Central and North West London NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICU) Stephenson House	Campbell Centre Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre Park Royal Centre for Mental Health St Charles Mental Health Centre The Gordon Hospital	RV3Y1 RV3AN RV383 RV312 RV320 RV346
Wards for older people with mental health problems	Beatrice Place Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre St Charles Mental Health Centre TOPAS Waterhall Care Centre	RV329 RV3AN RV383 RV320 RV3Y2
Wards for people with learning disabilities or autism	Kingswood Centre	RV3CA
Community based services for adults of working age	Stephenson House	RV3EE

Summary of findings

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Outstanding** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

After this most recent inspection we have changed the overall rating to **good** because:

- Following the last inspection In February 2015, the trust had implemented a comprehensive improvement plan.
- In February 2015, we rated one of the sixteen core service as inadequate and a further two of the sixteen core service as requires improvement. At this inspection we found the trust had worked to make improvements and the trust had taken action to meet the requirement notices issued following the February 2015 inspection.
- In February 2015, we recommended the trust should take a number of actions to improve services. At this inspection we found that the majority of recommendations had been met and improvements had been made.
- Following the this inspection, we have changed ratings of the following key questions from inadequate to requires improvement:
- the safe key question for wards for adults of working age and PICU
- Following the this inspection, we have changed ratings of the following key questions from inadequate to good:
- the responsive key question for adults of working age and PICU
- Following this inspection, we have changed ratings of the following key questions from requires improvement to good:
- the well led key question for wards for adults of working age and PICU
- the effective key question for wards for older people with mental health problems
- the caring key question for wards for older people with mental health problems
- the responsive key question for wards for older people with mental health problems
- Following this inspection we have changed the ratings for the following key questions from good to outstanding:
- the effective key question for wards for people with learning disabilities or autism
- the caring key question for wards for people with learning disabilities or autism
- the responsive key question for wards for people with learning disabilities or autism
- Following this inspection we have changed the rating of one core service from inadequate to good. This is the core service for wards for adults of working age and PICU.
- Following this inspection we have changed the rating of one core service from requires improvement to good. This is the wards for older people with mental health problems.
- Following this inspection, we have changed the rating for one core service from good to outstanding. This is the core service for wards for people with learning disabilities and autism.
- Following this inspection the rating for one core service remains as requires improvement. This is the core service for community services for adults of working age.
- We have not yet re-inspected the rehabilitation mental health wards and crisis services and health based places of safety. The requirement notices for these services will be checked at future inspections.
- We also carried out a 'well led' review and found that the trust had continued to strengthen its senior leadership team and refine the trust governance processes.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

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

- In February 2015, we rated two of the sixteen core services as requires improvement and one core service as inadequate. This led us to rate the trust as requires improvement overall for this key question. At this inspection three of the core service remained requires improvement for safe.
- In February 2015, we identified that staff were not completing physical health observations following administration of rapid tranquilisation medication on the acute wards for adults of working age and psychiatric intensive care units. At this inspection we found some improvements had been made though gaps and inconsistencies remained.
- The number of incidents of restraint taking place across the acute wards for adults of working age and PICU was significant and there were variation in the levels of restraint across hospital sites. In addition, despite the training in restraint being updated about 70% of the restraints were still in the prone position.
- Incident records of physical restraint on acute wards for adults of working age and wards for older people with mental health problems were not completed fully.
- Risk assessments for patients in the acute wards for adults of working age and PICU and community based mental health services for adults of working age were not always completed thoroughly to reflect current risks.
- Whilst staffing levels had improved, there were still areas of high staff turnover and this was impacting on the consistency of patient care especially in community based mental health services for adults of working age.
- Milton Keynes CMHT did not have arrangements to support staff and patient safety such as access to alarms for staff to call for assistance if needed.
- Mandatory basic life support for non-clinical staff and fire training completion rates were low in some community mental health teams.

However:

- At this inspection we have changed the rating for acute ward for adults of working age and PICU, from inadequate to requires

Summary of findings

improvement. This is because the service had addressed the problems with staffing levels, training for staff on safe restraint, seclusion recording and risk management of blind spots and ligature points on wards.

- Across the services inspected there were sufficient numbers of staff to deliver care. A programme of staff recruitment and retention was being implemented in the trust to work towards reducing staffing vacancies across services.
- The trust had made improvements to the safety of the wards for older people with mental health problems including ensuring gender segregation on took place, emergency resuscitation equipment was safely accessible, medicines were securely stored and staff were able to monitor and track safeguarding referrals.
- The trust had made improvements to the safety of the community based mental health services for adults of working age. These included ensuring that defibrillators and resuscitation equipment were checked and serviced across the community mental health teams.
- Patients received care in clean and hygienic environments.

Are services effective?

Good

We rated effective as **good** because:

- In February 2015, we rated two of the sixteen core services as requires improvement. This led us to rate the core service as good overall for this key question.
- We have changed the rating for this key question for the wards for older people with mental health problems from requires improvement to good. This is because In February 2015, we identified that physical health checks were not routinely being completed. At this inspection we found this had improved and an early warning score system was being used to support early identification of deterioration in physical wellbeing.
- Patients had comprehensive mental and physical health assessments in place.
- Patients with mental health needs were receiving improved support with their physical health.
- Staff understanding and application of the Mental Capacity Act had shown improvement.

However:

- We have not changed the rating for this key question for community services for adults of working age.

Summary of findings

- Care plans were not always reflect the patients identified needs in some of the community based mental health services for adults of working age.
- Patients were often not able to access any or sufficient psychology input which meant their treatment was not in line with best practice. Whilst the trust was working to introduce alternative arrangements for patients to access talking therapies, there was still more to do.

Are services caring?

Outstanding ☆

We rated caring as **outstanding** because:

- In February 2015 we rated the trust as outstanding for caring overall. Many of the services that were previously outstanding for caring at the last inspection were not inspected this time but there is no new information to suggest those ratings have changed.
- We have changed the rating for this key question for wards for older people with mental health problems, from requires improvement to good. This is because improvements had been made to maintain the privacy and dignity of patients, increase patient participation in care planning, and improve provision of personal lockable space for patients.
- Patients were treated with kindness, compassion and respect across the services we inspected.
- Patients and carers were supported to be involved in care decisions and also in the wider operation of the trust.
- Patients and carers were encouraged to give feedback about the services being delivered by the trust.

However:

- On the acute wards for adults of working and PICU and community mental health services for adults of working age care plans did not always include patient views and evidence of their involvement. The format and language used in care plans did not always support patients' involvement.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- In February 2015, we rated three one of the sixteen core services as requires improvement and on core service as inadequate for this key question. This led to an overall trust rating of requires improvement for this key question.

Summary of findings

- At this inspection we inspected the one core service previously rated as inadequate and one the core services previously rated as requires improvement.
- We have changed the rating for this key question for acute wards for adults of working age and PICU from inadequate to good. This is because improvements had been made to ensure patients had access to a bed when needed and patients could return to a bed after going on leave from hospital.
- We have changed the rating for this key question for wards for older people with mental health problems from requires improvement to good. This is because improvements had been made to the management of clinically inappropriate admissions to the wards.
- In February 2015, we recommended that the areas used by patients at Hillingdon West CMHT (Mead House) be refurbished. At this inspection, we found this had improved and refurbishment had been completed.

However:

- Whilst there was clear information displayed throughout the services visited to explain to patients and carers how to make a complaint, informal verbal complaints were not being recorded and so it was not possible to ensure these had been addressed or to look at themes and areas for learning.

Are services well-led?

Good

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

- In February 2015, we rated all but one of one of the sixteen core services as good for well led. The exception was wards for adults of working age and psychiatric intensive care units (PICU); which we rated as requires improvement for this key question. Following this most recent inspection, we changed the rating of well led for acute wards for adults of working age and PICU to good. This means that all seven community health core services and nine of the ten mental health core services are now rated as good for well led. The wards for people with a learning disability or autism are rated as outstanding for this key question.
- The trust had a skilled and experienced leadership team who were committed to providing high quality services.
- There were clear strategies in place which put the patients and carers at the centre of the work of the trust, whilst addressing the financial challenges.
- The leadership team were cited on the risks facing the trust and had robust action plans in place to address these areas.

Summary of findings

- Patients, staff and external stakeholders were actively engaged in the trust. Further developments in carer engagement were being promoted.
- The trust welcomed innovation and was introducing a systematic approach to quality improvement.

Summary of findings

Our inspection team

Team Leader: Our inspection team was led by Jane Ray, head of inspection, David Knivett, inspection manager and Rekha Bhardwa, inspector.

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

The team that inspected this service comprised nine CQC inspectors, two CQC inspection managers, one head of hospital inspection, two assistant inspectors, two pharmacy inspectors, three Mental Health Act reviewers, seven specialist advisors who had experience of working in acute and psychiatric intensive care units and three experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar mental health services.

Wards for older people with mental health problems

The team that inspected this service comprised four inspectors, one CQC inspection manager, two pharmacy inspectors, one Mental Health Act reviewer, five specialist advisors who had experience of working in wards for older people with mental health problems and five experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar mental health services.

