of risk and treatability (START) and Historical Clinical Risk Management-20 (HCR-20).

Forensic inpatient or secure wards

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff we spoke with had a good understanding of each patient and the risks they posed. Patient risk and management were discussed in the daily whiteboard meetings, safety huddles, at handovers and in the weekly multidisciplinary meetings. This enabled staff to focus on the current risks and review how effective management and mitigation plans were working.

All care records for patients had up-to-date risk assessments.

Staff proactively contributed to meaningful discussions about the progress of patients and changes to their individual risk following any recent incidents. Handover meetings were clearly documented for staff to refer to and stored on the ward shared drive.

Staff mostly identified and responded to any changes in risks to, or posed by, patients, for example where required additional observations were carried out, or additional staff rostered on shift. However, we found shortfalls in patients physical health monitoring.

Staff used the National Early Warning Score (NEWS2) track and trigger system. NEWS2 is a tool used to score a patient's vital signs to identify those at risk of physical deterioration. We reviewed six NEWS2 charts and found that staff were not using NEWS2 guidance correctly. For example, two patients had a NEWS score of 3. Whilst the vital signs had been repeated for both patients the staff had not escalated the concerns to the doctor, as outlined in the trust policy.

Where patients refused to have their NEWS2 vital signs taken five out of the six records showed gaps. Where patients had refused to have their vital signs taken staff did not record this. This meant that it was difficult to ascertain when monitoring had been carried out or refused. The ward manager escalated the recording omissions on the physical health monitoring app as a priority.

Patients prescribed clozapine had detailed management plans in place. However, these patients did not have in place plans for constipation monitoring. Whilst staff told us that they asked patients about their bowel movements, this was not recorded in the patient record or followed up at the ward round. There was a risk that patients could have clozapine induced constipation that would not be recognised.

Patients did not always have a venous thromboembolic (VTE) assessment completed upon admission to the ward in line with trust policy. VTE is a condition that occurs when a blood clot forms in a vein. The consultant psychiatrist reported that this was a required standard for all new admissions. In 2021 following the death of a patient on Tasman ward, there was immediate learning identified for staff to escalate any raised scores to medical staff and that VTE assessments were to be undertaken for all new admissions.

We found gaps in blood glucose monitoring for one patient on Tasman ward for 9 days, for another patient we could not find blood glucose monitoring readings since April 2023.

The system for following up on any physical health monitoring actions from ward rounds was not robust, for example medical staff had requested an electrocardiogram (ECG), there was no evidence in the patient record that this had taken place and no follow up recorded in the ward round notes.

Whilst we could find no impact or evidence of harm caused related to physical health monitoring, we were concerned that learning from the death was not consistently and robustly embedded within the service. There was a lack of assurance that patients had received the right response to their physical health condition. A recent physical health audit had identified recording issues. The ward manager told us about the plan they would be implementing to address the shortfalls identified.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff conducted room searches at random and whenever they received information that a patient may have prohibited items. Staff searched all patients when they returned from leave and risk assessed those patients that needed regular searches due to the risk presented. Where required staff carried out urinary drug screening.

Staff observed patients in line with the trusts policies and procedures. Staff checked all patients at least once during every hour. When patients presented a heightened level of risk, this was increased to four times within one hour or every 30 minutes. All levels of observations were agreed and reviewed by the multidisciplinary team.

Use of restrictive interventions

Staff participated in the service's restrictive interventions reduction programme, which met best practice standards. Staff were trained in the prevention and management of violence and aggression (PMVA). Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff restrained patients only when these failed and when necessary to keep the patient or others safe. None of the patients we spoke to had been restrained or witnessed any restraints during their admission.

Levels of restrictive interventions were low. In the six months before the inspection there had been 2 incidents involving restraint on Tasman ward. There had been no episodes of prone restraint. There were no episodes of restraint on Java House. Managers reviewed all restraint incidents at the clinical governance meeting.

There had been 1 incident requiring the use of oral rapid tranquilisation on Tasman ward and none for Java House. Seclusion was rarely used. In the six months prior to the inspection there had been one episode of seclusion. None of the patients we spoke with had been secluded.

Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation. Staff described the physical health checks they carried out on patients post rapid tranquilisation.

All incidents of restraint, seclusion and rapid tranquilisation were reviewed at the clinical governance meeting. Managers were also able to access CCTV footage from communal areas to review incidents of restraint.

Safeguarding

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.

At the time of the inspection 100% of staff were up-to-date with their level 3 safeguarding adults and children training.

All staff said they had training appropriate for their role on how to recognise and report abuse, and they knew how to apply it. Staff felt confident that if they did raise concerns they would be listened to and action taken.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, a safeguarding alert had been raised and a safety plan developed following a patient being financially exploited by other patients.

Staff followed clear procedures to keep children visiting the service safe. Visits from children were planned in advance and closely supervised. Visits from children took place off the ward.

Safeguarding concerns were regularly discussed in multidisciplinary meetings and handover meetings and referrals were discussed in clinical governance meetings. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that if they had concerns that someone was at risk of abuse, they spoke with the forensic social worker who was the safeguarding lead for the service.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain clinical records – whether paper-based or electronic.

Overall patient notes were comprehensive and all staff could access them easily. Records were stored securely. When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service had systems and processes to prescribe, administer, record and store medicines, however staff did not always do this safely. Staff regularly reviewed the effects of medications on each patient's mental and physical health, however patients on clozapine were not monitored for constipation.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Staff used an electronic system to prescribe medicines and record their administration. However, we found some inconsistencies in record keeping. For example, one patient's medicine administration records showed missed doses, but no records were available to explain why. In another example, records showed that staff rotated the injection site for one patient but for another patient, the injection site was not rotated for one dose. During the inspection, staff verbally explained why, but this was not recorded in the patient's records. Medicine records need to be accurate to ensure there is an up-to-date record of a patient's treatment.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. Patients could speak to pharmacy staff about their medicines.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely and at appropriate temperatures. On Java House, external quality assessment kits were being stored inappropriately in the medicine's fridge. Whilst there were no controlled drugs being stored at the time of the inspection, staff knew how to manage them.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Each patient's medicines were reviewed by the multidisciplinary team at the weekly ward round.

Staff did not always review the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence (NICE) guidance. There were no arrangements in place for the monitoring of

constipation in patients taking clozapine. However, staff took some appropriate actions to safeguard patients' safety and monitor the effects of their medicines on them in accordance with NICE guidance. For example, relevant blood tests were completed for patients on clozapine before the medicine was dispensed. Staff had oversight of patients requiring additional monitoring due to the use of high dose antipsychotic therapy. Patients were offered electrocardiogram (ECG) readings on admission. Staff could access a physical health nurse for advice.

Track record on safety

The service had a good track record on safety.

The service had no serious incidents in the previous 12 months.

When serious incidents had occurred they were investigated, and lessons learned were shared with the staff team.

Reporting incidents and learning from when things go wrong

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.

The service managed patient safety incidents well. All staff knew what incidents to report and how to report them using the electronic incident reporting system. Staff told us that they would report any incident of harm, potential harm and/ or risks to safety in line with trust policy.

Staff told us incidents and never events were discussed in handover, multidisciplinary team meetings, in reflective practice, supervision, ward clinical governance and staff meetings. However, team meeting minutes we reviewed did not include learning from incidents as a standing agenda item.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong, for example staff apologised to a patient due to a medicine incident.

Arrangements were in place for de-brief sessions to take place for both staff and patients following a serious incident. This was to ensure that staff and patients were provided with appropriate support.

When something went wrong there was a thorough review or investigation which involved members of the multidisciplinary team, patients and their family members as appropriate.

Staff received feedback from investigation of incidents, both internal and external to the service. Ward meeting minutes from both wards showed that staff discussed learning from incidents. Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

The trust resuscitation lead carried out emergency simulation exercises on both wards. They acted out an unannounced emergency scenario such as a sudden collapse incident and assessed how staff responded. Where shortfalls were identified during the exercise the trainer recommended actions for improvement to ensure that the chance of errors occurring when a real emergency incident happened were reduced.

Forensic inpatient or secure wards

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

The service assessed patients before they were admitted to check they were suitable for admission. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed.

Both wards ran a weekly physical health clinic where patients could raise any concerns about their physical health.

Staff developed individual care plans, which were reviewed regularly through multidisciplinary discussion and updated as needed, for example staff put in place a plan to manage the risk and support a patient with a nut allergy.

Care plans were personalised, holistic and recovery orientated. They reflected the assessed needs of the patient. Staff regularly reviewed and updated care plans when patients' needs changed. Care plans reflected the patient's voice, views and involvement about their care and treatment.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatments suitable for the patient group and consistent with national guidance on best practice. Patients had limited access to psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE), this was because there was a psychologist post vacancy that the trust were recruiting to.

Patients across both wards received input from the occupational therapist to acquire daily living and life skills. There was a timetable of varied activities for the patients. We observed patients engaging in group activities throughout our inspection. On Java House staff supported patients with budgeting, shopping, cooking and cleaning as part of their recovery goals.

Forensic inpatient or secure wards

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care throughout their admission, including specialists as required. Staff had positive working relationships with other professionals at the local acute hospital including neurologist and haematologists.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The service where possible made dietary adjustments for patients' religious, cultural and other needs. The occupational therapist completed an activities of daily living skills assessment. On Java House patients were supported to prepare and cook their own meals and group meals as part of their rehabilitation programme.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. All patients spoke positively about the various sports groups, regular healthy living groups and smoking cessation services offered.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The multidisciplinary team measured the severity and progress of patients' conditions using the Health of the Nation Outcome Scores (HoNOS). Psychologists used the Clinical Outcomes in Routine Evaluation framework to monitor change and outcomes for patients, and other standardised measures of patients' well-being.

Staff used technology to support patients. For example, since May 2023 the service was trialling the use of a physical health monitoring App on Tasman ward. There were some teething problems that the ward was working through. Plans were in place for an interactive board in the seclusion room. This would allow patients who were in seclusion to undertake activities and listen to music. Patients had access to computers and had their own passwords. This usage was monitored carefully but allowed patients to make use of accessing the internet in a safe way.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers ensured staff carried out a range of audits to check that staff followed best practice guidance. For example, there were audits of care plans, physical health, risk assessments and infection prevention and control. Managers reviewed the performance of the wards at monthly ward clinical improvement group meetings. Audit results were used to identify where improvements were needed.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included doctors, nurses, healthcare assistant, occupational therapist, social worker, pharmacists, sport therapist, psychologist, drug and alcohol specialists, art, music and drama therapists. There were vacancies in the forensic psychology team which the trust were planning to recruit into. The service had a part -time clinical psychologist who was supported by two trainees. The lack of a full psychology team meant that there was a waiting list for psychology which impacted on specific assessments of some patients.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The service was in the process of recruiting a physical health lead nurse. The psychologist had been trained to assess for autism using Autism Diagnostic Observation Schedule (ADOS). The trust had started to offer the Oliver McGowan eLearning training since June 2023 and Autism and Learning Disability face to face training.

Forensic inpatient or secure wards

Managers gave each new member of staff a full induction to the service before they started work. Staff we spoke with confirmed they had undertaken a comprehensive trust and forensic induction before starting work on the wards.

All staff we spoke with confirmed they had access to regular clinical and managerial supervision. The percentage of staff that had completed clinical and managerial supervision was 100% on Tasman ward and 75%on Java House. Staff reported that they used supervision to discuss the current patients, to reflect and learn from practice, incidents and for personal support and professional development. Staff supervision records reflected these discussions. Regular bank staff also received regular supervision.

Managers supported staff through regular, constructive appraisals of their work. The percentage of staff that had had an appraisal in the last 12 months was 100%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff attended regular business and governance meetings.

The continuing development of staff skills, competence and knowledge was recognised as an essential component for providing high quality care and treatment. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge, including accessing specialist training, for example, the forensic social worker was due to commence family therapy training, band six nurses were undertaking leadership development training.

Managers made sure staff received any specialist training for their role. The specialist doctor had undertaken training on diabetes management, the clinical psychologist was also available to advise staff on risk formulation and positive behaviour support. The team were in the process of recruiting a physical health nurse.

Managers recognised poor performance, could identify the reasons and dealt with these through supervision and performance management plans.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All members of the multidisciplinary team and staff worked together to understand and meet the range and complexity of patient's needs. Patients were invited in to discuss their care and treatment and where patients had given consent family members could also attend the meeting either in person or virtually. Staff said the multidisciplinary team worked very well together and valued each other's input.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Each shift held a handover where incidents, patient care and risk were discussed.

Ward teams had effective working relationships with other teams in the trust and external teams and organisations. Staff reported that they had good relationships with commissioners, local authority social services, voluntary organisations, the community forensic team and housing services.

Forensic inpatient or secure wards

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff told us that they had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support. Training on the Mental Health Act and the Mental Health Act Code of Practice were not mandatory for the service. The trust reported they had planned service specific training to be completed by November 2023.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The advocate supported patients with tribunal hearings, ward rounds, care programme approach (CPA) meetings and complaints.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patient records we looked at showed staff were discussing patient rights with them on a regular basis.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. All section 17 leave was risk assessed beforehand by the multidisciplinary team. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Forensic inpatient or secure wards

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Regular audits of patients' capacity to consent to treatment were carried out and reviewed at the monthly ward clinical governance meeting.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed a range of interactions between staff and patients on the ward. We saw instances where staff spoke with patients to discuss their daily activities, discharge and concerns where patients were involved in making decisions.