Wards for people with learning disabilities and autism

The team that inspected this service was comprised three inspectors, one pharmacy inspector, two specialist advisors who had experience of working in wards for people with learning disabilities and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar mental health services.

Community services for adults of working age

The team that inspected this service comprised seven inspectors, two inspection managers, one pharmacy inspector, five specialist advisors two of whom were consultant psychiatrists and three nurses who had experience of working in community based mental health services for adults of working age.

Well Led Review

The team that completed a well led review comprised one head of hospital inspection, a CQC inspection manager, a CQC inspector, a Mental Health Act reviewer and a specialist advisor with experience of working at board level within an NHS trust.

Why we carried out this inspection

For this inspection we looked at the mental health core services which had been rated as inadequate or requires improvement at the last inspection. We also looked at one good core service to see if standards had been maintained. We did not inspect the community health services provided by the trust.

We undertook this inspection to find out whether Central and North West London NHS Foundation Trust had made improvements to their acute wards for adults of working age and the psychiatric intensive care units; wards for older people with mental health problems; wards for people with learning disabilities or autism; and community based services for adults of working age since our last comprehensive inspection of the trust, that we undertook in February 2015, where we rated the trust as **requires improvement** overall.

When we last inspected the trust In February 2015, we rated the **acute wards for adults of working age and the psychiatric intensive care units** as inadequate overall. We rated the core service as inadequate for safe, good for effective, good for caring, inadequate for responsive and requires improvement for well-led.

Following that inspection, we told the trust it must make the following improvements to the acute wards for adults of working age and the psychiatric intensive care units:

Summary of findings

- The trust must address the blind spots in the ward environment of St Charles MHC, Park Royal MHC and the Gordon Hospital to enable clearer lines of sight and reduced risks to patients and staff.
- The trust must ensure that staff working on the wards are able to articulate how they are assessing and managing the potential risks from ligature points for the patients using this service. The use of blanket restrictions must be reviewed and risks from ligatures managed to reflect the needs of the patients on the ward.
- The trust must ensure that staffing levels are adjusted to reflect the actual numbers of patients on the wards. This number must include those patients spending the day on the ward even if they are sleeping on another ward or at another hospital overnight
- The trust must implement the training of all staff in new restraint techniques to ensure that staff working together on wards are all trained in the same techniques and in line with current best practice on the use of prone restraint, to prevent injury to staff and patients.
- The trust must ensure that staff working on the wards are able to articulate how they are assessing and managing the potential risks from ligature points for the patients using this service. The use of blanket restrictions must be reviewed and risks from ligatures managed to reflect the needs of the patients on the ward.
- The trust must take further steps at the Gordon Hospital and other sites where acute inpatient services are provided to ensure that risks to detained patients from being absent without authorised leave are minimised
- The trust must ensure that records relating to the seclusion of patients provide a clear record of medical and nursing reviews, to ensure that these are carried out in accordance with the code of practice.
- The trust must take further steps at the Gordon Hospital and other sites where acute inpatient services are provided to ensure that risks to detained patients from being absent without authorised leave are minimised.
- The trust must ensure that, on admission to a ward, patients have a designated bed that is within the ward occupancy levels.
- The trust must ensure that staff always monitor and record physical vital signs in the event of the use of rapid tranquilisation until the patient is alert. They must improve medical reviews of patients receiving rapid tranquilisation to ensure patients are not at risk.
- The trust must promote the privacy and dignity of patients. Patients must be able to make calls in private. At the Campbell Centre patients in shared rooms must be able to attend to their personal care needs with an adequate level of privacy and dignity
- The trust must ensure that, on admission to a ward, patients have a designated bed that is within the ward occupancy levels.
- The trust must ensure that patients returning from leave have a bed available on their return to the ward. The trust must take steps to reduce the number of times that patients are moved to other wards to sleep for non-clinical reasons. Where it is unavoidable, staff must ensure that a thorough handover takes place to promote continuity of care. Patients must only be moved at reasonable times so that they are not adversely affected.
- The trust must ensure that information is available to inform patients how to make a complaint. They must ensure verbal complaints are addressed and, if needed, patients and carers have access to the formal complaints process.
- The trust must ensure that the acute wards for adults of working age are well led by having contingency plans in place for when the numbers of patients needing a bed increases above the beds available.

In addition we recommended the following actions:

- The trust should provide individual lockable space for patients to keep their possessions safe
- The trust should ensure that maintenance issues at Park Royal MHC are resolved in a timely manner.
- The trust should ensure that patients are not confined to bedrooms and that seclusion is implemented in accordance with the code of practice: Mental Health Act 1983.

Summary of findings

- The trust should address the sound of the alarms at St Charles MHC so that they are as least disruptive to patients as possible, and do not affect their wellbeing.
- The trust should improve the new multi-disciplinary care planning system to ensure that all disciplines record directly onto this. Nurses informed us that they make entries for other professionals following reviews of care. The expectation for nurses to do this is not in the spirit of the system and could lead to inaccurate professional judgements being recorded.
- The trust should ensure that male staff are interacting appropriately with female patients on Pond ward following a safeguarding investigation. Further support should be provided to staff to enable patients to approach any member of staff for support.
- The trust should ensure that staff encourage all patients to get involved in planning their care and treatment. This involvement should be clearly recorded.
- The trust should ensure that staff incorporate discharge planning into the care planning for patients so that care and treatment is recovery focussed.
- The trust should monitor the impact of bed management pressures and the ability of staff to facilitate patients' entitlement to take Section 17 leave off the ward.
- The trust should promote any staff and patient feedback processes so that all people have an opportunity to be involved in the trust.

When we last inspected the trust In February 2015, we rated the wards **for older people with mental health problems** as **requires improvement** overall. We rated the core service as requires improvement for safe, requires improvement for effective, requires improvement for caring, requires improvement for responsive and good for well-led.

Following that inspection, we told the trust it must make the following improvements to the wards for older people with mental health problems:

- The trust must ensure that Oak Tree ward and TOPAS comply with same sex accommodation guidelines to promote peoples safety, privacy and dignity.
- The trust must ensure that staff on Redwood ward at St Charles do not leave medication unsupervised in reach of patients.
- The trust must ensure that on Redwood ward at St Charles staff keep medication used for emergency resuscitation in one place so it is easily accessible in an emergency.
- The trust must ensure that at the TOPAS centre in Milton Keynes staff have access to a record of safeguarding alerts so they can know what action to take to keep people safe and learn from previous events.
- The trust must ensure that on Redwood ward people's physical healthcare checks take place as regularly as each patient needs to ensure their health is monitored.
- The trust must ensure that on Redwood ward primarily but also on other wards for older people, patients are supported to be dressed in a manner that preserves their dignity, have access to a lockable space to protect their possessions preferably their bedroom, have night time checks that are the least intrusive as possible, be able to close their observation panels in their door from inside their room and participate in the preparation of their care plan and have a copy where appropriate.
- The trust must ensure on Redwood ward that beds are only made available for patients' who are clinically appropriate for a service for older people.
- The trust must ensure that a bed is available for patients who are on leave in case they need to return to the ward.

In addition we recommended the following actions

- The trust should ensure staff working on wards for older people can clearly articulate how they are supporting patients to keep safe in terms of the ligature risks on the ward.
- The trust should ensure that at St Charles chairs with split covers are repaired or replaced and enough chairs are available so people can eat together.
- The trust should ensure that where actions are needed following environmental risk assessments, these are followed through.

Summary of findings

- The trust should review the layout at Beatrice Place to try and provide gender separation in terms of bathroom facilities.
- The trust should ensure on Redwood ward that risk assessments are updated following incidents.
- The trust should ensure staff have opportunities to discuss and learn from incidents across the trust and not just their site.
- The trust should ensure that Mental Health Act documentation is completed correctly for patients on TOPAS and Redwood ward to ensure people are being supported to understand their rights, their medication is authorized and their leave is approved.
- The trust should ensure that staff have been supported to have the training needed to support patients with their physical healthcare in line with the training provided at Beatrice Place.
- The trust should ensure that where patients are subject to a deprivation of liberty safeguard that the authorisations are kept under review and updated as needed

When we last inspected the trust In February 2015, we rated the wards for people with learning disabilities or autism as **good** overall. We rated the core service as good for safe, good for effective, good for caring, good for responsive and good for well-led. We did not issue any requirement notices to the core service.

In addition we recommended the following actions:

- The trust should ensure the recruitment of staff to work in the services both nursing and other allied professions continues to be a priority for the trust until posts are filled.
- The trust should ensure that care planning processes are individualised. Care plans should be in a format that is meaningful to that person, there should be a strong recovery focus and the care plans should be put into practice for each person.
- The trust should ensure that the service has accurate training records so that people's training needs can be identified and addressed.
- The trust should ensure that the service works with commissioners to make arrangements for a replacement independent mental health advocacy services at the Kingswood Centre and staff should know who to contact when this service is needed.
- The trust should ensure that activities on people's programmes happen in practice.
- The trust should ensure that patients receive the support they need to practice their faith if they wish to do so.

When we last inspected the trust In February 2015, we rated the community services for adults of working age as **requires improvemen**t overall. We rated the core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.

Following that inspection, we told the trust it must make the following improvements to the community services for adults of working age :

- The trust must ensure that where automated external defibrillators (AEDs) are provided because there is a clinical need for this equipment, for example at Hillingdon community recovery team (Pembroke Centre), that they are maintained on a regular basis, accessible, and available for use. The provider must ensure that other teams also have resuscitation equipment if needed.
- The trust must ensure that all patient risk assessments in Harrow community recovery team are comprehensive, detailed and thorough. They must be reviewed regularly and updated after incidents. There must be a personalised crisis plan in place for each patient.
- The trust must ensure there are sufficient staff available to work as care co-ordinators so that duty workers in some services are not holding large numbers of patients which could potentially create a risk for the safety and welfare of patients.
- The trust must ensure that patients using community services are referred for regular physical health checks.

In addition we recommended the following actions:

Summary of findings

- The trust should ensure that people using services have crisis plans that reflect their individual circumstances.
- The trust should support staff to learn about incidents from services in other parts of the trust so they can apply the lessons learnt to their work.
- The trust should ensure that where people using the service are being supported by a lead professional clinician that their care plans should aim to be more person centred.
- The trust should ensure that psychological therapies are available for patients using community based mental health that reflect NICE guidance.
- The trust should focus recruitment to fill posts where the vacancies mean that a team does not have internal input from a particular care professional.
- The trust should ensure that all staff in all services fully understand the Mental Capacity Act and code of practice.
- The trust should address with staff at the Harrow community recovery team how they approach and support patients with a personality disorder.
- The trust should ensure that the areas used by patients at Mead House (Hillingdon CRT) are refurbished so that it is a pleasant environment for patients to use.
- The trust should ensure that risk registers in Harrow and Hillingdon community recovery teams reflect all risks. Risk registers should be detailed, thorough and risk rated.

We issued the trust with **24** requirement notices that affected these four core services.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 12 Safe care and treatment

Regulation 17 Good governance

Regulation 18 Staffing

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Central and North West London Foundation NHS Trust and asked other organisations for information. We also attended a board meeting on 10th May 2017. We gave the trust one week notice prior to visiting core services.

We carried out a series of short notice announced visits to core services on the following dates:

Acute wards for people of working age and psychiatric intensive units – 3rd to 6th October 2016

Wards for older people with mental health problems – 30th January 2017 to 2nd February 2017

Wards for patients with learning disabilities or autism – 27th March 2017 to 29th March 2017

Community based mental health services for adults of working age – 8th May 2017 to 15th May 2017

We looked at information provided to us on site and requested additional information from the trust both immediately before and following the inspection visit relating to the services.

We also contacted Healthwatch groups and clinical commissioning groups to gather feedback on progress made since the last CQC inspection.

We also carried out a 'well led review' on the 15 and 18 May 2017 to look at any changes that had taken place in the leadership and governance of the trust since the previous inspection. This also involved receiving feedback from external stakeholders.

During the **five** inspection visits, the inspection team:

- visited 20 inpatient wards for adults of working age and PICU across six hospital locations

Summary of findings

- visited all six of the wards at the hospital sites for wards for older people with mental health problems
- visited two wards for people with learning disabilities or autism
- visited eight community mental health teams for adults of working age and one early Intervention Service in Brent, Hillingdon, Harrow, Westminster and Milton Keynes
- held a focus group with service directors and borough directors
- spoke with the managers for each of the teams and wards visited
- attended 5 bed management meetings
- accompanied eight home visits to see patients in their home settings
- spoke with 285 staff members; including doctors, nurses, occupational therapists, health care assistants, recovery and support workers, psychologists and peer support workers
- spoke with 45 carers or relatives of patients
- spoke with one continuing care lead for the local clinical commissioning group covering Beatrice Place in the wards for older people with mental health problems
- attended patient handover meeting and multi - disciplinary meeting
- spoke with 169 patients receiving care or treatment in services inspected
- reviewed 27 comment cards
- reviewed the arrangements for managerial supervision of staff
- looked at a range of policies, procedures and other documents relating to the running of the services and teams
- checked the arrangements for transporting medicines and recording stock medicines in the community teams.
- reviewed 224 patient care and treatment records
- reviewed 209 prescription charts
- attended seven handover meetings, 14 multi-disciplinary team meetings, four zoning meetings, 5 activity groups, one quality meeting, two patient community meetings
- interviewed members of the senior executive team including the chief executive, chief operating officer and director of nursing
- spoke with service directors and borough directors in the trust in a focus group meeting

The inspection looked at four mental health core services and we did not inspect the community health services provided by the trust.

Information about the provider

Central and North West London NHS Foundation Trust (CNWL) provides integrated health and social care services to a population of around three million people living in the South-East of England including London, Milton Keynes and Buckinghamshire. The trust has an annual income of £439 million, employs nearly 6500 staff who provide about 300 services from more than100 locations. Sixty per cent of the trusts services are provided in the community, in people's homes, clinics and schools. The trust also has specialist inpatient services for people needing intensive treatment. Services are provided to children and young people, adults of working age and to older people. CNWL was formed in 2002, following the merger of three mental health trusts. It became a foundation trust in 2007. Over the years additional contracts were awarded to the trust so it now provides mental health and community health services.

The mental health services provided by the trust are located mainly in the five London boroughs of Westminster, Kensington and Chelsea, Brent, Harrow and Hillingdon as well as Milton Keynes. The community services provided by the trust are located mainly in Camden, Hillingdon and Milton Keynes. Other services are provided outside these areas.

In addition the trust also provides health services in 17 prisons, young offenders institutions and immigration removal centres. These services were not inspected during this inspection but will be inspected jointly with HMI of prisons.

The trust works in a complex commissioning environment, with services commissioned on a local and national level. The trust has 28 locations registered with CQC.
CNWL locations have been inspected on 33 occasions at 18 of the locations

Summary of findings

The current inspection focussed on areas of non-compliance identified In February 2015. The most recent inspection took place between October 2016 and June 2017.We have re-rated the four core services that have been the subject of this most recent re-inspection and completed a 'well led review.'

What people who use the provider's services say

Overall, patients we spoke with during the inspection of services said that staff were kind, patient, compassionate and caring.

On the acute wards for adults of working and age and PICU, some patients said they did not always feel involved in their care planning. Patients told us they felt safe on the ward and there were enough staff present in ward environments.

On the wards or people with learning disabilities, patients we spoke with said that staff were respectful and professional. Patients spoke highly of the support they received from the advocate in making decisions around their care and treatment. Carers said staff fully involved them in decision-making, care planning and discharge planning.

On the wards for older people with mental health problems, The feedback from patients to tell us, family members and carers we received was overwhelmingly positive. They described staff as kind, caring, helpful and supportive.

Carers told us they were welcomed and supported on the wards and could attend carers meetings.

Patients and carers told us that they had been provided with a range of leaflets and other information and had good access to the recovery college and employment advisors.

Good practice

- The positive attitude of staff was very evident throughout the inspection. This was reflected in their pride in working for the trust and their service, and in their commitment to provide the highest standards of care to people using the service.
- The trust had recently implemented a quality improvement project (The Shine Project) to improve assessment and monitoring of physical health of patients receiving care and treatment in services. A patient held record and single physical and mental health assessment form were being rolled out across the trust as part of the physical health implementation strategy. The Shine project has been used as a case study of national best practice.
- On Oak Tree ward the consultant psychiatrist held a weekly open surgery which relatives and patients could attend with an appointment to discuss their care.
- The trust implemented a peer support worker programme, employing full time staff who had a lived experience of using mental health services. Peer support workers were employed in the wards for older people mental health problems and the acute wards for adults of working age and PICU.
- At Beatrice Place, the staff delivered a sensory stimulation group programme called Namaste. This evidence based programme focused on meeting the physical and emotional needs pf patients through meaningful activity which in turn decreases distress and resulting behavioural problems.
- On the wards for people with learning disabilities or autism, staff developed and used personalised communication tools for each patient such as the use of photographs to put together booklets to support patients with different aspects of their care such as planning for discharge and intensive interaction.
- On the wards for people with learning disabilities or autism, patient-led care programme approach

meetings took place where people were involved in chairing their care programme approach meetings, and supported with their preferred communication method.

- On the wards for people with learning disabilities or autism patients going out into the community were provided with an easy read crisis card which could be carried in their pocket. This provided essential information about them and details of people that could be contacted in the event of a crisis.
- The provider used the peer network through the Royal College of Psychiatrists' quality network for Inpatient Learning Disability Services to drive improvements. Preston ward met 100 percent of the standards in their annual peer review in February 2017.

Areas for improvement

Action the provider MUST take to improve

Action the trust MUST take to improve the acute wards for adults of working age

- The trust must ensure that physical observations following rapid tranquilisation are consistently carried out and recorded.
- The trust must take further action to reduce the number of incidents of prone restraint and the use of restraint across the service and also reduce the variations in the use of restraint between different trust locations
- The trust must ensure that risks to patients are identified and the risk management plans must contain sufficient information on the risk and how the risks are managed. These risk management plans must be easily accessible for staff.
- The trust must ensure that all records of physical restraint of patients comply with the policies and procedures of the provider.