Staff gave patients help, emotional support and advice when they needed it. Patients told us they could speak to staff and that they felt listened to and supported.

Staff supported patients to understand and manage their own care treatment or condition. For example, medical staff provided support so that patients could understand their medicines and their side-effects. Patients confirmed that staff supported them with their physical health needs and were able to discuss their care and treatment during ward round meetings.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. All patients told us they felt safe on the ward. We observed staff interactions with patients and found them to be calm and respectful.

Staff understood and respected the individual needs of each patient. They adapted their approach to each individual and worked with patients' individual preferences. The staff and management team spoke respectfully about the patients they cared for and talked of valuing people and respecting their human rights.

Forensic inpatient or secure wards

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff we spoke to told us they felt safe to raise any concerns if they had them. They were also aware of the freedom to speak up guardian and knew how to access this, should they need to.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each patient received a welcome pack including information about the ward.

Staff involved patients in care planning and risk assessment.. All care plans we viewed were person centred and reflected the individual patient's voice.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties, for example, through the use of interpreters. Staff held regular individual sessions with patients and involved patients in their care programme approach (CPA) meetings.

Staff involved patients in decisions about the service, when appropriate. Patients were part of staff interview panels such as the appointment of the service forensic social worker. The service had two patient representatives on the North London Forensic Consortium patient council.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients participated in regular weekly community meetings on each ward. Patients were able to use these meetings to input their suggestions, give feedback and express any concerns. These meetings were recorded. However, whilst there were opportunities for patients to provide feedback at community meetings, they did not feel that concerns raised were always followed up and they did not always receive updates or feedback on the matters they discussed.

Staff made sure patients could access advocacy services. Advocacy and contact details were displayed throughout the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff explained how they maintained contact with families and carers during each patient's stay at the service.

We spoke with three family members or carers. All carers reported that their family member was safe and well looked after. They reported that they were involved in care programme approach meetings, ward rounds, discharge planning and Mental Health Act tribunals, in accordance with the wishes of their family member. However, all carers told us that they were not always kept updated and communication could be improved.

The service did not have a carers forum. The forensic social worker reported these were due to start imminently and all carers had been written to.

Forensic inpatient or secure wards

Is the service responsive?

Good 

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Patients followed a pathway through assessment, treatment, preparation for discharge and discharge.

Bed occupancy was at 100% on wards. All referrals to the service were received from the North London Forensic Consortium Collaborative. There was a clear admissions criteria and process. Clinical staff assessed patients before they were accepted into the service. Pre-admission assessments were carried out to ensure that the level of risk presented by the patient could be managed.

Some patients transferred from Tasman ward to Java House to access additional rehabilitation. Other patients moved straight to the community from Tasman or to a different rehabilitation ward in the trust. Patients were transferred back to higher levels of security when necessary.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. All patients were reviewed at the weekly referrals and discharge meeting.

Managers and staff worked to make sure they did not discharge patients before they were ready. When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient, for example a patient was moved from Java House back to Tasman ward as there had been a deterioration in their mental health.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with the Ministry of Justice, care managers, care co-ordinators and commissioners to make sure this went well. Service leads and managers monitored and reviewed upcoming and delayed discharges at the weekly referral and discharge meeting. Actions and recommendations were discussed and implemented to support discharges. Weekly ward round meetings were also used to plan patient discharges. We observed a discussion around a patient's discharge during a ward round review.

Managers monitored the number of patients whose discharge was delayed. At the time of the inspection there were five delayed discharges. Delayed discharges were discussed at the weekly referral meetings, monthly ward clinical governance meetings and at the quarterly North London Forensic Consortium performance meeting. Each patient's progress was tracked. Some delayed discharges related to finding appropriate placements.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients' families and care co-ordinators were invited to care programme approach (CPA) meetings prior to discharge.

The service followed national standards for transfer and staff supported patients when they were referred or transferred between services for example during admissions to local acute hospitals or transfer to the community forensic team.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Each patient had a secure place to store personal possessions. Patients had access to bathrooms and toilets.

Both wards had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. On Tasman ward patient had access to an occupational therapy kitchen and on Java House patients accessed the main kitchen area so that patients could be supported to prepare their own food as part of their rehabilitation. A visiting room was available for families and children within the service. All children visits were risk assessed by the clinical team.

Java House had access to its own garden area. Tasman ward was on the first floor. Access to the outdoor area was via a staircase. Staff supervised all garden access on Tasman ward.

Patients could make phone calls in private. Patients' use of mobile telephones was risk assessed. Patients could make their own hot drinks and snacks and were not dependent on staff.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. A range of activities were available for patients on each ward. Sessions provided for patients on the wards included art, music, drama, cooking, and access to educational and vocational courses either online or in person.

Patients spoke positively about the range of sports groups on offer and the access to the gym. This included football, basketball, swimming and running groups. To facilitate gym access over the weekend the service was training two health care support workers to support patients.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Java House was a ground floor ward with disabled access to the ward and garden. Tasman ward was on the first floor and not fully accessible for patients with mobility difficulties. There were stairs within the ward to access the outside space allocated. The ward manager reported that any patients referred to the service with mobility needs would be assessed beforehand to ensure that they could access all areas of the ward before being admitted.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Staff made information leaflets available in languages spoken by patients if requested.

Managers made sure staff and patients could get help from interpreters or signers where the first person's language was not English to ensure patients and their families were fully included in care planning.

Staff on both wards had a good understanding of the cultural and religious needs of individual patients.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Staff supported patients to obtain specific food items where possible. However, most patients on Tasman ward reported that the food was not of good quality. The patients provided this feedback at the community meetings. In response to this a representative from the external food provider attended the weekly community meeting to hear patients' feedback and implement improvements.

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support in these areas. There was a multi-faith room set aside on Tasman ward.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers we spoke with understood how to make a complaint and told us they would feel comfortable doing so. Complaints were regularly discussed at community meetings. Patients were also able to raise complaints through the advocate.

The service clearly displayed information about how to raise a concern in patient areas. The patient information pack contained information about how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Between 1 April 2022 and 31 March 2023 the service had received 3 complaints. These had been investigated and a response sent to each complainant.

Managers investigated complaints and identified themes. All complaints were discussed at the ward monthly clinical governance meetings and any themes or trends identified shared with the wider service.

Forensic inpatient or secure wards

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us complaints were discussed in handovers, clinical governance and staff meetings; this information was used to inform patient care. Actions points from complaints were completed and followed up at the appropriate level.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders had the integrity, skills, knowledge and experience to perform their roles. The interim ward manager had been in the post since May 2023.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. They understood the issues, priorities and challenges the service faced and managed them.

Leaders were visible in the service, approachable and accessible for patients and staff. The service director for Health and Justice Services attended patient community meetings. Staff reported they could raise any concerns they had with them. We saw that managers responded immediately to rectify urgent issues that emerged during the inspection.

The ward manager confirmed they had opportunities for development and had access to the trust's leadership development programmes. The trust offered the Chief Nurse Fellowship programme which supported BAME nursing staff to develop their nursing leadership skills and support career progression. The ward manager received peer support from other managers and the matron within the service.

Staff below team level also reported that they could access the trust's development programmes.

Leaders were aware of the challenges with staff turnover, recruitment and retention and how this effected patients, staff morale and staff wellbeing on the wards.

Staff on both wards reported that they felt the staff team was more stable since the interim manager joined the service and a new matron had been appointed.

Forensic inpatient or secure wards

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff were familiar with the trust's vision and values and how they applied to their work. Staff understood their role in delivering the trust vision which is 'Wellbeing for life'.

Staff told us they felt that the trust supported them to deliver high quality care and to work in partnership with patients. Staff reported that senior managers visited the wards and had meetings with staff. They said they had the opportunity to share their views and contribute to developments in the service.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff said they felt respected, supported and valued. They said the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution. Staff knew about the role of the trust's Freedom to Speak Up Guardian and knew how to contact them. Staff were aware of the whistleblowing policy.

All staff told us morale within the staff team was improving and described a supportive culture on the wards.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression, for example the psychologist was undertaking further training in eye movement desensitization and reprocessing (EMDR) therapy.

The service provided a preceptorship programme for newly qualified nurses.

Staff had access to support for their own physical and mental wellbeing through the trust's occupational health service. Staff reported that they were supported appropriately following serious incidents, received debriefs and were signposted to emotional support.

Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved.

Governance

Our findings from the other key questions demonstrated that governance processes mostly operated effectively at team level and that performance and risk were managed well. However, arrangements for physical health monitoring were not robust.

Our findings from the other key questions demonstrated that governance processes mostly operated effectively at ward level and that performance and risk were managed well.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. There were sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. Staff had completed most current mandatory training; they were supervised and appraised

appropriately. Staff worked to ensure positive patient outcomes and clinical effectiveness. However, we found that physical health monitoring was not robust, there were gaps in NEWS2 records, staff did not escalate NEWS2 scores in line with the trust policy, patients on clozapine were not monitored for constipation, VTE assessments were not carried out for all patients upon admission to the service. Recent physical health audits had identified shortfalls with recording and the ward manager acknowledged that improvements needed to be made in this area.

Managers reviewed the performance and effectiveness of the service at the monthly ward clinical governance and at the health and justice care quality meeting. They looked at mandatory training and supervision rates, incidents, infection prevention and control, patient feedback, complaints, staffing, audit findings and lessons learned.

There was a clear framework for communication, this enabled staff to be kept updated about the service, incidents, safeguarding, complaints and essential information through regular team, clinical governance, whiteboard and daily handover meetings.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Leaders were aware of the current risks to the service they were providing, and these were reviewed at the monthly ward clinical governance meetings. The service had a risk register. For each risk entry current mitigations and action plans to address the risk were in place.

Risk management was embedded throughout the service and recognised as a collective responsibility of all the staff. Staff discussed risk daily through the safety huddles, handover meetings and multidisciplinary team meetings to ensure that patients were safe. Clinical teams had a good understanding of individual patient risks and were able to discuss any changes to patients' care or new insights into their presentation at the daily handover.

The service had plans for emergencies, for example, adverse weather or a flu outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held key data about the service. This included key information such as incident reporting, staffing, complaints, safeguarding, and training.

Information governance systems included confidentiality of patient's records. Training in data protection regulations was included in the hospital's mandatory training.

The service notified external bodies of relevant incidents, including commissioners and the Care Quality Commission as and when required. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about possible abuse of patients using the service.

Forensic inpatient or secure wards

Engagement

The service was part of the North London Forensic Collaborative (NLFC) and strongly engaged with local health and social care partners to share best practice, promote quality improvement and to ensure that patients had a positive experience of care.

Staff received regular information about the trust and the service through the trust intranet, bulletins and emails. Staff also received a weekly health and justice newsletter which provided updates on other services in the Health and Justice Directorate.

Patients had opportunities to give feedback on the service they received. Patients had completed surveys as part of the NLFC patient led 'speak up campaign' by the patient council. The service was in the process of developing an action plan following the survey results.

Learning, continuous improvement and innovation

There was a systematic approach to improvement on both wards. Staff were encouraged to develop their skills in this area and to contribute to the quality improvement initiatives in the service. Staff accessed support from the trust's improvement academy to undertake quality improvement projects on both wards. These projects aimed to improve the quality of care and outcomes for patients. During 2022 Tasman ward had run a project on violence reduction. As a result of the project the number of violent incidents with patients had reduced.

There were two quality improvement projects underway at the time of our inspection, one related to improving patients' physical health and the other to improving patient flow through the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Safe and clean care environments

Safety of the ward layout

The trust had completed ligature risk assessments for the long stay rehabilitation wards. For the high dependency units this assessment was completed at trust level, with local managers completing the assessments for the open rehabilitation wards. Staff we spoke with on several wards were not always aware of the location of ligatures that were in the assessments, and a key mitigation of risk in the assessments were reliant on staff knowledge and behaviour.

Not all ligature points had been amended to reduce their risk. At Roxbourne House we saw an exposed metal pipe in the garden area that had not been cased-in like other pipes. We raised our concern about the exposed pipe with the trust who confirmed the issue was addressed shortly following our inspection. The trust said all patients admitted to Roxbourne House at the time of inspection were deemed as being safe to have free access to the garden.

Staff could not easily observe patients in all parts of the wards due to the age and design of the buildings. Westfield House, Ascot Villa and Roxbourne House accepted patients with higher risks. Staff at Roxbourne House said they mitigated the risks to keep patients safe by allocating staff members to observe specific parts of the ward, but we saw during our inspection this was not always effective. Westfield House was set across three floors, with the nursing station on the ground floor. At Westfield House the ward areas were disjointed and patient areas dispersed across large areas, the lighting and natural light was poor, and corridors were extremely narrow. These aspects of the environment hampered easy observation of patients on this ward. Live CCTV footage of communal areas was displayed to help mitigate these risks. The trust confirmed Westfield House was closed 3 months after our inspection and was no longer in operation.

Some patients at Roxbourne House and Westfield House were on increased observations to manage their risks, but staff did not always complete these observations at random times throughout the hour as per the trust policy.