Action the trust MUST take to improve the wards for older people with mental health problems

- The trust must ensure that all staff on wards for older people with mental health problems have an understanding of the trust policy on reporting incidents and reporting restraint so that incidents are recorded and the trust can monitor the levels of restraint to have an understanding of the quality of care.

Action the trust MUST take to improve community based mental health services for adults of working age

- The trust must ensure that staff working in the Milton Keynes CMHT have access to an appropriate alarm system.
- The trust must ensure that risk assessments are comprehensively completed and reviewed.
- The trust must ensure that all non-clinical staff undertake basic life support training and all staff undertake fire safety mandatory training to enable them to fulfil the requirements of their role.
- The trust must ensure that each patient has a care plan which is person-centred and that needs identified in the care plan are met or there is a clear indication of why they cannot be met.
- The trust must ensure that patients in the service have access to psychological therapies in line with best practice guidance.
- The trust must ensure that care co-ordinators regularly contact patients on their caseloads.

Action the provider MUST take to improve the long stay / rehabilitation mental health wards for working age adults which have not yet been re-inspected

- The trust must ensure in all the rehabilitation services that information is available to inform patients how to make a complaint. They must ensure verbal complaints are addressed and if needed have access to the formal complaints process and that learning also includes verbal as well as written complaints.

Action the provider MUST take to improve mental health crisis services and health based places of safety which have not yet been re-inspected

Summary of findings

- The trust must ensure that when a person is assessed as requiring an inpatient bed that they are able to access a bed promptly.
- The trust must ensure that the access to the trust's places of safety promotes the patients' dignity and privacy by the provision of a separate entrance.
- The trust must ensure people's private conversations cannot be overheard in adjoining interview rooms at St Charles hospital.

Action the provider SHOULD take to improve

Action the trust SHOULD take to improve the acute wards for adults of working age

- The trust should ensure that 'blanket' restrictions are reviewed regularly on the acute wards to ensure where possible that patients had access to quiet rooms, outside spaces, snacks and hot drinks.
- The trust should collate information on the numbers of patients on the acute and PICU wards where planned escorted leave is postponed.
- The trust should ensure that information on incidents and learning from incidents across the PICU wards is shared with all the hospital sites, so that this information can be used to improve all the wards. The trust should ensure that the records of team meeting minutes on the PICU wards reflect the discussions regarding incidents.
- The trust should ensure that staff complete the planned mandatory training on fire safety and intermediate life support.
- The trust should ensure that patients are fully involved in the planning of their care and that care plans are recovery focused.
- The trust should ensure that where wards support patients who have a learning disability or autism that staff have received training on how to meet their needs.
- The trust should ensure that MEWS records are monitored and appropriate action taken in response to changes in patient's physical health.
- The trust should ensure that handover information is communicated to the health care assistants working at the Campbell Centre.
- The trust should ensure that staff treat patients with appropriate levels of dignity and respect, including when staff wish to enter patients' rooms.
- The trust should ensure that ward information leaflets on Caspian ward provide accurate information about any restrictions that are in place.
- The trust should continue to monitor and reduce the number of patients waiting more than four hours for an inpatient bed especially out of hours.
- The trust should continue to monitor and ensure that discharges from acute and PICU services are planned and the length of time for any delays for discharge is reduced.
- The trust should ensure that feedback provided by patients is responded to in a timely manner.
- The trust should ensure that food provision meets patients' individual cultural, religious and dietary needs.
- The trust should ensure that all facilities meet the needs of patients, including the provision of faith rooms and appropriately furnished and decorated lounge areas.
- The trust should ensure that there are sufficient activities available for patients to participate in at weekends to appropriately support their recovery.
- The trust should ensure that systems to records verbal complaints and any responses are implemented.
- The trust should ensure that the modified early warning score system is used to monitor the physical health of patients in the acute services

Action the trust SHOULD take to improve the wards for older people with mental health problems

- The trust should ensure that the ligature risk assessment on TOPAS ward includes details of the ligature points in the garden and the steps taken to mitigate these risks.
- The trust should ensure that an overall environmental risk assessment is completed on Redwood and Kershaw wards.
- The trust should ensure that arrangements are in place to share learning from incidents across all the wards to inform and improve practice.

Summary of findings

- The trust should consider the impact of using medicines charts which do not specify times on people whose medicines require exact dose timings or intervals and act accordingly.
- The trust should ensure that there is adequate staffing to enable staff members to take breaks without disrupting the delivery of care and that patients have regular one to one time with a staff member.
- The trust should continue to ensure that supervision is provided regularly for staff in line with trust policy and that the system for recording and monitoring supervision is embedded across the service.
- The trust should ensure on TOPAS ward that there is a sign on the door stating that informal patients can leave the ward.
- The trust should ensure that patients on Redwood ward and at Beatrice place have timely access to psychology input.
- The trust should ensure that care plan audits have an action plan with timescales in place when shortfalls are identified.
- The trust should ensure that capacity assessments are completed fully and include details of the decision and the discussion with patients to assess the level of capacity to make a specific decision.
- The trust should ensure that all relevant staff have an understanding of the deprivation of liberty safeguards and ensure that the correct legal status of patients is reliably recorded in patient's records.
- The trust should ensure that the ward environments are adapted to meet the needs of patients with dementia and cognitive impairment.
- The trust should ensure that care plans, menu and other information is provided in easy read and pictorial formats to support people with dementia and cognitive impairment.
- The trust should ensure that informal complaints are logged and that a system is implemented to ensure that relatives receive an update or feedback from informal concerns or complaints raised.

Action the trust SHOULD take to improve the wards for people with learning disabilities:

- The trust should ensure that timescales are included in the risk register for the replacement of wooden beds.
- The trust should review how it records and monitors its training requirements relating to the Mental Health Act

Action the trust SHOULD take to improve community based mental health services for adults of working age

- The trust should continue to ensure that lone working practices in the North Kensington and Chelsea and Milton Keynes CMHTs are followed.
- The trust should continue to focus recruitment strategies in the areas where there are the highest need of permanent staff particularly for nurses and social workers to work towards a more stable staff teams especially in Brent and Hillingdon.
- The trust should support patients to have crisis plans and contact details that reflect their individual needs.
- The trust should ensure that safeguarding referrals in the Milton Keynes CMHT are tracked so that progress of alerts, investigations and outcomes are known.
- The trust should ensure that locum staff and new permanent staff, especially in Brent have prompt access to essential patient record systems to perform their roles.
- The trust should ensure that patient rights are explained consistently when patients are on a CTO in accordance with the MHA Code of Practice.
- The trust should ensure that privacy issues identified in the reception area at the East and West Harrow CMHTs are addressed.
- The trust should ensure that patient involvement is clearly recorded in the care records and each patient provided with a copy of their care plan.
- The trust should continue to work at reducing the average referral to assessment time.
- The trust should ensure that all audits have an action plans to address any shortfalls identified.
- The trust should ensure that agreements are in place with local GPs in Brent so that patient discharges are not delayed.

Summary of findings

- The trust should continue to ensure that patients waiting for an assessment or their first appointment are engaged with and monitored to support their risk management.
- The trust should ensure that casework discussions are detailed in staff supervision records.

Action the trust SHOULD take to improve the long stay / rehabilitation mental health wards for working age adults which have not been re-inspected

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

Action the provider SHOULD take to improve mental health crisis services and health based places of safety which have not been re-inspected

- The trust should ensure the building work to make the Gordon Hospital places of safety is completed.
- The trust should ensure people's risk assessments are updated on the trust's electronic records system to accurately reflect their changing risk.
- The trust should review arrangements for lone working to ensure that all teams have robust systems in place.
- The trust should ensure that where appropriate, staff record when they have assessed a person's capacity to make a decision within the written records.
- The trust should ensure that teams consider ways to collect regular feedback from people who have used their services.

Central and North West London NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

- The trust had clear structures and procedures for monitoring the administration of the Mental Health Act administration. Policies were reviewed and a range of sub groups monitor the day to day functioning of Mental Health Act activity.
- Despite the large size of the trust, the mental health law team were able to visit inpatient sites and also spend time in community settings. The director of nursing is the executive lead for mental health law and oversees the work of the mental health law team.
- A yearly Mental Health Act performance report was presented to the board by the mental health law group. This included an analysis of trends over the past year, but also recorded incidents of unlawful detentions, unlawful treatment, and problems with MHA assessments.
- Detention paperwork was generally filled in correctly, was up to date and was stored appropriately.
- There was a good adherence to consent to treatment and capacity requirements and copies of consent to treatment forms were mostly attached to medication charts where applicable.
- Within all of the wards and teams visited we found that people had access to Independent Mental Health Advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust provided a statutory mental health law training course all staff working in clinical settings. This included training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.
- The trust had an up to date policy on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- There was a trust wide MCA lead and also leads in different services to support staff as needed.
- Adherence to the MCA was monitored through the Mental Health Law group which provided a governance process. This looked at the results of audits and considered new methodology as needed.
- The administration of Deprivation of Liberty Safeguards under the Mental Capacity Act was managed by the safeguarding and Mental Capacity Act leads, who reported to the head of social work and social care.