Not all wards complied with guidance in relation to mixed sex accommodation. Most wards we visited had male and female patients, and most wards had clearly separated male and female areas which included lounges and bathrooms. However, all patients at Westfield House had to collect their meals and hot drinks from a kitchen located within a female area of the ward. This meant male patients regularly walked past bedrooms and bathrooms allocated to female patients. This posed a potential risk to sexual safety. We reviewed community meeting minutes where patients had raised concerns about this on 2 separate occasions. One female patient we spoke with said she stayed in her bedroom because she felt unsafe on the ward due to this. We informed the trust of our concerns who reduced the number of females on the ward, which ensured males no longer had to walk through female only areas.

Not all patients had access to nurse call systems in their bedrooms, however staff had easy access to alarms. We saw examples where staff had used risk assessments to identify patients who were vulnerable and either moved them to a bedroom closer to the nursing station or increased staff observations. Staff had access to mobile call alarms they could give to patients.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced most risks they identified, although we found some occasions where these were missed.

Maintenance, cleanliness and infection control

Staff made sure cleaning records were up-to-date and the premises were clean. Ward areas were well furnished. Cleaning staff at Roxbourne Lodge had been awarded a 5-star rating for cleanliness.

However, we found ongoing issues with maintenance problems being addressed across London and Surrey wards. For example, glass door panels in patient areas at Roxbourne House and Rosedale Court in London had been broken. Staff had reported these issues to the maintenance team and some attempts had been made to board up the unsafe areas. Despite escalating the issue, Roxbourne House had waited months for a replacement pane of glass. At the Surrey site, the TV bracket in the male lounge had been broken for a month. At Westfield House the floor of the female shower was uneven which made it difficult to open and close the door. One patient at Westfield House said the floors felt uneven and were a trip hazard. Staff and site managers had escalated their concerns to senior leaders, added it to the risk register and implemented mitigations, but the issues remained.

Staff usually followed infection control policy, including handwashing. However, at Westfield House we found some issues with food storage. For example, a patient fridge contained home cooked food that was not labelled with a date. This meant staff could not ensure food was consumed within 48 hours as per the trust's policy. Patients ate meals delivered by the local supermarket which staff stored in fridges and freezers off the ward. We observed the freezers had built up ice and needed to be defrosted, and we found some refrigerated food items had recently passed their use by date. We informed staff about these items and they confirmed the food would be discarded.

Clinic room and equipment

Clinic rooms were generally fully equipped, but the clinic rooms at Roxbourne House and Westfield House were very small. This meant some equipment used for physical health examinations at Westfield House had to be stored in a different room, and that staff at Roxbourne House had to move equipment to access the examination couch.

Staff checked, maintained, and cleaned equipment. Clinic rooms had accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked clinic room and medicine fridge temperatures every day and kept a record of these.

Equipment had been calibrated at a suitable frequency according to manufacturer's recommendations. However, the medicine fridges at Westfield House and Roxbourne Lodge were visibly dirty. At Rosedale Court and Westfield House, we found some items had been disposed of in incorrect containers. For example, the sharps bin at Westfield House contained empty medicine blister packs and medicine bottles.

Safe staffing

The service had enough nursing and medical staff who knew the patients.

Long stay or rehabilitation mental health wards for working age adults

Nursing staff

The service had enough nursing and support staff to keep patients safe. There were some vacancies of qualified nursing staff at Roxbourne House and The Cottages, and the trust shared their plans to fill these vacancies.

The service had very low rates of agency nurses and nursing assistants.

Over the last 12 months, an average of 18% of shifts were covered by bank staff. The trust informed us that most of these bank staff were substantive trust employees and were therefore familiar with the wards and patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff we spoke with confirmed they had received an induction.

The service had moderate turnover rates. The average staff turnover for 5 of the wards we visited for the last 12 months was between 6.8% and 12.9%. The Cottages was higher at 20.9%, and staff described challenges this presented. The trust's target turnover rate for rehabilitation services was 10%.

Managers supported staff who needed time off for ill health. They could seek support from the human resources department and occupational health to manage long term sickness and help staff members back to work.

Sickness rates across the wards varied. Sickness rates on Ascot Villa were generally low over a 12-month period, and rates on Rosedale Court had continued to reduce significantly from 22.7% in July 2022 to 1.95% in June 2023. The Cottages had the highest average sickness rate over a 12-month period; monthly rates varied from 0.7% to 21.5%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward managers could adjust staffing levels according to the needs of the patients.

Some patients had regular one-to-one sessions with their named nurse, but from our conversations with patients, not all patients had these sessions. Our review of patient care records found one-to-one sessions were not always well documented.

We found some evidence during our inspection to suggest escorted leave was sometimes cancelled due to staffing matters. Patients rarely had their activities cancelled, although we found cooking sessions on Westfield House did not happen as scheduled. We raised this with the trust who informed us the sessions had been restarted with immediate effect.

Staff shared key information to keep patients safe when handing over their care to others. Staff discussed any changes in patients' needs, support and presentation at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings.

Medical staff

The London wards had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers described how this had recently improved.

Horton had medical cover during the daytime, but staff had to phone an ambulance or take patients to the local acute hospital outside these hours if there was a medical emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

The trust shared data which showed a broad programme of mandatory training which was comprehensive and met the needs of patients. Managers monitored mandatory training and alerted staff when they needed to update their training.

Most staff had completed and kept up-to-date with their mandatory training. The trust explained where mandatory training compliance rates were lower than targets, this was often because some staff were new starters or preceptees and therefore excluded from the process of completing all mandatory training.

Shortly before our inspection, the trust had expanded the staff groups that were required to complete Immediate Life Support (ILS) training. This represented an upgrade of their training from a more basic level. Of the wards we visited, between 0% and 44% of staff had completed Immediate Life Support (ILS) training, but most staff were trained in Emergency Life Support (ELS). Staff described challenges with getting a place on the training courses due to them booking up quickly. Following the inspection, the trust confirmed all eligible staff should be ILS trained within the next 12 months.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly. We reviewed 34 electronic patient records and found patients had risk assessments in place. We saw that most of these had been regularly updated, however, 3 patient's risk assessments had not been completed for between 9 days to 2 months following admission. Another patient was admitted from a different hospital almost 6 weeks before our inspection and their risk assessment had not been updated by the rehabilitation service since this admission.

Staff updated risk assessments after incidents. For example, we found updated risk assessments after incidents of verbal and physical threats to staff and after a patient had a fall. However, we found occasions when assessments had not been updated. Two patients on 2 different wards had gone absent without leave (AWOL) from the wards and their risk assessments had not been updated. Both of these patients were taking Clozapine, which when stopped abruptly, can lead to serious side effects. Staff had not updated the patient's risk assessments or care plans which could mean that staff may not be aware of risks to the patients or actions to take if and when they returned to the ward. We found other examples where risk assessments had not been updated following incidents.

We informed the trust of our concerns who informed us of actions they planned to take, which included a review of existing risk assessments and additional staff training.

Management of patient risk

We found that in general, staff knew about risks to each patient. However, there was some incidences where staff did not always act to prevent or reduce risks. For example, a female patient's risk assessment stated she needed to be nursed on an all-female ward due to her vulnerability, however one month after the assessment she remained on a mixed sex ward. Her risk assessment was not updated with the rationale for why this was the case. A patient at Roxbourne Lodge was noted as being at risk of financial exploitation from their family, yet there was no plan in place to address this risk. We raised our concerns for the patient at the time of our inspection and managers made a safeguarding referral to the local authority.

Long stay or rehabilitation mental health wards for working age adults

Staff created personal emergency evacuation plans (PEEPs) for most patients who may need help and assistance to leave the ward environments in the event of an emergency. However, one patient with mobility issues at The Cottages did not have a PEEP, and PEEPs at Westfield House did not contain adequate details to guide staff in how to assist patients in the event of an emergency evacuation. We informed the matron at the Horton site of our concerns, and they confirmed this was immediately rectified.

Due to the layout of most wards, staff could not observe patients in all areas. Staff followed procedures to minimise risks where they could not easily observe patients, but we found these were not always followed in line with policy. For example, some patients at Westfield House and Roxbourne House were on intermittent observations. We found that staff completed observations at predictable times on the hour. This was not in line with the trust's observation and therapeutic engagement policy which stated the times of intermittent observations should not be fixed and should be done randomly during the hour.

We found examples of positive risk management practices. For example, 1 patient at Roxbourne House had mobility issues and staff completed falls risk assessments, gave regular nursing support and physical health checks, and allocated the patient a bedroom on the ground floor with an en-suite. Another patient had a detailed management plan for their diabetes.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Staff participated in emergency simulations to practice their responses safely. For example, staff at Roxbourne House had completed a ligature simulation and a report outlining actions for improvement was created. Staff received additional training and a follow-up simulation demonstrated improvements had been made.

Use of restrictive interventions

At Westfield House we found some ongoing issues with blanket restrictions. For example, all patients had to request hot drinks from ward staff because the downstairs kitchen was kept locked, and the upstairs kitchens had no tea or coffee in them. Furthermore, each patient was allocated a plate and a cup which they had to use for all meals and drinks. We witnessed a patient decline a hot drink from a member of staff because they had left their cup upstairs in their bedroom. We informed the trust of our concerns who made immediate changes to improve this for patients. Patients on other wards could make their own hot drinks.

At Ascot Villa staff did not always follow good practice guidance when using injectable medicines. For example, we found 5 instances where 2 patients had been given injectable medicines. The absence of physical health monitoring after the administration of injectable medicines could place a patient at risk of harm. Only 2 out of 5 instances were documented in the patients' daily progress notes, but these were only brief mentions.

Levels of restrictive interventions varied across the wards. In the 6 months prior to the inspection there had been 21 recorded occasions where restraint had been used across all wards. Of the wards we visited, Ascot Villa, Rosedale Court and Roxbourne Lodge did not record any restraints. However, we found evidence the data may not always be reliable. During our inspection of Ascot Villa we found evidence that restraints had taken place during this timeframe, but staff had not recorded these on the system.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Senior leaders informed us they had made changes as a result of attending these meetings. For example, they had ordered safety pods, beanbags designed to support safe patient care during restraint.

Long stay or rehabilitation mental health wards for working age adults

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. For example, some records we looked at showed oral medicines were offered before staff administered intramuscular rapid tranquilisation. We saw evidence staff attempted verbal de-escalation techniques first. One patient was restrained so staff could administer their medicines each month, however, the patient did not have a care plan for this. We informed staff who immediately updated the patient's care plan.

The trust informed us there had not been any episodes of seclusion in the 6 months prior to our inspection.

Safeguarding

Staff we spoke with said they knew how to make a safeguarding referral to protect patients from abuse and who to inform if they had concerns. However, we reviewed notes for 3 patients on the London wards which detailed potential safeguarding concerns, but the records did not show what immediate protective actions staff had taken. We spoke to one of the patients involved who said they felt worried about their situation, which had been ongoing for a several months. We raised our concerns at the time of our inspection and the trust made safeguarding referrals for 2 of the matters, which were subsequently closed by the local authority. Managers reminded all staff to escalate such issues and seek advice about making referrals.

Staff received training on how to recognise and report abuse, appropriate for their role.

Most staff kept up-to-date with their safeguarding training.

Staff within the trust also met regularly to discuss safeguarding matters.

Staff followed clear procedures to keep children visiting the wards safe. Patient with children visiting had access to visitor rooms off the ward.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic. However, internet connectivity at the Horton site was unreliable.

Patient notes were comprehensive and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

However, some staff we spoke with said internet connectivity at the Horton site was sometimes unreliable for staff and patients. During our inspection we experienced some delays accessing documentation due to issues with the internet connection. The trust was aware and following the inspection completed a multisite project to improve internet connection.

Medicines management

The service usually used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Long stay or rehabilitation mental health wards for working age adults

We reviewed 46 medicine charts during our inspection. Staff completed medicines records accurately and kept them up-to-date. Staff used an electronic prescribing system and we noted no gaps in the administration of medicines. Any known allergies for patients were clearly noted on all wards except at Westfield House.

Staff followed systems and processes to prescribe and administer medicines safely, but some staff raised concerns about the systems for ordering medicines. At the time of our inspection, the Horton site did not have an on-site pharmacist. This reduced support to staff and added to their workload. The trust had processes in place to ensure continuous medicine supplies were available, but ward staff did not always follow these processes. For example, 3 staff members at Westfield House said patients had run out of medicines and that staff have needed to travel to London sites or take patients to the local hospital to get an emergency prescription. Staff said the pharmacy delivery vehicle visited the hospital once a week which caused issues if staff failed to order medicines on time.

A new pharmacist started at the Horton site shortly following our inspection.

Staf reviewed each patient's medicines regularly and provided advice to patients about their medicines, although 6 patients we spoke with said they had not been told about possible side effects.

Staff on most wards stored and managed all medicines and prescribing documents safely. However, at Westfield House, we noted that cupboards were very full and overflowing with clinical items including medicines. At Rosedale Court we found a liquid medicine which had been opened but was not labelled with a date to inform staff when to stop using it. We found staff were still using a glucose and ketone testing control solution that required disposal over a month before.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff learned from safety alerts and incidents to improve practice.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patients receiving medicines requiring blood monitoring, including clozapine, received regular blood tests. Staff usually provided patients information leaflets about their medicines. However, we observed a medicines round at Rosedale Court and staff did not ask 2 patients on clozapine about their bowel movements, instead only asking if they had eaten. It is common for patients on clozapine to experience constipation, and if left unnoticed or untreated, could lead to serious medical complications.

Track record on safety

Reporting incidents and learning from when things go wrong

Managers investigated incidents and shared lessons learned with the wider service. However, in some areas staff did not recognise incidents or report them appropriately.

Staff knew how to report incidents, but we found evidence that staff did not always recognise an event as an incident. For example, we found an incident between 2 patients on Rosedale Court that staff did not report on the system until after we raised concerns. We reviewed an incident report following a restraint at Westfield House which stated the patient was placed in the prone position, but the details had not been fully recorded in line with trust policy and legislation. This indicated staff did not always know what incidents to report and how to report them. It also meant managers could not be assured they were sufficiently monitoring the use of restraint or reporting on accurate incident data.

Long stay or rehabilitation mental health wards for working age adults

Staff received feedback from investigation of incidents, both internal and external to the service. Some staff we spoke with were able to give us examples of learning from incidents that had happened within long stay rehabilitation wards as well as from across the wider trust. However, we did not see consistent evidence in team meeting minutes that lessons learnt was a standard agenda item.

There had been 1 serious incident across the service in 2023, after a patient from Roxbourne Lodge died by suicide during unescorted leave. Managers investigated the incident and staff informed us of learning that had come from it.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly.

Staff met to discuss the feedback and look at improvements to patient care, for example during handover meetings and ward rounds. However, we only saw evidence that Rosedale Court staff discussed specific patients' care during team meetings.

There was evidence that changes had been made as a result of feedback. For example, a bank member of staff at Roxbourne House gave a patient the wrong injected medicines. In response, the ward decided 2 nurses, including a regular member of staff, should be present during administration of these medicines.

The service had no never events on any wards.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

We reviewed 34 records and found that staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and on most wards we saw that this was regularly reviewed.

Staff used National Early Warning Scores (NEWS2) charts to monitor patient's vital signs. The trust's management of deteriorating patient policy outlined where NEWS2 scores required additional monitoring or escalation. For 4 patients across 4 of the wards we visited, we found instances where scores had not led to a repeat of the patients' vital signs as frequently as they should have been, such as after 4 to 6 hours when a patient scored between 1 and 4. Despite this, we saw that staff had repeated the patient's vital signs and scoring the next day.

All electronic patient care records we looked at showed patients had care plans, but these varied in quality and in how regularly they were reviewed and updated by staff when patients' needs changed. For example, some care plans were updated monthly, but we found 2 care plans at Westfield House which had not been updated for over a year. One patient

from Westfield House and another from Rosedale Court had care plans from previous ward admissions. For some care plans we found no record that doctor's requests to monitor vital signs had been completed at the frequency set, or that patients who wanted to use the gym had their gym clearance forms completed by staff. This meant patients did not always have care plans which reflected their current needs.

Care plans were not always personalised, holistic and recovery-orientated. Most patients had care plans in place that described their physical and mental health needs, although we found that many did not adequately focus on recovery and rehabilitation needs. We found that some patients were offered a range of treatment options, including activities, psychological interventions, medicines, and occupational therapy. Patients with physical health needs, such as diabetes, had detailed care plans. However, not all care plans met patients' mental and physical health needs. For example, 2 care records for patients at the Horton site mentioned the patient would benefit from referrals to the psychology department, but due to the lack of psychology presence at the Horton site this had not happened.

We found most care plans had been written in the first person, but it was clear the language used was often by clinical staff rather than patient's voices. One manager we spoke with said they had recognised this and encouraged staff to write views using patients' own words.

Across the Horton site and Roxbourne House, we found 4 care plans in which the patient had been noted to have drug and/or alcohol misuse issues. We did not see evidence that staff had helped patients meet these needs through referrals or treatment. Staff informed us the trust had recently stopped using the external team who helped patients address their drug and alcohol issues. The trust planned to train some internal staff on dual diagnosis, but at the time of our inspection we found proactive provision was very limited.

Senior managers for the London wards showed us examples of monthly audits completed for care plans and informed us of actions they had taken when shortfalls were identified. For example, Roxbourne House's July 2023 audit showed 7 patients had not been offered copies of their care plans. In response, managers had created a new process which required staff to evidence this had been completed. However, although the audit assessed if care plans were present and in date, the audit did not assess the quality of what was written within the care plans. Senior managers said they were addressing the quality of care plans and had taken steps to arrange training for staff.

The service was in the process of trialling DIALOG+ within the rehabilitation services. The aim was to move away from the current long and complicated care plans. At the time of our inspection, the Horton site was piloting this new approach, with the future aim of rolling it out to the rest of the core service. The trust said monthly audits of the new approach will be conducted to ensure patient views and priorities are integrated into care plans.

Best practice in treatment and care

Patients across all wards had access to an employment specialist, dance and movement therapy, and art therapy. Some patients cooked their own meals. Most patients we spoke with said they enjoyed the activities on offer.

However, there were gaps in the range of care and treatment suitable for the patients in the service. Psychological therapies were not available for patients at the Horton site; there had not been a psychologist in place for over a year. The ward manager for Ascot Villa was currently completing their training to become a Cognitive Behavioural Therapist. The head of psychology planned to have a full-time CBT therapist for the service by early 2024. Occupational therapists were not always available for patients at Westfield House or The Cottages.

We also found patients at The Cottages who had been assessed as being able to self-administer their medicines, but had not been fully supported by staff to do so. Furthermore, we noted that despite visiting 3 open rehabilitation wards, very few patients self-administered their medicines.

Patients at the Horton site had access to one-to-one and group sessions at the recovery centre, and most wards had activity timetables. However, these were only available during weekdays. Most patients we spoke with across all wards said there was nothing for them to do during the evenings or on weekends. One patient said this meant they went to bed at 6pm and others described feelings of boredom.

We found that staff across most wards assessed those needing specialist care for nutrition and hydration. For example, one diabetic patient had been prescribed water to ensure they were adequately hydrated, and another diabetic patient had been referred to a dietician. However, one patient who had diabetes and was insulin dependent did not have a care plan for this.

We saw in the records that most patients' physical health needs were recorded in their care plans. Care notes for patients at Roxbourne House were noted to be of a particularly high standard in relation to physical health care.

Staff helped patients access physical health care, including specialists as required. Roxbourne House and Roxbourne Lodge were based next to a GP surgery. A GP visited the Horton site once a week. All patients we spoke with said they were able to access a GP when needed. Staff gave examples where patients with long-term health conditions were referred to other healthcare services when required. Staff supported patients to attend medical appointments when required and provided guidance and resources for healthier lifestyles including stopping smoking.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the model of human occupation screening tool (MoHOST) and health of the nation outcome scales (HoNOS). However, there were some gaps as not every patient record we reviewed had a completed outcome scale.

Staff used technology to support patients. Family members, carers and external professionals could be dialled into meetings by phone or video calls. The occupational therapist from Rosedale Court was working on an app which aimed to support people after they are discharged from rehabilitation wards.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Audits were completed at set intervals and results collated centrally by the trust. Nursing staff had started to use a new electronic auditing system for audits which included checks of medical devices, hand hygiene, and environmental checks of the wards. If an audit fell below 70%, staff were expected to inform the ward manager.

Skilled staff to deliver care

Teams on the London wards included or had access to the full range of specialists required to meet the needs of patients. Patients at the Horton site did not have access to dedicated qualified psychologists and the occupational therapy team had vacancies. This meant patients and families did not have access to psychological therapies, which was not in line with best practice. A new assistant psychologist had recently started, but was not yet fully embedded in the role. The head of psychology visited the Horton site once a week and was providing a service to a limited number of patients.

Long stay or rehabilitation mental health wards for working age adults

Patients at Ascot Villa had access to a full-time occupational therapist, but patients at Westfield House and had limited occupational therapy input. The occupational therapist was part-time and based off the ward. We did not see evidence they attended ward rounds. One member of staff we spoke with felt this meant patients did not have clear goals, which was reflected in some of the care plans we reviewed. The trust said they planned to increase occupational therapy input on Westfield House when they filled the vacancy.

Westfield House had access to a full-time activities coordinator who ran group sessions between 9am and 5pm on weekdays. Patients had access to individual and group sessions at the on-site recovery centre, but this was closed in the evening and on weekends. Three patients we spoke with at the Horton site expressed dissatisfaction with there not being enough therapies like psychology or occupational therapy.

Managers described challenges with recruiting to these posts despite trying different methods, and had included this as a high priority item on the service risk register. The head of psychology had plans to recruit 4 new assistant psychologists and a Cognitive Behavioural Therapist by early 2024. Once in post, the aim was for them to be present in all ward rounds and to provide lower level psychological interventions. At the time of inspection, care records showed a lack of attendance from therapy staff at ward rounds.

The London wards we visited had access to psychologists and full-time occupational therapists, although this was limited for some wards. For example, patients at Roxbourne House only had access to a psychologist on site one day a week, which was about half the time the ward should have had. Two patients we spoke with at Roxbourne House said there was not enough therapy. All patients we spoke with at Roxbourne Lodge and Rosedale Court said they received good quality therapies. As with the Horton site, there was no occupational therapist or activities coordinator on weekends. Most patients across all sites said there was nothing to do at weekends. Managers were aware and had started to engage nursing staff in conversations about how to make improvements, but these needed to be embedded.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff on the London wards received reflective practice from the psychologists. The art therapist at the Horton site was due to start reflective practice sessions from October 2023. Training on rehabilitation was available to staff, although this was not mandatory.

Managers gave each new member of staff a full induction to the service before they started work. Staff spoke positively about the induction they received. Temporary staff were expected to meet competencies before starting work within the service.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, some staff were supported to complete their nursing training.

Managers made sure staff received any specialist training for their role. For example, some staff had completed training in phlebotomy and carrying out electrocardiograms.

Managers recognised poor performance, could identify the reasons and dealt with these.

Managers supported staff through regular, constructive appraisals of their work. The percentage of staff that had had an appraisal in the last 6 months was 92%.

Managers supported staff through regular supervision of their work. In the last 6 months, an average of 91% of staff across the rehabilitation services had received their clinical and managerial supervision. Staff we spoke with said they used supervision to discuss topics such as patient care, how to reflect and improve their practice, and for personal support.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed a selection of team meeting minutes and found these varied in quality and detail across the wards.

Multi-disciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The frequency of these meetings differed between wards. For example, some patients had a multidisciplinary team (MDT) meeting every 2 weeks, and some patients had them once a month. We attended the ward rounds of 2 patients at Roxbourne House and 2 patients at Westfield House. Staff at Roxbourne House discussed a wide range of matters during the ward rounds and involved patients and external professionals. Although we observed that staff at Westfield House involved patients and carers in ward rounds, discussions lacked clear recovery focused goals. Staff identified patients' needs but did not make a clear plan for how they would support the patients with these.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed a handover meeting where a range of information was shared, such as information about physical health, medicines, appointments, and requests from family members. The MDT attended weekly whiteboard meetings where they shared updates about patients and discussed any matters that needed escalating.

Ward teams had effective working relationships with other teams in the organisation. However, due to limited resources across the MDT at the Horton site, there was a lack of wider MDT presence such as occupational therapists or psychologists at ward rounds. Most care records from across the Horton site showed ward rounds were mostly attended by the consultant, ward manager, a nurse, and the patient. One member of staff we spoke with said they did not have time to attend ward round which they felt negatively impacted on goal setting. As mentioned above, the lead psychologist for the core service planned for new assistant psychologists to attend all ward rounds once recruited.

Staff said they regularly liaised with other teams such as the local acute hospital, GPs, and housing services. When reviewing patient care records regarding ward rounds, we saw evidence that London wards regularly involved external agencies in these, for example, patients' solicitors, social workers, and care coordinators.

Patients at Roxbourne House and Roxbourne Lodge had easy access to the GP based next door. A GP visited the Horton site once a week. The trust had recently ended their contract with an external organisation who provided drug and alcohol services for patients with substance misuse issues. During our inspection we saw evidence staff recognised some patients who had needs around addressing their substance misuse, but their records did not show this had happened in practice.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. Most staff kept up-to-date with this, although compliance was lower on Rosedale Court and Ascot Villa with 80% and 78% of staff respectively having completed the training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Long stay or rehabilitation mental health wards for working age adults

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. At our last inspection in 2015, we said the London services should ensure that staff have an understanding of the role of advocates so patients could be supported to access the most appropriate service. We found improvements to staff knowledge during this inspection. All the wards displayed information about advocacy services available to patients.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Most patients we spoke with said staff regularly explained their rights to them and that they understood this information.

Staff usually made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. However, a patient from Roxbourne Lodge said their leave had been cancelled due to the ward being short staffed. A carer of a patient at Westfield House said they did not have escorted leave at one point due to a lack of staff. Some staff we spoke with said they made every effort for patients to have their section 17 leave even when short-staffed.

Staff requested an opinion from a Second Opinion Appointed Doctor when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service usually displayed posters to tell them this. Roxbourne Lodge did not display a sign at the time of inspection, and staff informed us it had been temporarily removed. Staff replaced the sign immediately.