Detailed findings

- Staff working in the wards for people with learning disabilities or autism displayed an excellent understanding of the Mental Capacity Act. During the inspection we consistently observed examples of staff understanding the needs for gaining consent and supporting patients to make their own decision where possible.

Requires improvement

Are services safe?

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

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

Summary of findings

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

- In February 2015, we rated two of the sixteen core services as requires improvement and one core service as inadequate. This led us to rate the trust as requires improvement overall for this key question. At this inspection three of the core service remained requires improvement for safe.
- In February 2015, we identified that staff were not completing physical health observations following administration of rapid tranquilisation medication on the acute wards for adults of working age and psychiatric intensive care units. At this inspection we found some improvements had been made though gaps and inconsistencies remained.
- The number of incidents of restraint taking place across the acute wards for adults of working age and PICU was significant and there were variation in the levels of restraint across hospital sites. In addition, despite the training in restraint being updated about 70% of the restraints were still in the prone position.
- Incident records of physical restraint on acute wards for adults of working age and wards for older people with mental health problems were not completed fully.
- Risk assessments for patients in the acute wards for adults of working age and PICU and community based mental health services for adults of working age were not always completed thoroughly to reflect current risks.
- Whilst staffing levels had improved, there were still areas of high staff turnover and this was impacting on the consistency of patient care especially in community based mental health services for adults of working age.
- Milton Keynes CMHT did not have arrangements to support staff and patient safety such as access to alarms for staff to call for assistance if needed.
- Mandatory basic life support and fire training completion rates were low in some community mental health teams.

However:

- At this inspection we have changed the rating for acute ward for adults of working age and PICU, from inadequate to requires improvement. This is because the service had addressed the problems with staffing levels, training for staff on safe restraint, seclusion recording and risk management of blind spots and ligature points on wards.
- Across the services inspected there were sufficient numbers of staff to deliver care. A programme of staff recruitment and retention was being implemented in the trust to work towards reducing staffing vacancies across services.
- The trust had made improvements to the safety of the wards for older people with mental health problems including ensuring gender segregation on took place, emergency resuscitation equipment was safely accessible, medicines were securely stored and staff were able to monitor and track safeguarding referrals.
- The trust had made improvements to the safety of the community based mental health services for adults of working age. These included ensuring that defibrillators and resuscitation equipment were checked and serviced across the community mental health teams.
- Patients received care in clean and hygienic environments

Our findings

- The environments were clean and well maintained across the core services inspected. The services we inspected adhered to infection control procedures and measures were in place to minimise the spread of infection.

Requires improvement

Are services safe?

- Across the environments used by community mental health services for adults of working age there were appropriate access arrangements with intercoms operated by reception staff to keep the clinic areas safe for patients and staff.
- In February 2015, we identified that where automated external defibrillators (AED's) where provided, that they were not always correctly maintained and checked. This was a particular concern at the Pembroke Centre at the Hillingdon community recovery team. At this inspection we found this had improved. All of the teams had an automated external defibrillator which was serviced regularly.
- In February 2015, we recommended the trust should ensure that maintenance issues at Park Royal MHC in the acute wards for adults of working age were resolved in a timely manner. At this inspection we found this had improved and response to maintenance issues was prompt.
- In February 2015, we identified that there were a number of blind spots in the wards in the acute wards for adults of working age. At St Charles Mental Health Centre, Park Royal Mental Health Centre and the Gordon Hospital the wards did not have a clear line of sight to safely observe patients. At this inspection we found that improvements had been made in this area. The trust had improved the physical environments of the wards. Risks to patients and staff had been mitigated by the use of mirrors, staff observations and individual risk management of high risk patients. Some wards also had CCTV installed in communal areas.
- In February 2015, we found that although numerous ligature risks had been identified. On the acute wards for adults of working age and wards for older people with mental health problems staff were not able to articulate the measures being taken to manage these risks for the patients using the service. At this inspection, we found that improvements had been made. The trust had implemented a ligature competency assessment, which staff completed annually. This provided annual updates for staff on the awareness and management of ligature risks. This competency assessment was also completed by bank and agency staff, ensuring consistency of training across all staff groups.
- In addition, the trust had carried out extensive work to reduce the number of ligature points on the wards. On Pond and Shore wards maps indicating the position of potential risks were placed in the staff office to remind staff of their location, including temporary staff who were less familiar with the environment. Work to reduce the presence of ligature risks within the wards for older people with mental health problems had also been undertaken since the last inspection.
- In February 2015, we recommended the trust improve the environment on the wards for older people with mental health problems. In particular the chairs which were split and broken should be repaired or replaced, and enough chairs should be available so people can eat together. At this inspection we found this had improved and the furnishings had been replaced and were suitable for use. In addition the seating arrangements allowed patients to eat together.
- The wards for people with learning disabilities or autism were clean, well-furnished and welcoming. The trust was completing a programme of renovation of the wards. The ward risk register had identified two wooden beds which required replacing. However there was no timescale or action plan for this work to be completed. This identified risk was not being sufficiently mitigated with a plan for replacement furniture.
- Environmental risk assessments were not completed fully on some of the wards for older people with mental health problems. On Redwood and Kershaw wards despite mirrors being installed some blind spots remained on the ward. In addition on Kershaw ward risks associated with bin liners had not been identified on environmental audits. On TOPAS ward, the risk assessment of the garden was insufficient. It stated there were various ligature points identified but contained no subsequent actions. There was no overall environmental risk assessment for TOPAS
- In February 2015, we identified on the wards for older people with mental health problems that Oak Tree and TOPAS wards did not comply with the guidance on same sex accommodation. At this inspection we found that improvements had been made. At Oak Tree ward there was gender separation for five single bedrooms. On TOPAS ward, we found that, as far as possible, men and women had bedrooms on separate corridors. Also at Beatrice Place the trust was managing admissions to

the unit to ensure that male and female patients were separated. At Beatrice Place male patients were accommodated on the ground floor and female patients accommodated on the first floor.

- Personal alarm systems and nurse call alarm systems were accessible across most of the core services which were re inspected. However in the community based mental health services for adults of working age, Milton Keynes CMHT did not have a personal alarm system for staff to use. There were no fixed wall alarm system in rooms which patients would meet with staff. This posed a risk to the safety of staff and patients, who would find it hard to call for help in an emergency.

Safe Staffing

- The trust continued to face ongoing challenges in the recruitment and retention of staff. The trust had an active recruitment and retention strategy. This included improving how it attracted potential staff through targeted recruitment schemes. Ideas being put into practice were working with the universities to attract nursing students, engaging with local communities to attract staff and national & international recruitment. The trust was also introducing financial assistance including 'golden hellos' and help for staff who were relocating. The trust also attracted staff through offering opportunities for learning and development. For example nurses were being offered the opportunity to rotate between different roles to develop their experience and there were 175 nurses on this programme. They were also supporting non-qualified staff to develop skills and competencies to assume expand and diversify roles in care delivery within services.
- The services used bank and agency staff to cover vacant posts. Where temporary staff were used, the trust tried to use regular staff who had received an induction to maintain the consistency of care as much as possible.
- In February 2015, we identified that staffing levels on the acute wards for adults of working age needed to be adjusted to reflect the actual numbers of patients on the wards including patients spending the day on the ward, even if they were sleeping elsewhere overnight. At this inspection we found that improvements had been made. Ward managers planned and reviewed the staffing skill mix to ensure patients received safe care and treatment. Each ward had a minimum of qualified and unqualified staff on duty. Staffing was determined by the number of patients on the ward and their assessed needs.
- In February 2015, we identified male staff were reluctant to interact with female patients on Pond ward, an acute ward, following a safeguarding investigation. In February 2015, we recommended further support should be provided to staff to enable patients to approach any member of staff for support. At this inspection we found this had improved and staff were receiving support when working in challenging situations.
- In February 2015, we recommended that the trust should monitor the impact of bed management pressures on the cancellation of patient leave. At this inspection we found this had partially improved. On the acute wards for adults of working age there were enough staff to facilitate planned leave from the ward. Staff prioritised patient leave and if leave was cancelled it was recorded as an incident. However on the PICU wards we received feedback from patients and staff that scheduled leave was often cancelled or postponed due to staffing shortages. However on these wards data was not collated on the number of occasions this occurred. Further work was needed to monitor any cancellation of planned leave to support the identification of where improvements were needed.
- Across the wards for older people with mental health problems we identified ward managers could source additional staff if there was an increase in patient needs or for increased levels of observations. However, the staff we spoke to on the inspection told us that when the ward required additional staff it was often due to high levels of need and patient risk. When working in these situations staff often did not have time to take a break during their working hours. On Ellington ward staff reported that regular one to one session with patients did not happen as often as they would like due to staffing pressures.
- In February 2015, we recommended in the wards for people with learning disabilities or autism that the recruitment of staff, both nursing and other allied professions, should continue to be a priority for the trust. At this inspection we found this had improved.

The trust was ensuring sufficient numbers of staff were in post to deliver patient care in a way that was safe and effective. There was an ongoing recruitment process to fill staff vacancies across the service.

- The trust had re-designed the community mental health services for adults of working age in March 2016. Staffing was a challenge and there were high levels of vacancies across the service. At our inspection in February 2015 we identified that there were insufficient staff available to work as care co-ordinators, which meant that duty workers in Harrow, Brent and Hillingdon CMHTs were responsible for supporting a significant number of patients. At this inspection we found that this was not the case and duty workers did not have appointments or assessments with their regular patients when they were on duty so that they could concentrate solely on urgent and duty enquiries.
- Staff in all the community mental health teams told us that staff turnover was a particular challenge, particularly as some locum staff did not stay in the team for a long period, leading to increased disruption. This sometimes impacted on care delivery. Some of the feedback from staff in the Brent CMHTs included concerns for patients when there were a lot of changes in care co-ordinators. At the North and South Brent CMHTs we heard that this was impacting on the regularity of contact with patients. We asked the trust to provide information about how many patients allocated within the service had not had any contacts with the Brent CMHTs for over 4 months. In Brent, 19% of patients had had no contact with the team for over 4 months and 62% of patients had their last contact with the team between 1 and 3 months previously. A contact included visits for routine depot injections and medical review meetings as well as regular meetings with a care coordinator. This meant that some patients had not had regular contact with a care co-ordinator for a significant period of time. The Brent operational policy for adult community mental health teams indicated that there is an expectation that all people being held either on CPA or with a lead professional, would be seen a minimum of once a month. This meant that for the majority of patients, this was not the case and people were at risk of not having their assessed needs met. Staff also described the difficulties of keeping records up to date due to the volume of work.
- Across the acute wards for adults of working age and PICU the average completion rate for mandatory training was 85%. At this inspection we identified that training for intermediate life support (2 year training) was below 40% and inpatient fire safety training was below 65%. These areas had been identified and were being monitored by the trust. Where staff had not attended mandatory training they had been booked for the next available course. The trust operated an electronic system to track and monitor training completion rates.
- In February 2015, we recommended that the wards for people with learning disabilities or autism should have accurate records of training so that people's needs can be identified and addressed. At this inspection we found this had improved. Staff were up to date with their mandatory training. The overall compliance rate for mandatory training for this core service was 97%
- Across the community based mental health services for adults of working age on the 1 May 2017, the mandatory training compliance was 89% against the trust target of 95%. However we found that at North Kensington and Chelsea, Hillingdon North and Harrow CMHT's basic life support training was below 75% which meant that there was a risk that staff may be in situations where they need to provide immediate support and their training would not be up to date.

Assessing and managing risks to patients and staff

- In February 2015, we identified that all staff required training in new restraint techniques to ensure that staff working together on acute wards for adults of working age and PICU were all trained in the same techniques and in line with current best practice on the use of prone restraint, to prevent injury to staff and patients. At this inspection we found that improvements had been made. Staff received training in restraint. The majority of staff on the wards had undertaken training in supine restraint and de-escalation techniques with new staff booked to undertake this. Staff we spoke with had a good understanding of the use of preventative strategies and that physical intervention was a last resort.
- On the acute wards for adults of working age and PICU and the wards for older people with mental health problems there were inconsistencies in the recording of physical restraints. Physical restraint records were not

always completed fully. This included information on the numbers and identity of staff involved and the length of restraint. Further work was required to ensure that the recording of restraint was comprehensive, clear, detailed and reflected trust policy.

- The trust had introduced a restrictive practice working group which continually reviewed the use of restrictions and restraint across the trust. The trust recognised that there were significant variations in the use of restraint across the trust and that there needed to be a particular focus on the inpatient services with higher levels of restraint. The trust had set a target of reducing the use of prone restraint by 50% across all services by June 2016. They had achieved a 30% reduction and recognised there was more to do. A number of initiatives were taking place including the ongoing updated training, looking at alternative ways to administer injected medication, ensuring debriefs took place after the use of restraint and reviewing the data on restraint.
- In February 2015, we identified that monitoring of vital signs was not always maintained until the patient was alert following the use of rapid tranquilisation (RT) on the wards for adults of working age and PICU. At this inspection we found that some improvements had been made but there were still gaps in the recording of post RT physical observations. We identified inconsistencies in completion and recording of physical health monitoring following rapid tranquilisation at St Charles mental health centre and the Campbell Centre. This meant that the monitoring of physical health observations post rapid tranquilisation was still not safely and consistently carried out across this service. This was a continuing breach of regulation.
- Between March 2016 and 27 September 2016, there were 174 incidents of the use of seclusion across the acute ward for adults of working age. The highest use of seclusion was on Pond, Pine and Shore wards at Park Royal MHC.
- In February 2015, we recommended in the acute wards for adults of working age, the trust should ensure that patients were not confined to bedrooms and that seclusion was used in accordance with the code of practice: Mental Health Act 1983. At this inspection we found this had improved. Staff were appropriately identifying the seclusion of patients
- In February 2015, we identified on the acute wards for adults of working age and PICU that the monitoring and reviewing of secluded patients was not always taking place. At this inspection we found this had improved. We reviewed seclusion records and found that overall staff had appropriately monitored and reviewed the care of secluded patients. Staff kept seclusion records in a secure and appropriate way.
- Between 27 March 2016 and 27 September 2016, there were 2 incidents of the use of long-term segregation across the acute wards for adults of working age. These were both on Pond ward. Staff had completed the necessary safeguards and checks during periods of long term segregation.
- In February 2015, we identified a number of detained patients were absconding from acute wards for adult of working age and PICU. At this inspection we found this had improved significantly and the number of patients absconding from the acute wards for adults of working age and PICU had reduced. The trust had implemented measures to address this risk. For example, wards had signs reminding all people leaving the wards to look behind them before opening the door to the ward and, having passed through it to wait for it to sound closed properly before moving away. At St Charles MHC, the trust had implemented a lock down mechanism that that could be activated by ward staff. This enabled the main entrance doors to the unit to be locked down. Further work had been identified at the Riverside MHC as there had been an increase in the number of patients leaving the wards without leave prior to this inspection. The trust was continuing to review and implement measures to minimise the absconding of patients from the acute inpatient wards.
- At this inspection we identified some use of blanket restrictions on the acute wards for adults of working age and PICU. The kitchen area at the Campbell Centre was locked between midnight and 6am as potential ligature risks had been identified. This had the consequence that patients were unable to make hot drinks during these times. Also on Caspian ward information leaflets provided to patients about restricted items were inaccurate and gave patient the wrong impression about which personal items were restricted.
- At this inspection personal alarm systems for staff to use were in place across the core services inspected.

However, in the community based mental health services for adults of working age, lone working protocols were not being robustly implemented. North Kensington and Chelsea CMHT was not monitoring the daily movements of staff conducting home visits. Milton Keynes CMHT did not have a lone working protocol, and there was no robust system to monitor staff movements and provide any safeguard. Following the inspection prompt actions were put in place ensuring the duty team monitored the movements and activities of staff on a daily basis. Further work was needed to improve this area of safety in community based mental health services.

- At this inspection we looked at the availability and content of patient risk assessment across the four services inspected. There was variation in the quality of risk assessments across the services inspected. For example on the acute wards for adults of working age we found occasions where risk management plans were vague and lacked important guidance following risk assessments.
- In February 2015, we identified the trust must ensure all patient risk assessment in Harrow community recovery team were comprehensive, detailed and thorough. In addition they should be reviewed regularly. At this inspection we found this had improved. However, in North Kensington and & Chelsea and Brent CMHTs further improvements were needed.
- In February 2015, we recommended risk assessments should be updated following incidents on Redwood ward which is a ward for older people with mental health problems. At this inspection we found that risk assessments were being updated regularly following incidents across this core service risk was routinely discussed and reviewed during multidisciplinary team meetings. Risk assessment where multifactorial including health and social care needs of older people.
- The trust had systems in place to safeguard patients from abuse. Across the four services which were inspected, staff were aware of how to escalate and report safeguarding concerns, and were aware of local process in the service areas to raise safeguarding alerts. However, staff at the Milton Keynes CMHT did not have arrangements in place to track the number of safeguarding concerns raised with the local authority, the progress of alerts, investigations and outcomes.
- In February 2015, we found that staff at the TOPAS centre, in the wards for older people with mental health problems did not have access to a record of safeguarding alerts. At this inspection, we found that improvements had been made. The service had introduced a safeguarding log which clearly showed all the incidents that had been reported, the progress of any investigation and the outcome of completed investigations.
- The trust had robust pharmacy arrangements to ensure service users were protected against the risks associated with the inappropriate treatment of medicines. We found that care and treatment was provided in a safe way for service users and medication was stored safely.Medication incidents were reported and the trust safe medication practice group produced a medication safety bulletin published quarterly with the aim of increasing awareness and promoting learning from medicines incidents. The trust completed an annual safe handling of medicines audit across all locations.
- In February 2015, we found on Redwood ward for older people with mental health problems service, that the medicine trolley was left unlocked and medicines had been left where a patient could have picked them up. In addition on Redwood ward drugs to be used for emergency resuscitation were not stored together. At this inspection, we found that improvements had been made.
- Across the trust approximately 770 community patients were prescribed clozapine. Each CMHT had a local clozapine clinic run by a community mental health nurse. At these clinics there was a point of care testing which meant there were instant blood test results so patients did not have to return for a second time to collect their medication. Appropriate arrangements were in place for the dispensing and collection of clozapine across these services. Each CMHT also ran local depot medicines clinics. Since January 2017 the use of electronic prescriptions had been fully implemented for these clinics. Each prescription was valid for 6 months and was clinically checked by a pharmacist.
- However at this inspection we identified the trust medicines prescription charts used on the wards for older people with mental health problem did not

specify times for medicines administration. This meant that there was a potential risk that a patient could receive medications too close together and not within prescribed frequency of administration.