We saw that managers and staff were auditing how the service applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

Most staff received and kept up-to-date with training in the Mental Capacity Act, although only 43% of staff at Ascot Villa had completed this mandatory training. No Mental Capacity Act training figures were submitted for Westfield House.

There was a clear policy on the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS), which staff knew how to access. The policy was stored on the staff intranet and the public internet.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff at Roxbourne House had recently completed a quality improvement project on capacity assessments. Care records on this ward demonstrated frequent and good quality capacity assessments. However, in some patient records it was not clear how decisions around capacity had been reached. For example, 2 records at Rosedale Court noted the patients did

not have capacity around their finances, but this was written as a statement which meant there was no clear rationale to explain how staff had reached their conclusions. The trust was conducting an audit of Mental Capacity Act processes across the rehabilitation wards to monitor how the act was being implemented and recorded, and ward staff were auditing 5 patient records every three months to monitor standards.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. However, staff assessed a patient on Roxbourne Lodge to not have capacity to manage their finances. We did not see evidence of a best interests decision, best interests meeting, or a referral to advocacy around this matter.

Is the service caring?

Good ➔➔

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. During our inspection we carried out a short observational framework for inspection (SOFI) at Westfield House. This is a tool developed and used by inspection teams to capture experiences of people who use services who may not be able to express this for themselves. We observed many positive interactions between staff and patients. Staff treated patients with respect and encouraged patients to take part in activities. Most patients across all wards spoke highly of the staff that supported them. We spoke with 31 patients during our inspection, and spoke with a further 5 patients informally.

Staff gave patients help, emotional support and advice when they needed it. Patients appeared at ease with staff.

Staff usually directed patients to other services and supported them to access those services if they needed help.

Most patients said staff treated them well and behaved kindly. One carer said staff had helped their relative keep their hair and nails well maintained because they knew that mattered to them.

Staff understood and respected the individual needs of each patient. Three carers we spoke with described the challenging behaviours their relatives presented on the wards. These carers said staff responded with patience and kindness.

Most staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Staff ensured noticeboards with patient information was not visible outside of the nurses' stations.

However, not all patients felt staff supported them to understand and manage their own care treatment or condition. Three patients from Roxbourne House and 2 patients from Ascot Villa said they did not have regular one-to-one sessions with a named nurse. Our review of patient care records found one-to-one sessions were not always well documented. Such sessions are important to ensure patients can develop therapeutic relationships and express any individual needs they may have.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff ensured that patients had easy access to independent advocates. Not all patients fully understood their care and treatment.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Some patients we spoke with said they were given a welcome information pack.

Staff involved patients and gave them access to their care planning and risk assessments, although 2 patients from Roxbourne House said they had not been given a copy of their care plan. This had been picked up through an audit of care plans and managers had taken steps to improve this for patients. Care records showed patients were invited to attend their ward rounds.

Staff made sure patients understood their care and treatment, although 6 patients from across the wards said they had not been informed about side effects of medicines. Staff mostly found ways to communicate with patients who had communication difficulties. Staff said they booked interpreters for ward rounds and some therapy sessions, but were unable to book them for all activities due to the costs.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. The service had developed feedback forms patients which enabled patients to express their feelings if they did not want to verbalise them during these meetings. Headings included what had gone well and not well for patients, as well as sections for medicines, social concerns and physical health.

Staff held weekly community meetings across all wards where patients were able to express their thoughts, feelings, and suggestions for improvements that could be made. However, a patient at Westfield House said they had repeatedly raised their dislike for the food but felt staff had not listened. We reviewed some community meeting minutes from Westfield House and did not see evidence that staff had discussed food with patients. Not all patients we spoke with knew how to complain.

Staff supported patients to make decisions on their care. We observed a planning meeting at Rosedale Court where patients looked at recipes and voted on what they wanted to cook.

Staff made sure patients could access advocacy services. Most patients we spoke with had heard of the advocacy service and wards displayed posters on the services available.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, some carers experienced issues with being invited to meetings.

Long stay or rehabilitation mental health wards for working age adults

Staff usually supported, informed and involved families or carers. We spoke with 23 carers. Most carers we spoke with spoke highly of the ward staff and said it was usually easy to speak with staff on the wards. Most carers we spoke with said they were invited to their relative's ward round with their consent and felt staff listened to their views. However, 2 carers of patients at Roxbourne House and 2 carers of patients at Westfield House said they experienced difficulties being invited to ward rounds, despite their relatives consenting to this. They repeatedly asked staff to invite them but experienced ongoing issues.

Staff helped families to give feedback on the service. Wards had carers meetings and had recently started a carers forum which the occupational therapist and head of service attended. Managers said this was in response to requests from carers to speak with senior managers within the service. Some carers said they had been contacted to provide feedback on the service before their relative had been transferred or discharged from the wards.

Managers planned to involve carers in recruitment processes.

However, most carers across 4 of the 6 wards we visited had not been told how to complain or did not know how to. Carers felt comfortable raising concerns with nursing staff.

Is the service responsive?

Requires Improvement 

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

Access and discharge

Staff worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not usually have to stay in hospital when they were well enough to leave.

The service accepted patients from across 8 different London boroughs. Managers described that referrals were received, triaged, and patients were allocated to wards across the different areas. The service had low out-of-area placements. Some patients and carers we spoke with described the challenges the Horton location sometimes presented. For example, many patients and carers were based in London which some said reduced how frequently they visited Horton.

At the time of inspection, most wards were fully occupied or almost fully occupied. Ward managers told us that there had been an increase in the acuity of patients referred to some wards in the rehabilitation pathway and at times this led to inappropriate referrals.

There were pathways through the rehabilitation services so patients could move from high dependency rehabilitation wards to open rehabilitation wards.

Managers regularly reviewed length of stay for patients, but acknowledged some discharges were delayed which had caused some patients to stay longer than they needed to. The average length of stay varied between wards, but data showed some patients exceeded the average length of stay across all wards.

Long stay or rehabilitation mental health wards for working age adults

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient. For example, if a patient presented with a higher risk than the wards could safely manage, they were transferred to a high dependency rehabilitation ward or a more appropriate acute setting. One manager explained there could sometimes be short delays whilst waiting for more intensive mental health support beds, but staff increased observations to manage any risks if this happened. We found examples of 2 patients who had been assessed as not suitable for a rehabilitation setting, but remained on rehabilitation wards while they waited for a more suitable setting.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and knew which wards had the most delays. Senior leaders attended weekly meetings along with community mental health teams and housing services to review the number of people whose discharge was delayed. Data received shortly following our inspection showed there were 3 patients across the wards we visited who were clinically ready for discharge but were experiencing delays. Reasons for these delays included challenges with finding suitable community placements and patient disengagement. During our inspection, leaders acknowledged there were many delays across the wards at the time and said they planned to conduct a deep dive into each patient whose discharge was delayed.

Some care records we reviewed contained clear discharge planning and involved external professionals. Staff said patients prepared for discharge gradually, which included trialling longer periods of leave in the community.

The trust had internal and external processes with stakeholders to facilitate patient discharge. However, records we reviewed at the Horton site lacked detail around actions staff were taking to facilitate timely patient discharge. The records usually noted information such as discharge destinations, barriers to discharge and expected time for discharge, but care plans we reviewed lacked details of discharge planning.

Staff usually supported patients when they were referred or transferred between services. Staff took steps to ensure patients felt comfortable in prospective onward placements, such as supported or independent housing, and helped them explore alternative options when necessary.

Facilities that promote comfort, dignity and privacy

The facilities available to patients at Westfield House did not meet what was expected from a rehabilitation ward environment. However, the design, layout, and furnishings of most wards we inspected supported patients' treatment, privacy and dignity. Each patient had their own bedroom. There were quiet areas for privacy.

Along with the elements of the poor environment at Westfield House which impacted negatively on patient care, we also found issues with poor facilities on this ward which negatively impacted on patient experience. At Westfield House, patients could not always make their own hot drinks and snacks. On all other wards we inspected patients had free access to hot drinks and snacks. Patients at Westfield House needed to request this from staff. Staff we spoke with gave different reasons for this blanket restriction which had been introduced in January 2023. Patents at Westfield House were required to keep a cup and plate in their bedroom and use this when they wanted to have food or make a drink.

During our inspection, we observed a staff member ask patients if they wanted a hot drink. One patient who said they wanted a hot drink was told by the staff member to get their allocated cup from their bedroom. The patient chose not to have the hot drink. The restrictions around access to hot drinks and cups on Westfield House meant that some patients' hydration needs were not met. The trust's policy stated fluids, including tea and coffee, should be freely available to all patients.

Long stay or rehabilitation mental health wards for working age adults

Most of the rehabilitation wards we inspected gave patients a choice of hot food prepared by external caterers. This was not the case at Westfield House. The patients at Westfield House had frozen ready meals from the local supermarket every lunchtime except Sundays. Evening meals consisted of supermarket food such as sandwiches, soups and tinned spaghetti. Staff helped prepare all meals.

Four patients at Westfield House told us they disliked the food. They used words such as “horrible, diabolical,” “not a nutritious diet,” and “not nourishing” to describe it. One said they were “sick of microwave meals” and another said “I have been complaining about the food since I got here in every single community meeting, but nothing has been done.” We reviewed some community meeting minutes from 2023 and these did not show food as an agenda item. There was no evidence patients were specifically asked for their feedback about the food. One carer said they brought their relative home-cooked meals because they disliked the food so much. We were not assured the trust had ensured these meals provided suitable nutrition to patients or always met dietary needs. We raised our concerns with the trust who took immediate steps to improve food provision for patients at Westfield House. This included being provided with lunches from the same catering company that serviced the other HDUs at Horton.

Two patients at Roxbourne House told us they did not like the food. However, most patients from the other wards liked the food and said it catered to their dietary and religious needs.

During our 2015 inspection, we said the trust should look at the arrangements for patients to have or replace keys for their rooms to ensure they could lock their rooms without having to rely on staff doing this for them. The trust described processes in place to ensure patients were asked regularly if they had room keys. However, not all patients at the Horton site could secure their possessions. For example, 1 patient at Westfield House said staff gave them a key to their room on the day of our inspection. This was the first key they had been given since being admitted over 3 months before. A different patient complained to a staff member that another patient had taken something from their bedroom. The staff member from Westfield House informed us that some patients did not have keys to their bedrooms because they had lost them. None of the bedrooms we observed at the Horton site contained lockable storage facilities.

After the inspection we raised a range of concerns about the environment and facilities at Westfield House with the trust. Senior leaders at the trust took immediate steps to address key findings such as patients’ access to food and drinks.

Each patient had their own bedroom, which staff said they could personalise. However, we observed bedrooms at Westfield House and Roxbourne House were very bare. This was the same for the communal environments on these wards. Aside from notice boards, the walls were very bare which did not promote a hopeful or motivational rehabilitation environment. Westfield House was divided into 9 flats. Of these 9 flats, only 1 had a piece of artwork on the wall. Since the inspection, the trust confirmed Westfield House has been closed, and provided evidence to show improvements to the communal areas of Roxbourne House. The other wards displayed pictures, cards and patients’ artwork on the walls which made them feel more like rehabilitation environments.

Staff used a full range of rooms and equipment to support treatment and care, although the communal space was small for the number of patients at Westfield House. For example, there was only seating space for a few patients in the activities room and the shared lounge. There were 22 patients admitted to Westfield House at the time of our inspection, which the trust has since reduced to 18.

The service had outside spaces that patients could access easily. Most wards, except Ascot Villa, had open access to the gardens and courtyards. The garden areas varied in quality. For example, the Horton site was set in attractive grounds which some patients could access freely. Each ward had their own gardens, but we observed these were quite overgrown. Roxbourne House had a large fenced outside area but it was bare and contained only 4 chairs and

rubberised flooring. Trust leaders informed us they planned to buy plants, seating and a table tennis table. Roxbourne Lodge and Rosedale Court had inviting garden spaces. Rosedale Court had a quality improvement plan to develop the garden so it would have a gym in the summer house and an allotment. Carers, patients and community volunteers were involved in the plan.

The service had quiet areas and a room where patients could meet with visitors in private. Staff at Rosedale Court told us male patients did not have a designated visitor room but could use the courtyard, female lounge, or an area of the main lounge. One carer of a patient at Rosedale Court said there was not always a designated space when they visited.

Patients on all wards could make phone calls in private.

Patients' engagement with the wider community

All wards could refer patients to employment specialists employed by the trust and had access to the local recovery college. The service offered a variety of support including CV and cover letter writing, benefits support, and applying for college courses and voluntary roles. Patients we spoke with from Roxbourne Lodge were most positive about these resources. The trust said 81% of Horton patients received support from the employment service. However, six patients we spoke with from the Horton site said they had not been asked or offered support about their goals for employment or education. At the time of our inspection, no patients were in paid or voluntary roles. One patient felt they had not been considered for education or employment because they were not good with technology, and another patient said they did not feel considered. One patient we spoke with from Westfield House said they attended English language classes.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community, although some carers of patients at Roxbourne House said this could be improved. For example, three carers we spoke with felt their relatives would benefit from attending more groups within the community. They said staff were good at facilitating trips to the local café or shop, but that community-based group activities did not happen. One carer said they took their son to community groups themself to ensure he had this experience. Patients said they would like different community outings and to visit places during the most recent patient survey.

Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service

Staff we spoke with said that the rehabilitation wards could access interpreter services for patients for whom English was not their first language. However, we found from feedback from patients and carers and within care records that this was not happening consistently for all patients who required this service. One patient's care record noted they had disengaged from art therapy due to a language barrier. The carer of another patient said their family member did not always join in with activities because they did not understand English. Care records for a patient showed staff had tried to contact the Polish embassy on their behalf, but could not proceed because the embassy staff did not speak English. This meant some patients who did not have English as a first language did not always have their needs met.

Patients had some access to spiritual, religious and cultural support. Patients had access to multi-faith rooms and some patients had visits from local religious leaders. Some wards displayed spiritual and cultural information on notice boards around the ward. However, patient care records did not always capture patients' spiritual and cultural needs. For example, staff at Rosedale Court confirmed a patient only ate halal meals, but we found this was not captured within that patient's care plan. We observed a ward round for a patient at Westfield House. During this meeting the patient told

staff they wanted to eat Afro-Caribbean food and did not like the microwaved meals provided. Staff informed the patient they were able to buy ingredients and cook food in the ward's kitchen, but during our inspection staff at Westfield House informed us patients did not cook their own food. Two patients from Ascot Villa informed us they wanted to go to a local church and mosque, but said staff had not supported them with this.

The service could usually support and make adjustments for disabled people and those with communication needs or other specific needs. Most wards we visited could accommodate patients who used wheelchairs and some wards had lifts. Staff provided examples of how they had supported disabled patients. However, Westfield House and The Cottages did not have lifts due to the age of the buildings. Furthermore, despite Westfield House having an accessible bathroom on the ground floor, the corridors were very narrow which would make it challenging for someone with a wheelchair to move around the ward.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service generally provided a variety of food to meet the dietary and cultural needs of individual patients, although some patients told us this could be better. Staff informed us they could cater for dietary needs such as halal or vegetarian food. A carer said staff catered for their relative's allergies. However, as outlined above, we raised concerns about the food provision at Westfield House during our inspection and the trust made immediate changes to improve this for patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. However, some carers and patients did not know how to complain.

At our last inspection we said the trust must ensure all wards provide information to inform patients how to make a complaint. We said the trust must ensure verbal complaints were addressed, have access to the formal complaints process, and that learning came from verbal and written complaints. During this inspection we found improvements had been made.

The service clearly displayed information about how to raise a concern in patient areas. Although several patients and carers we spoke with said they were unclear how to use the complaints system.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed a sample of complaints during the inspection and found staff dealt with them well and in a sensitive manner. At Rosedale Court, the ward administrator kept a folder of all verbal complaints that had arisen from community meetings and how they had been resolved. Some wards displayed information about concerns patients had raised and the actions staff had taken to resolve them. However, 2 patients we spoke with at the Horton site did not feel staff took their complaints seriously.

Managers shared feedback from complaints with staff and learning was used to improve the service. However, we didn't see consistent evidence in team meeting minutes that staff discussed and learnt from the outcome of complaints.

Long stay or rehabilitation mental health wards for working age adults

The service captured compliments from patients and carers on their electronic reporting system to learn, celebrate success and improve the quality of care. Some wards displayed cards given to staff by patients. However, we reviewed 10 team meeting minutes and did not see any evidence compliments or achievements were discussed in these venues.

Is the service well-led?

Requires Improvement ↓

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

Leadership

Leaders had the integrity, skills, knowledge and experience to perform their roles. Of the wards we visited, the ward managers had been in post for between 12 months and 6 years. One ward manager was on long-term sickness leave, but staff spoke highly of the support provided by the deputy ward manager in their absence.

Leaders had a good understanding of the services they managed and generally understood the issues and challenges the service faced. Leaders appeared aware of the impact the depleted MDT at the Horton site was having on staff and on quality of care. They outlined priorities for further improvements to the service, such as continuing to recruit into vacant posts, increasing contact with carers, and improving evening and weekend activities for patients.

Most staff spoke highly of the senior leaders and managers within the service. Generally, staff felt managers were supportive, visible in the service and listened to their views. Carers we spoke with also spoke very highly of the managers at the service.

We did however have some concerns that restrictive practices found at Westfield House had gone unresolved, despite some issues about the ward being identified and recorded by service leaders. When we raised our concerns, leaders responded immediately to rectify any urgent issues.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff were familiar with the trust's visions and values and how they applied to their work. Staff at all levels spoke enthusiastically about caring for patients and seeing notable improvements to their wellbeing. We saw staff displayed the provider's values during our observations. Most patients and carers said staff were caring, kind and respectful.

The service had recently been through a clinically led transformation with the aim of improving the pathways through the service for patients. Leaders said they had worked hard to improve the admission process, but acknowledged there were several delayed discharges which they planned to focus their attention on. Leaders attended weekly meetings to discuss referrals and delayed discharges.

Culture

Most staff felt respected, supported and valued. They said they could raise any concerns without fear. Most staff said the trust provided opportunities for development and career progression, but some areas regarding staff culture could be improved.

Long stay or rehabilitation mental health wards for working age adults

Overall, staff told us they felt respected, supported and valued in their role. Most staff we spoke with said they would feel comfortable to raise concerns and these would be listened to. Staff said leaders had provided funding so teams could purchase items to support wellbeing. For example, staff at Roxbourne Lodge had purchased a massage chair.

Staff generally spoke positively about development opportunities and career progression, but 2 staff expressed frustrations with the lack of internal progression which they said had resulted in staff leaving. We spoke to several staff who had been supported by the trust to complete additional qualifications to secure nursing and management roles. The trust provided a preceptorship programme for newly qualified nurses.

Staff had access to physical and mental wellbeing support through the trust's occupational health service. Staff reported they were appropriately supported and debriefed following incidents. London staff received reflective practice sessions from the psychologist, and Horton staff were due to start receiving this shortly after our inspection.

Some staff we spoke with felt their hard work was not acknowledged, and the service did not have staff awards. Three staff we spoke with felt they did not have enough time in their working day to attend the trust's race and equality network. This had been reflected in the most recent staff survey. Not all staff were aware of the trust's independent Freedom to Speak Up Guardian service, and 2 staff who were aware of it said they would not feel comfortable using it. Trust leaders told us they planned to use staff survey results to enhance staff engagement and ensure staff are recognised and rewarded.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively.

Managers reviewed a range of matters related to the running of the service during regular quality and business meetings. They shared information at a ward level, such as lessons learnt and medicine alerts. Staff received information through regular team meetings, handovers and MDT whiteboard meetings. The service's risk register reflected issues we found during the inspection. There were usually sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. The trust had an audit schedule and allocated staff to complete these. Systems and processes were in place to monitor compliance with training and supervision. We saw evidence that managers usually identified areas that required improvements during care quality meetings and monitored the progress via actions plans. However, some shortfalls were not effectively addressed, and some areas of concern we found during the inspection had not been recognised by leaders. For example, governance arrangements had not identified the restrictive practices we found at Westfield House such as the restrictions on access to hot drinks and crockery. They had also not identified the issues with male patients passing female bedrooms and bathrooms to access meals and hot drinks, despite evidence to suggest female patients had raised concerns about this.

Whilst systems were in place for staff to report incidents, we found that several incidents had not been reported in practice. This meant service managers did not always have oversight of incidents that happened on the ward, and could not always monitor them to ensure appropriate action was always taken and that patients received safe care and treatment. Handovers and clinical auditing were not always robust in identifying when restraints and safeguarding matters had occurred. A lack of oversight of incidents may mean that managers are unable to identify where improvements to care is required, and learning may not always be shared with staff.

There was not an effective system across the service to ensure that staff always escalated NEWS2 scores in line with the trust policy and patients on clozapine were always monitored for constipation.

However, managers were responsive to feedback provided during the inspection and responded immediately to urgent concerns.

Management of risk, issues and performance

The rehabilitation services held regular monthly business and quality meetings that discussed and reviewed items relating to safety, caring, human resources and performance. These were attended by the service's senior leaders, and ward staff held local team meetings.

Items were discussed, minuted and leaders used an action plan to monitor progress of areas for improvement they identified. However, as outlined above, the management of risk, issues and performance was not always effective. For example, the environment at Westfield House was discussed at the Quality Meeting in May 2023 and described as dark, dingy, with no natural light and narrow corridors. At the time of inspection we observed the environment to be as described in May, with no discernible improvement that would improve the experience of patients on this ward. Part of the environment had been redecorated and brighter lights installed, but this had not resolved the issues leaders had identified. Also, at the Quality Meeting in June 2023 it was agreed to set aside 30 minutes at the July meeting to discuss the implementation of a dual diagnosis operational plan for rehabilitation services. There was no discussion of dual diagnosis recorded in the July meeting, nor any minutes of what happened to the plan for this in the June meeting.

The service held a local risk register which highlighted the most serious risks which were impacting or could impact the delivery safety or quality of the services, and described the controls that were in place to mitigate the risks. Key risks included at the time of inspection included gaps in key professional roles including occupational therapy, pharmacy and psychology; under-performance of the maintenance contract.

Information management

Managers had access to dashboards that gave them an overview of the ward performance including mandatory training, supervision and appraisal compliance.

Ward staff generally had access to the information they needed from trust systems to provide safe and effective care. However, we had some concerns that managers did not always have access to reliable information about restraint and safeguarding incidents after we found staff had not recorded several incidents, or had not recorded instances of restraint in sufficient detail. Following concerns we raised at the time of our inspection, leaders had arranged additional safeguarding training for staff.

The service used a secure electronic patient record system to keep information confidential. Staff completed mandatory information governance training each year. Most audits were completed electronically which allowed staff and managers to clearly see any areas that still needed to be resolved. Staff at the Horton site had issues accessing the auditing app at times due to the unreliable internet connection.

Staff told us about quality improvement initiatives. This included introducing a proforma which allowed patients to consider all aspects of their care ahead of their ward round meeting. Staff said this gave patients the option to consider what they wanted to say about their care and facilitated a more structured conversation. Senior managers informed us the service planned to introduce more streamlined care plans having identified the challenges with current complexity of care plans at the time of our inspection. The Horton site was trialling this before a planned roll out to other rehabilitation wards.

The service notified external bodies of relevant incidents, including commissioners and the Care Quality Commission when required.

Long stay or rehabilitation mental health wards for working age adults

Engagement

There were good links with community mental health staff on the London wards. We saw evidence that community care co-ordinators were regularly invited and attended patient ward rounds.

Leaders reported good relationships with the West London forensic services, and could escalate patients no longer suited to a rehabilitation setting where required.

Previously the rehabilitation wards had a patient pathway to support them with substance misuse needs. However, the trust no longer had links with the external dual diagnosis team and as outlined elsewhere in this report, we found evidence to suggest this impacted on some patient's care.

Leaders said they attended regular multi-agency meetings to discuss delayed discharges and discuss how to overcome any barriers to discharge. The service had referred some patients to the National Psychosis Unit if they felt patients had additional treatment needs.

Patients had opportunities to give feedback on the service they received. Patients had completed surveys and could also feedback via ward community meetings. At the time of our inspection it was not clear how the trust planned to address all shortfalls identified during the most recent patient survey.

Learning, continuous improvement and innovation

Despite finding several quality issues across the core service that required action, we felt most staff displayed a clear commitment to development and improvement. Staff engaged in appropriate audits and were encouraged to develop their skills through training, experience and career development opportunities.

Leaders had acknowledged a need for greater focus on quality improvement (QI) and had arranged a QI summit shortly before our inspection. Staff we spoke with informed us about QI projects they had been involved in or had planned across all wards we visited. For example, staff at Roxbourne Lodge had completed a QI project on food experience for patients after some patients had complained about the food. During our inspection we asked 5 patients at Roxbourne Lodge about the food and they all spoke positively about it. The ward manager at Roxbourne House planned to complete a QI project about how to reduce incidents of violence on the ward. Each ward had listed future areas for improvement they planned to work on.

When we raised issues to senior leaders, such as the concerns about restrictions at Westfield House, immediate changes were made to improve patient experience.

Of the wards we visited, Rosedale Court and Ascot Villa had achieved their accreditation of inpatient mental health services for rehabilitation (AIMS-Rehab). This is a set of standards determined by the Royal College of Psychiatrists designed to improve the quality of rehabilitation services. Roxbourne House planned to prepare for AIMS-Rehab accreditation shortly after our inspection. Roxbourne Lodge had recently applied for AIMS-Rehab accreditation and were awaiting the outcome at the time of our inspection.

Child and adolescent mental health wards

Inspected but not rated

Is the service safe?

Inspected but not rated

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The service had completed comprehensive risk assessments that covered fire, first aid, hazardous waste, lifting and handling of young people, security, slips trips and falls, violence and aggression. This assessment was reviewed annually.

Staff could observe children and young people in all parts of the wards. The service had fitted cameras on all parts of the ward and had convex mirrors for blind spots. At the time of the inspection, all young people were nursed on 1:1 observations by staff.

The ward complied with guidance and there was no mixed sex accommodation. Each bedroom had en-suite facilities for young people to use their toilet and shower in private. The ward had a female lounge.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. The service had completed a ligature suspension point risk policy, that highlighted all ligature points on the ward. The service mitigated these risks by having 1:1 observations of young people at all times.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Staff were provided with a personal alarm. Young people had access to call alarm bells in their rooms. Young people also had access to alarms in communal areas on the ward such as the soft play room and classroom.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. The ward had a dedicated domestic staff member who cleaned the ward Monday to Friday.