- In February 2015, we recommended that risk registers in Harrow and Hillingdon community recovery teams should reflect all risks. Risk registers should be detailed, thorough and risk rated. At this inspection we found this had improved. Risks were recorded, scored and rated according to severity, and there was evidence of some review of risks. Overall, team managers were familiar with the local risk areas for their teams and risks were reviewed and monitored at a local level.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report incidents using the trust incident reporting system. We found there was a positive incident reporting culture across the trust. An example of this was in the learning disability services where there were a high number of incidents due to the challenges presented by the patients and the staff understood the importance of reporting and learning from the incidents.
- Lessons learned from incidents were shared with staff and led to improvements in the care and treatment provided. The trust communicated information about serious incidents and learning from incidents through variety of mechanisms. Staff received updates through team meetings, email bulletins and notifications on the trust intranet.
- In most areas staff were able to describe changes in every day practice following learning from incidents. However, we also found that learning was not always shared across similar services in different geographical areas such as across the PICUs and some wards for older people with mental health problems. We also found that for community mental health services, that where a patient died in a care home or was receiving care from other providers, the sharing of the investigation work and learning across providers did not always work well. This meant that opportunities for identifying improvements to services could be missed.
- Staff had the opportunity to debrief after incidents. On the wards for people with learning disabilities or autism staff were supported with debriefing following incidents. These debrief sessions also included patients who were supported with debriefing using pictorial aids and assist with communication. This demonstrated a positive, reflective culture towards learning from incidents.
- Within the community services for adults of working age the teams had recently started to use 'feedback huddles' which were dedicated communications and memos to feedback about incidents within teams and across the service.

Duty of Candour

- Staff working across the four core services understood their responsibilities in relation to duty of candour.
- Overall, we identified staff were open and transparent with service users when something went wrong. For example, at North Kensington and Chelsea CMHT a face to face meeting was arranged with a patient following a medicine error so that staff could provide an explanation and apology for what had gone wrong. At the East and West Harrow CMHTs we saw that staff had apologised in writing to patients who had their care plans or letters to GPs inadvertently sent to other patients.

Good

Are services effective?

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

Summary of findings

We rated effective as **good** because:

- In February 2015, we rated two of the sixteen core services as requires improvement. This led us to rate the core service as good overall for this key question.
- We have changed the rating for this key question for the wards for older people with mental health problems from requires improvement to good. This is because In February 2015, we identified that physical health checks were not routinely being completed. At this inspection we found this had improved and an early warning score system was being used to support early identification of deterioration in physical wellbeing.
- Patients had comprehensive mental and physical health assessments in place.
- Patients with mental health needs were receiving improved support with their physical health.
- Staff understanding and application of the Mental Capacity Act had shown improvement.

However:

- We have not changed the rating for this key question for community services for adults of working age.
- Care plans were not always reflect the patients identified needs in some of the community based mental health services for adults of working age.
- Patients were often not able to access any or sufficient psychology input which meant their treatment was not in line with best practice. Whilst the trust was working to introduce alternative arrangements for patients to access talking therapies, there was still more to do.

Our findings

Assessment of needs and planning of care

- At this inspection we identified that services assessed patient needs comprehensively. Patients received a prompt assessment of their physical and mental health needs upon referral to services. Assessments were holistic and thorough, incorporating a wide range health and social needs. Care plans were then developed and in most cases these reflected the needs of the individual and included input from the multi-disciplinary team. However in the community mental health teams for adults of working age further work was needed to ensure care plans reflected the current needs of the patients being supported.
- On the acute wards for adults of working age and PICU patients had a physical health check upon admission to the service and staff regularly reviewed their physical health using the modified early warning system (MEWS). The majority of records we looked at showed that staff appropriately responded to the physical health needs of patients using this system. However the accuracy of the completion of the MEWS charts needed further work.
- In February 2015, we found that patients' physical health needs were not being monitored on Redwood ward in the wards for older people with mental health problems. During this inspection, improvements had been made and patient's health needs were being monitored. Regular physical health observations were carried out and staff used national early warning scores to support early identification in deterioration in physical health and wellbeing.
- In February 2015, we identified that patients using community based mental health for adults of working age must be referred for regular physical health checks. In the Harrow community recovery team some patients had not been referred for a physical health check. At this inspection, we looked at 24 care records and found that all patients except one had received physical health checks in the previous year.
- In February 2015, we recommended the care planning process should be more individualised on the wards for people with learning disabilities or autism. Care plans

should be in a format that is meaningful to that person, there should be a strong recovery focus and the care plans should be put into practice for each person. At this inspection we found this had improved significantly.

- In February 2015, we recommended on the acute wards for adults of working age that discharge planning be incorporated into patient care plans, so that care and treatment is recovery focussed. At this inspection we found this had improved and across this core service the majority of care plans reviewed demonstrated consideration of discharge planning.
- In February 2015, we recommended the trust improves the new multi-disciplinary care planning system on acute wards for adults of working age and the psychiatric intensive care units, to ensure that all disciplines record directly onto this. At this inspection staff from a range of disciplines were now able to record onto the electronic care records system.
- In February 2015, we recommended that the trust ensures that care plan in the community based services for adults of working age are more person centred when patients are being supported by a lead clinician. In February 2015, we found that in Harrow community recovery team care plans for patients supported by a lead clinician usually consisted of a letter for the patients' GP, some of which had technical language. During this inspection, we found that patients supported by a lead clinician had a care plan in their care records, which included patients' social needs and individual goals and were easy to understand. However, three care records reviewed at North Kensington & Chelsea CMHT did not have a care plan, and three other care plans were brief and not person centred. For one patient at the Brent South CMHT we identified their care plan had not been updated following an inpatient admission and that the care co-ordinator had not actioned the recommendations made by the occupational therapist. Two other care plans we looked at did not indicate any information about patients' physical health care needs and two other care plans did not have clear discharge plans to explain how people would move on from the team. This meant that there was a risk that patients' needs would not be met. Also at the North Kensington and Chelsea CMHT some patients or carers who we spoke with did not have a copy of a care plan.
- In February 2015, we recommended that in community based mental health service for adults of working age; the trust should ensure that people using services have crisis plans that reflect their individual circumstances. We specifically identified that some crisis plans in the Harrow community recovery team were not always specific to the patient or their needs. At this inspection we found that patients care records at the East and West Harrow CMHTS contained crisis plans which were co-produced with patients and their families. However in other community teams some crisis plans were very generic and did not reflect people's individual circumstances or needs.

Best practice in treatment and care

- The trust had implemented a smoke free policy on all hospital grounds since October 2016. Across the four core services we inspected we saw that the trust was supporting patients to reduce or stop smoking and nicotine replacement therapy was being offered to patients. The trust had delivered training to staff on smoking cessation to improve the capability of the workforce to implement this change.
- Across the four core service inspected staff routinely participated in clinical audits. However, on Oak Tree ward, in the wards for older people with mental health problems, care plan audits did not detail the timescale or action required to address improvements which had been identified. Within the community based mental health services for adults of working age, local audits of care plans, did not have specific action plans to ensure that issues identified were remedied by the team.
- The trust was working to improve the physical health of patients with mental health needs. There was a physical health group to focus on this work. They were in the process of appointing a physical health nurse lead. There was a focus on training mental health nurses in physical healthcare and they had started delivering a two day training course for all the nurses. The trust recognised that they had made good progress for patients in inpatient services, but more was needed for patients receiving community mental health services.
- Across the community based mental services for adults of working age staff supported patients to engage with the GP practice regularly. The trust had recently started to implement the SHINE quality improvement

programme across the teams. The SHINE programme aimed to improve routine assessment and detection of physical health problems and lifestyle risks in people with long-term mental health conditions. A physical health and wellbeing group was also led by the peer support worker at the North Kensington & Chelsea CMHT. This provided psychosocial support for patients to make healthy lifestyle choices and improved understanding and importance of healthy eating.