Staff followed infection control policy, including handwashing. Staff participated in hand hygiene audits to ensure effective hand washing techniques.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Access to medicines storage areas was appropriately restricted. These were clean and temperature controlled.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe.

At the time of inspection, there was an establishment of 9 whole-time equivalent registered nurses, with four registered nurse vacancies. Interviews for these vacancies were taking place on 31st July 2023.

There was an establishment of 12 whole-time equivalent healthcare assistant, with 3 healthcare assistant vacancies. These 3 vacancies had been recruited to and were undergoing HR recruitment checks.

The service had low rates of agency nurses and agency nursing assistants. The ward used bank staff who were often permanent staff working extra shifts. Managers emphasised the importance of using staff who were familiar with the ward and young people, to ensure consistency of care. In the last 12 months, 4 shifts were covered by agency staff members and 200 shifts were covered by bank staff to cover sickness, absence or vacancies.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This included key information relating to the young people such as risk management, care plans, observation and engagement.

In the last 12 months, the average staff turnover rate for the multidisciplinary team was 24%. The ward manager told us that the reason for staff leaving was due to transferring to a higher band within the trust, career progression and staff relocating to another area.

Managers supported staff who needed time off for ill health.

Levels of sickness were low and were reducing. For example, in July 2022 the sickness rate was 26.5%, and had reduced each month. In June 2023, the sickness rate was 0.2%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the children and young people.

Children and young people had regular one to one sessions with their named nurse.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep children and young people safe when handing over their care to others.

Child and adolescent mental health wards

Medical staff

The service had enough daytime medical cover. There was a permanent consultant psychiatrist who worked all day on Monday, Wednesday, Thursday, and half a day on Tuesday, and a permanent part-time speciality doctor worked on the ward. A GP visited the ward every Friday morning. Medical staff from the on-site adult ward for people with learning disabilities provided consultant psychiatrist input if needed to cover annual leave or sickness.

There was no onsite night time or weekend medical cover. In the case of a medical emergency staff would need to call for an ambulance or attend A&E. Staff did not report any concerns with this arrangement.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training. However, 66% of staff were not up to date with immediate life support (ILS) training (at the time of the inspection four staff member's training were 10 days out of date). The ward manager told us that these staff members were booked onto ILS training in September 2023.

The mandatory training programme was comprehensive and met the needs of young people and staff. It included modules such as inpatient fire safety, information governance, infection prevention and control, physical intervention, mental capacity act, mental health act and safeguarding.

In June 2023, the trust introduced the Oliver McGowan E-training and autism and learning disability face to face training for all staff. On Crystal House, 14 out of the 22 staff members had completed the Oliver McGowan E-learning training. Those staff who had not completed the training were due to complete this after they returned from annual leave. All staff were due to complete the autism and learning disability face to face training in September 2023, which was a trust priority.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Managers had identified that staff would benefit from training on trauma-informed care and training dates would be available from September 2023.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, staff did not fully follow a young person's dysphagia care plan.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool.

Child and adolescent mental health wards

Management of patient risk

Staff knew about any risks to each young person and mostly acted to prevent or reduce risks. However, during our inspection, we observed that staff did not fully implement recommendations set out in a young person's dysphagia care plan. Staff prepared part of the young person's meal in accordance with the dysphagia care plan, but did not ensure the remainder of the meal was cut into smaller chunks as advised. This meant the young person was at risk of choking on their food. This incident was raised with the ward's speech and language therapist who said they would review mealtime safety. This was also raised with senior leaders on the day of inspection who subsequently, reminded staff of the young person's dysphagia care plan in handover, via email to the ward team, and ensured the care plan was clearly displayed in the kitchen area.

Staff identified and responded to any changes in risks to, or posed by, children and young people. Staff held regular safety huddles on the ward to discuss changes in risks and how these would be safely managed.

Staff could observe children and young people in all areas of the ward as each young person was nursed on a one-to-one observation.

Staff followed trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

The ward was smoke free. None of the current cohort of young people smoked.

Use of restrictive interventions

In the last 12 months before the inspection, there were no episodes of seclusion. There was no seclusion room on the ward.

At the time of the inspection, there were no young people subject to long-term segregation. In the last 12 months before the inspection, there were 2 episodes of long-term segregation. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation. Staff worked hard to support young people so they no longer needed this restriction. One young person who had been in long-term segregation between March 2023 and April 2023 had made good progress whilst being on the ward and staff were preparing them for discharge to a community placement. The young person told us that the positive behaviour support approach had helped them, and since being on the ward they had learnt to be kinder to themselves.

In the last 12 months before the inspection, there were 72 restraints reported. Of those incidents of restraint, 4 of these incidents were in the prone position. The trust reviewed the restraints on Crystal House at regular quality committee meetings. In June 2023, there were 8 restraints reported at Crystal House involving two young people, the restraints were following distressed behaviour and 1 following self-harm by headbanging and4 following assaults on staff.

In the last 12 months before the inspection, 28 incidents of rapid tranquilisation were reported, and 15 of these incidents were intramuscular. Intramuscular rapid tranquilisation was used on the ward as a last resort. This was only used if de-escalation and offers of oral medicine alternatives had not been successful. The trust had a robust system in place to ensure every use of rapid tranquilisation was in line with trust policy and that appropriate physical health monitoring also took place.

Use of 'when required' (PRN) medicines to manage agitation and aggression on the ward was consistent with the acuity of the young people. Whenever possible, de-escalation techniques were used to avoid using a PRN medicine. Records demonstrated why a medicine was needed and if it was successful in achieving the desired outcome. Staff also considered potential triggers to any situation and how to avoid or manage these in future.

Staff participated in the provider's restrictive interventions reduction programme. The ward manager attended monthly least restrictive practice meetings. Violence and aggression, and restrictive interventions were reviewed at quarterly learning disability care quality meetings.

The ward used 'safety pods' which were big bean bags that enabled staff to carry out seated restraints, rather than supine restraints. Safety pod training was incorporated in the trust's mandatory physical intervention training.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training. All staff on the ward were trained in Safeguarding Children level 3. Staff had access to safeguarding reflective practice.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When children and young people transferred to a new team, there were no delays in staff accessing their records. The system the provider used was available to community teams as well as the inpatient teams, so everyone involved in the patient's care could access the records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health. However, the service did not have a process in place to ensure epilepsy rescue medicines were available to staff who went on section 17 leave with young people who were prescribed these.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff used an electronic system to prescribe and record the administration of medicines. They also used this system to document young people notes.

Patient's Mental Health Act consent to treatment documents were kept as both physical and digital copies. Staff checked these against what they were administering each day. The pharmacy department also included additional prompts on the electronic prescribing and medicines administration (EPMA) system as a reminder to staff to check and follow the authorised treatment plan.

The pharmacy department provided expert clinical advice to prescribers and staff during regular visits to the ward. They also ensured additional monitoring and safety considerations were being followed prior to a medicine being administered. These actions were all recorded on the EPMA.

Medicines were dispensed by the pharmacy team and delivered to each ward daily. If medicines were required out of hours there was an emergency drugs cabinet that could be accessed with the authorisation of the pharmacy as well as an on-call pharmacy service.

The staff on each ward made use of the 'Omnicell' automated dispensing cabinets which improved patient safety by ensuring the correct medicine for each patient was dispensed. This system was tied to the EPMA system, and they worked together to ensure all prescribed medicines were available for a patient when needed.

The service did not have a process in place to ensure that epilepsy rescue medicines were available to staff who went on section 17 leave (an authorised leave of absence from a hospital where a person is detained under the Mental Health Act) with young people who were prescribed these. This meant that staff may not have access to such medicines should they need to administer to the young person if out in the community.

Staff had access to medicines disposal facilities and any disposed of medicines were recorded appropriately.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines.

Young peoples' needs including prescribed medicines were discussed with a multidisciplinary team. Young people were also able to attend reviews to discuss their care with the team and with their families or carers. A pharmacist attended the ward weekly and would offer support to both the clinical team and patient where required.

Staff working out of hours could access the trust on-call pharmacy service for medicines advice or additional supplies.

The pharmacist could access blood results and other physical health monitoring records to ensure that high risk medicines were being used safely. Where young people were unable to be monitored regularly the pharmacy worked with the ward team to find other ways to ensure that a patient was being kept safe from avoidable harm. There was also a physical health nurse who supported the ward team to monitor and manage peoples health whilst on the ward.

Staff took appropriate action to safeguard patient's safety and monitor the effects of their medicines on them.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in a temperature-controlled clinic room. Access to the area was limited to medicines trained staff only. Temperatures for the room, cabinets and medicine fridges were monitored manually and review of recent records showed temperatures for both room and fridge were within the recommended ranges.

Staff followed current national practice to check young people had the correct medicines. The ward pharmacist completed a full medicines reconciliation within 24 hours of admission to a ward or 48 hours if over the weekend. This was documented on a patient's electronic and prescribing medicines administration record, and a copy given to the prescriber to make informed prescribing decisions.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Staff reported medicines incidents using an electronic system. The pharmacy team were involved in those related to medicines.

The trust shared learning from incidents with staff so improvements to practice could be made. Any learning from errors and incidents were discussed at the team huddle on a Monday morning.

The trust had a system to manage and act on medicines safety alerts and recalls.

Medicines audits were carried out regularly. These included 'safe and secure handling of medicines', 'controlled drugs', 'antimicrobial' and 'medicines reconciliation' audits.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service worked towards achieving the aims of STOMP (Stop Over Medicating People with a learning disability). Staff worked alongside prescribers to ensure the principles of STOMP and STAMP (Supporting Treatment and Appropriate Medication in Paediatrics) were followed. We saw evidence of use of antipsychotics being reviewed and reduced where appropriate.

We saw one example where prescribing of an antipsychotic was not indicated by a clinical diagnosis. However, there was appropriate reasoning recorded in patients care records and a regular review of the prescribed medicine to ensure it was being used appropriately.

People using the service, or their advocates, staff and specialists were all involved in decisions made about the treatment given to a patient.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance.

Track record on safety

The trust reported 1 serious incident in the last 12 months, which involved a patient on staff physical assault.

Reporting incidents and learning from when things go wrong

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 children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported incidents on an electronic reporting system, which the ward manager reviewed and then reported to senior leaders for their oversight. These incidents were monitored at monthly learning disability care quality meetings.

Staff attended weekly incidents meetings to discuss recent incidents and any learnings, these were also discussed in the monthly team meetings.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on the ward.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. We saw evidence of this in relation to a recent incident where a patient had assaulted a staff member. Managers prioritised staff members' wellbeing. Staff told us they discussed incidents in daily safety huddles and covered risk and any learning.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Managers learnt about incidents that occurred in other trust divisions and were able to provide examples of these. Staff discussed learning from incidents during regular team meetings.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Inspected but not rated

Child and adolescent mental health wards

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after.

Within a week of a young person being admitted to the ward staff completed a clinical review and forward thinking (CRaFT) meeting. Carers were invited to this meeting. The aim of the CRaFT meeting was to set clear goals about what the hospital admission should achieve and to start planning care for discharge.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when children and young people's needs changed.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service.

Staff delivered care in line with best practice and national guidance. (From relevant bodies eg NICE).

Staff identified children and young people's physical health needs and recorded them in their care plans.

Staff ensured each persons' physical health was monitored regularly. The trust employed a dedicated physical health nursing lead who would support wards to monitor and manage children and young peoples' physical health as well as their mental health.

Staff made sure children and young people had access to physical health care, including specialists as required. Nursing staff measured young peoples' vital signs daily to ensure these were normal.

Staff met children and young people's dietary needs, and assessed those needing specialist care for nutrition and hydration. Young people had access to a dietician if required.

Staff helped children and young people live healthier lives. For example, the food menu had been developed by a dietician to ensure it was healthy. A fitness instructor visited the ward weekly and was able to support young people with their fitness goals. Staff encouraged young people to go for walks and to access the garden to ensure they regularly moved their bodies and accessed fresh air.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. For example, the occupational therapist used the standardised MOHOST (model of human occupation screening tool) which assess which factors facilitate or restrict an individual's participation in daily life. The occupational therapist also used the multidimensional assessment of interoceptive awareness tool to assess awareness of bodily sensation. Staff adapted assessments for reasonable adjustments.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of children and young people on the ward. The ward's clinical psychologist post was vacant, and the lead clinical psychologist was providing interim cover. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the children and young people on the ward. This included a consultant psychiatrist, specialty doctor, clinical psychology lead, ward manager nurse, positive behaviour support lead, registered nurses, health care assistants, social worker, advocate, speech and language therapist, art therapists, occupational therapist, teacher and activities coordinator.

3 of the 6 nurses were registered learning disability nurses who had been trained to provide specialist care, support, and treatment to people with a learning disability and to their families and carers. The other three nurses were registered mental health nurses.

The ward clinical psychologist post had been vacant since May 2023. Before this there had been a locum psychologist on the ward between March 2022 and May 2023. To ensure young people had access to psychological input, the lead clinical psychologist for learning disability services was providing interim cover. For example, the lead psychologist had conducted a cognitive assessment for a young person, and commissioned family therapy for another young person when this was required. The trust was actively trying to recruit into this post and was due to interview an applicant on 4 August 2023. Other forms of psychotherapy were offered to young people such as art psychotherapy and dance and movement therapy to ensure there was a psychological offer on the ward. This issue was identified on the learning disabilities risk register.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. The percentage of staff that had had an appraisal in the last 12 months was 100%.

Managers supported staff through regular, constructive clinical supervision of their work. In June 2023, 90% of staff had received clinical supervision and 86% of staff had received management supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed team meeting minutes from the last 3 months. They all followed a structured agenda, covering items such as learning from incidents, safeguarding and mandatory training.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

The occupational therapist was currently completing sensory integration training, which was important when working with young people with a learning disability or young autistic people.

Some staff were level 1 Makaton trained, which meant they were aware of signs and symbols for everyday situations.

The ward's speech and language therapist delivered specialist training to ward staff such as intensive interaction (this is a practical approach to interacting with people with learning disabilities who do not find it easy communicating or being social) and dysphagia training.

Managers recognised poor performance, could identify the reasons and dealt with these. At the time of the inspection, there were no staff being supported for poor performance.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care.

The art therapist led trauma informed formulated meetings to help the staff team look at what may have happened to the young person, including understanding any interpersonal difficulties.

There were weekly meetings between the occupational therapists, activities coordinators and gym instructor to ensure activities offered to young people were meeting their needs.

Staff attended the trust's learning disability effectiveness meetings. In these meetings staff discussed best practice, safe care, lessons learnt and serious incidents in other divisions.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. For example, external health and social care professionals attended young people's clinical review and forward thinking meetings.

There was monthly learning disability care quality meetings where staff reviewed incidents and serious incident action plans, and violence and aggression. This allowed staff to monitor themes and trends.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of the inspection, 86% of staff had completed mandatory Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of the inspection, 95% of staff had completed the mandatory Mental Capacity Act training.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered the their wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Is the service caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people. The young people we spoke with said they liked the staff and that they understood their needs.

Staff gave children and young people help, emotional support and advice when they needed it. The young people we spoke with were positive about the care and support they received from staff. One young person told us that during their time on the ward they had “learnt to be kinder to myself and to love myself”.

Young people told us that they felt safe on the ward. One young person told us that they rarely got bored on the ward and enjoyed activities such as boxing, drawing, cooking lessons, using the garden and going on community leave.

Staff supported children and young people to understand and manage their own care treatment or condition. One young person told us that the positive behaviour support had helped them.

Staff directed children and young people to other services and supported them to access those services if they needed help. We saw examples of staff supporting young people to access services for specialist physical health needs.

Children and young people said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each child or young person. Staff that we spoke with demonstrated a good understanding of each young person and their individual needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. Staff did not report any concerns in relation to abusive attitudes towards young people.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that children and young people had easy access to independent advocates and to child helplines.**

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission.

Staff involved children and young people and gave them access to their care planning and risk assessments.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties). For example, staff used pictures rather than words to communicate with young people who had communication difficulties. Doctors used easy read leaflets to inform young people about their medicines.

Staff involved children and young people in decisions about the service, when appropriate.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. This was mainly via weekly community meetings and multidisciplinary team meetings. We reviewed the last three community meetings minutes, which were well attended by young people and staff. Topics such as food and activities were discussed.

Staff supported children and young people to make decisions on their care. Staff often used resources with reasonable adjustments to help them understand information about their care and treatment. For example, easy read leaflets regarding their medicines, and the use of pictures during occupational therapy and psychological assessments.

Staff made sure children and young people could access advocacy services. There was an independent mental health advocate (IMHA) service which visited the ward once every two weeks. The IMHA provided support to young people such as attending their MDT and CPA meetings, and supporting them to understand their rights and discharge plans.

Child and adolescent mental health wards

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers appropriately. During the young person's first week of admission, carers are invited to the clinical review and forward thinking (CRAFT) meeting to discuss the admission, treatment goals and length of treatment. Carers are involved in their relative's care and treatment by being invited to multidisciplinary team meetings and care programme approach meetings. Staff also give carers regular updates via telephone calls.

Carers are given families and carers welcome packs which include information to access support.

We spoke with three carers during our inspection, which was largely positive. A carer told us that their relative had improved whilst at Crystal House, and staff were very welcoming and kept them informed.

Staff helped families to give feedback on the service.

The ward had two carer champions who provide information to carers about the trust carer's events.

Is the service responsive?

Inspected but not rated

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. However, sometimes young people had delayed discharges due to challenges in finding appropriate placements in the community.

Crystal House offered a service to young people aged 13 years up to their 18th birthday with a primary diagnosis of learning disability and/or pervasive developmental disorders with or without co-morbid mental health problems and significant impairment of behaviour requiring attention and or treatment. The service had clear exclusion criteria, for example, it was not suitable for young people without a primary diagnosis of learning disability.

The ward accepted referrals from tier 3 CAMHS, community learning disability services and tier 4 CAMHS. The matron received all referrals and discussed them with the multidisciplinary team for review.

Managers made sure bed occupancy did not go above 85%.

Young people were usually admitted from the North West London area. At the time of the inspection, one young person was admitted from outside of London.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. Staff completed a clinical review and forward-thinking meeting on admission that planned care and discharge.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned.

Staff did not move or discharge children and young people at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed, and took action to reduce them. In the last 12 months, the trust reported 1 delayed discharge. This delayed discharge was attributed to challenges in finding appropriate social care in the community. We saw evidence that staff were working hard to find an appropriate placement and were having weekly discharge meetings.

Mostly children and young people did not have to stay in hospital when they were well enough to leave, however, if there were delays these were mostly due to challenges in finding appropriate placements in the community.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well.

Staff supported children and young people when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make hot drinks and snacks at any time.

The ward corridors were quite narrow, and staff told us that it was not conducive for people with autism who would benefit from larger spaces. The narrow corridors meant the ward felt small and it was difficult for staff to walk side by side with the young people. We were told that the corridors were supporting walls for the building and therefore could not be moved. Staff told us that their mitigation was to consider the needs of young people at the point of referral and whether the current patient mix and environment would be appropriate.

Senior leaders were aware of this issue and had put forward capital bid projects to improve the ward environment in other ways. One improvement to the ward environment was the newly renovated sensory garden, which was designed to support sensory stimulation and regulation. For example, it contained a large swing, trampoline, and musical instruments. Young people told us they enjoyed spending time in the garden.

Each or young person had their own bedroom, which they could personalise.

Children and young people had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The young people admitted to the ward were required to take part in the education programme provided on-site. The teacher worked on the ward 2 days per week. The trust had a contract with the local education authority and the teacher also worked at a nearby school for children with learning difficulties. There was a designated schoolroom on the ward, but staff told us they felt it was a little small and only one young person could be accommodated at a time.

The service had quiet areas and a room where children and young people could meet with visitors in private.

Children and young people could make phone calls in private. Ward staff completed individual risk assessments regarding usage of mobile phones and iPads to ensure they were used safely. Young people were not able to use mobile phones on their own in their bedrooms.

The service had an outside space that children and young people could access easily. There was a spacious ward garden with a range of exercise and sensory equipment.

There was a programme of individual activities.

Children and young people could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education, and there was a teacher that worked on the ward 2 days per week.

Staff helped children and young people to stay in contact with families and carers. We saw that young people had regular contact with their families via visits in the community and telephone calls.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. We saw examples of staff accompanying young people in the community, such as walks in parks, visiting the cinema and playing football.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Some staff were trained in level 1 Makaton so they were able to use signs and symbols in everyday situations. Some staff were trained in intensive interaction, which supported communication with young people with learning disabilities. Staff adapted assessments and interventions so that young people with learning disabilities could understand them.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. Information was made available as easy-read.

Managers made sure staff, young people could get help from interpreters or signers when needed. We saw examples of an interpreter being used.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. For example, we saw that halal food was provided when requested.

Children and young people had access to spiritual, religious and cultural support. We saw that a young person was supported with Section 17 leave to spend Eid with their family.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. The ward's advocate was able to support young people with complaints if this was required.

The service clearly displayed information about how to raise a concern in patient areas.

In the last 12 months, the ward had not received any formal complaints. The ward manager told us they attempted to resolve any complaints on an informal basis in the first instance. If the ward manager was unable to find a local resolution they knew how to raise this as a formal complaint.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. In the last 12 months, the ward had received 17 compliments.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

Leaders, including the ward manager, had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the team was working to provide high quality care.

Child and adolescent mental health wards

Leaders were visible in the service and approachable for patients and staff. Staff told us that senior leaders often visited the ward.

Leadership development opportunities were available, including opportunities for staff below team manager level. For example, the trust had supported the ward manager to progress from a band 5 role to the ward manager role within 3 years. They were also encouraged to attend a leadership training programme in September 2023, to further support them in their new leadership role.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff knew and understood the provider's vision and values and how they applied in the work of their team. The values were compassion, respect, empowerment and partnership.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in the service. All staff that we spoke with were proud to work for the trust, and demonstrated compassion towards the young people they were caring for.

Staff had the opportunity to contribute to discussions about the strategy for their service. For example, staff member told us that they contributed to discussions around the ward layout, and made another lounge area so there were more areas that young people could be on their own if they wanted to.

Managers could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff were overwhelmingly positive about working on the ward. Staff told us that managers supported them to access further training to support them in their role. For example, a band 3 staff member had been supported to do assistant nurse training.

The trust invited staff to complete a survey to assess staff morale. Responses were reported across the learning disability service, rather than Crystal House. In the 2022 staff survey, there were 17 responses across the learning disability services, and they were mostly in line with the trust and divisional average. There had been no change since 2021.

Staff felt positive and proud about working for the provider and their team.

Staff felt about to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed. At the time of the inspection, there were no staff being monitored for poor staff performance.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how it could be supported.

Staff had access to support for their own physical and emotional health needs though an occupational health service. We saw an example of staff accessing the trust's occupational health service to support them with a physical health need.

The provider recognised staff success within the service – for example, through staff awards. The ward manager had been nominated for a trust star award for their work of supporting young people during an emergency.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. There were systems and procedures to ensure that wards were safe and clean, that there were enough staff, that staff were supervised and most were up to date with their mandatory training, that young people were assessed and treated well, that the ward adhered to the MHA and MCA, that beds were managed well, that discharges were planned, that incidents were reported, investigated and learnt from. However, not all staff who were required to, were up to date with their immediate life support training, These staff were due to complete the training in September 2023.

There was a clear framework of what must be discussed at a ward level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Minutes of these team meetings were emailed to the team, so all staff members had access to the information.

The matron attended health and safety meetings, and the professional nursing council and matron forum meetings to ensure oversight of key issues. The ward manager on Crystal House had weekly meetings with the ward manager of the adult learning disability ward to share learnings and best practice.

Senior leaders, including the ward manager, attended the trust's learning disabilities clinical effectiveness meetings, which covered topics such as incidents / physical intervention / rapid tranquilisation, learnings from incidents, bed management, and operational and estate issues.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. Such information was discussed at quarterly learning disability care quality meetings.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Audits included monthly care plan audits, infection control audits, medical device audits, S132 rights audits, and medication audits.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the young people. Staff often worked with young people's health and social care professionals in the community to support smooth discharges back into the community.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The ward manager did not have access to a risk register. The risk register was held at a service and directorate level. Senior leaders told us that they were working to ensure that the ward manager had access to the risk register.

Staff concerns matched those on the risk register. The learning disabilities risk register identified the lack of a psychologist in post despite recruitment efforts, and financial risk of not filling beds / future model of funding unclear.

Managers had oversight of the ward's performance via internal key performance indicators. This included information on bed occupancy, referrals, care plans, physical health assessments and risk assessments. In June 2023, 100% of young people had physical health assessments and risk assessments in place.

Information management

The service used systems to collect data from the ward and directorate that was not over-burdensome for frontline staff. Managers made quarterly data submissions to NHSE regarding staff recruitment, staff training and patient care.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff used a combination of paper and electronic records.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. They had an electronic dashboard, with key information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the young people. Managers from the service participated actively in the work of the local transforming care partnership.

Staff had access to up-to-date information about the work of the provider through the intranet, bulletins and regular team meetings. Young people had access to up-to-date information about the services they used through regular multidisciplinary team meetings and community meetings. Carers had access to up-to-date information about the services their relatives used via regular contact with ward staff and attending key meetings on the ward.

Young people had opportunities to give feedback on the service they used via regular community team meetings.

Young people and carers were offered to fill in easy read feedback forms.

Managers and staff had access to the feedback from young people, carers and staff and used it to make improvements.

Staff could meet with members of the provider's senior leadership team to give feedback. Senior leaders often visited the ward, and staff told us they were approachable.

Directorate leaders engaged with external stakeholders – such as commissioners.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.

The ward had recently taken part in a trust quality improvement (QI) project to improve staff supervision and appraisal. As a result of the QI project, the ward achieved a 100% supervision rate and were one of the highest performing teams for supervision and appraisal in the trust (In October 2022).

Crystal House was not part of any accreditation schemes. However, managers were in discussion about participating in the quality network for inpatient learning disability (QNLD).

Innovations were taking place in the service. The ward's occupational therapist had set up a sensory clinical network open to all allied health professionals to discuss best practice and were in the process of developing a sensory best practice guide.