- On the wards for people with learning disabilities or autism there was a strong focus on health promotion and healthy living. Patients had a health action plan in line with best practice guidance. Hospital passports were in place for patients on the wards for people with learning disabilities or autism, providing essential information for other healthcare professionals to ensure effective care and treatment and personalised care planning. For example if patients needed to attend the accident and emergency department.
- Patients on the wards for people with learning disabilities or autism received a high standard of physical health care. Dependant on the patient's individual needs, this included dental care, physical observations, weight reduction programmes, food and fluid monitoring, bowel monitoring. Staff regularly reviewed their physical health using the modified early warning system (MEWS). All patients had a cardiac health check. Physical health monitoring was in accordance with NICE guidance for patients prescribed antipsychotics and mood stabilisers.
- Whilst the trust provided access to psychological therapies in most areas the level was variable. In February 2015, we recommended that psychological therapies be available for patients supported by the community mental health teams for working age adults to reflect NICE guidance. At this inspection, we found little improvement in this area. For example, at the Milton Keynes CMHT a psychologist was not employed and none of the patients registered with the service were receiving a service from the psychological therapies team. Fifteen members of staff we spoke with across Brent North and South CMHTs, mentioned specifically how the low level of psychology provision had impacted on service delivery and also how many patients were having to wait long periods before receiving this input. Some of the teams were addressing the lack of one to one therapy. For example, the psychologists and psychology assistants at Hillingdon West CMHT were developing a group that people on the waiting list could attend whilst they waited for one to one treatment. In addition the team at North Kensington & Chelsea CMHT were working with the local psychotherapy department to provide group based services for group therapies to support patients and reduce waiting times. This was in response to concerns raised by patients on the waiting list.
- Access to psychology services varied across the wards for older people with mental health problems. Overall we found that patients and carers could access psychological support. However, on Redwood ward the psychologist post was vacant and this meant patients could not be referred for psychology input. At Beatrice Place and there was no dedicated psychology post or resource on the ward. If staff needed to make a referral for a psychology assessment they were able to make a referral to a psychologist in the trust who had an agreement to conduct assessments. This meant that all patients did not have access to specialist input from a psychologist available in a timely manner.
- In February 2015, we recommended staff working at Harrow community recovery team, part of the community based mental health services for adults of working age, should improve how they approach and support patients with a personality disorder. At tis inspection we found this had improved. Staff spoke about patients respectfully and demonstrated a good understanding when describing the needs of individual patients. The trust had provided specialist training for staff at East and West Harrow CMHT to support people with a personality disorder. The team had developed a focus to supporting staff to work with patients with a diagnosis of borderline personality. This had led to improved feedback about the approach of staff, form patients using the service.

Skilled staff to deliver care

- Staff received appropriate training, supervision, appraisal and professional development including bank and agency staff. Supervision and appraisal records were maintained on each ward.
- Across the wards for older people with mental health problems staff were receiving regular supervision to

support them in their roles. Overall staff told us they felt well supported in their teams and wards. The exception to this was at Beatrice Place where staff were not receiving supervision regularly.

- The trust recognised that they needed to train staff to be able to support people with a learning disability and a session was now provided on the trust induction. However in some areas staff did not feel sufficiently trained to meet the needs of the patients. For example at the Riverside mental health centre patients were admitted with a diagnosis of a learning disability or autism as well as a mental health diagnosis. However staff working on the unit had not received training to work with patients with a learning disability or autism.

Multi-disciplinary and inter-agency team work

- Within the acute wards for adults of working age and PICU, the recently introduced bed management meetings had fostered interagency working across teams and services in the local borough areas. Teams and agencies were meeting regularly to review and discuss patient care, admissions, discharges and treatment
- Within the wards for people with learning disabilities or autism the multi-disciplinary team (MDT) meetings were well staffed and patient focussed. We saw excellent examples of supportive practice, where patients were empowered to lead their MDT meeting.
- At the Campbell Centre healthcare assistants (HCA) were not attending the daily MDT handover meeting. In addition there was no established system for HCAs to feedback information to the MDT meeting. This limited involvement of HCAs in MDT working meant important information might not be communicated.

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

- The trust's systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. Administrative support and legal advice was available from the Mental Health Act lead in a centralised team within the trust, as well as Mental Health Act law managers and Mental Health Act administrators based at each hospital site.
- Training on the Mental Health Act and code of practice was non mandatory. Training was provided to staff centrally and within local teams. Role specific training was given where required. Overall staff appeared to have a good understanding of the Mental Health Act and code of practice.
- In February 2015, we recommended that Mental Health Act documentation was completed correctly for patients on TOPAS and Redwood ward in the wards for older people with mental health problems. This was recommended to ensure people were being supported to understand their rights, their medication is authorized and their leave is approved. At this inspection, we found this had improved. We looked at detention records on the wards that we visited. Across the core service mental health act documentation was completed correctly and stored appropriately.
- In February 2015, we recommended in the acute wards for adults of working age and PICU, staff at the Gordon Hospital should ensure copies of consent to treatment forms were attached to medication charts. At this inspection we found this had improved and consent to treatment forms were attached to medication charts.
- Across the four core services we found that patients were having their rights under the MHA explained routinely initially, and during the course of admission and treatment. However, at Milton Keynes CMHT in the community based mental health services for adults of working age one patient was not routinely having rights explained consistently when periods of CTO were being renewed, changes in treatment were being considered, or when there was a care programme approach review.
- At this inspection we identified that TOPAS ward which is one of wards for people with mental health problems did not have a sign on the door indicating the rights of informal patients to leave the ward. This meant that the rights of informal patients were not being upheld, by actively informing patient they can leave the ward if they wish or need.
- Patients had access to an independent mental health advocate (IMHA) to support them whilst they were detained. Patients were provided information about the Independent Mental Health Advocacy (IMHA) Service. This information was displayed on a notice boards across the services we inspected.
- In February 2015, we recommended that the wards for people with learning disabilities or autism should work

with commissioners to make arrangements for a replacement independent mental health advocacy services at the Kingswood Centre and staff should know who to contact when this service is needed. At this inspection we found this had improved. There was access to an independent mental health advocate and an independent mental capacity advocate to support patients. Patients told us they knew who their advocate was. The advocate supported patients when attending Mental Health Act tribunal hearings.

- Staff carried out regular audits to ensure the Mental Health Act was being implemented correctly. The trust produced a quarterly Mental Health Act Performance Report. A bi-monthly Mental Health Law group met to review Mental Health Act performance and trends and provided a governance structure.

Good practice in applying the Mental Capacity Act

- The trust did not include training on the Mental Capacity Act (MCA) as part of mandatory training. Despite this we found that staff received training on the MCA which had been organised within the core services.
- In February 2015, we recommended that staff in all services fully understand the Mental Capacity Act 2005 (MCA) and code of practice within the community based mental health series for adults of working age. At this inspection improvements had been made. Staff had a good understanding of the Mental Capacity Act. Staff assessed patients' capacity when there was a reason to do so and involved family members in making decisions where appropriate when patients lacked capacity.
- On the wards for people with learning disabilities or autism, training on the MCA was part of induction for all new staff and was incorporated into the trust safeguarding training. 100% of staff had completed this training. Staff demonstrated an excellent understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Supporting patients to make decisions was embedded throughout the service.
- As at January 2017, the overall rate of MCA training on the wards for older people with mental health problems was 75%. TOPAS had the lowest completion rate at 43% followed by Ellington ward (67%) and Beatrice Place (72%). Redwood ward had the highest rate at 100%.
- Overall across the core services, staff the understood the principles of capacity assessments and the five statutory principles of the MCA. However, on the wards for older people with mental health problems some staff on TOPAS ward staff were not able to articulate the statutory principles of the MCA. However there was awareness of the need to provide care in the least restrictive manner and the requirement to assume that patients have capacity unless it is established that they do not. At Beatrice Place which is a ward in the wards for older people with mental health problems, capacity assessment were completed however they were sometimes brief.
- On the wards for people with disabilities or autism we found positive examples of staff supporting patients in decision making where capacity was impaired. The assessment of capacity was embedded in all intervention and decision relating to patient care. We found that patients were routinely involved in decision making and where required, staff proactively supported patients to make decisions about care.
- Between 01 January and 31 December 2016, across the wards for older people with mental health problems, 75 Deprivation of Liberty Safeguards (DoLS) applications were made and 39 (52%) of these were approved. Within this core service applications were being made when required and staff were working to protect the rights of patients.
- Overall staff working the core services had a good understanding of DOLs. However in the wards for older people with mental health problems staff did not always have a robust understanding of which patients had a DOLs in place. For example on Kershaw three members of staff understood a patient to be placed on a DoLs when they were not currently subject to a DoLs. This meant that there was a risk that staff responsible for providing care, were not aware of the current legal status of every patient on the ward.
- In February 2015, we recommended the trust should ensure where patients are subject to DOLS there was a process to ensure that the authorisation are reviewed and followed up. At this inspection we saw good use of 'tracker' documents at Beatrice Place, TOPAS and Ellington wards, which tracked each application, when it was authorised and the renewal dates.

Good

Are services effective?

- Staff we spoke to in the wards for older people with mental health problems told us there were often delays in response to DOLS applications from local authorities. This was impacted by the high number of applications that local authorities were required to process.
- The trust had recently begun to train best interest assessors within the trust. This initiative aimed to increase the response and accessibility of DOLS assessments and support the waiting list time for DoLS assessments experienced by the local authorities.

Outstanding ☆

Are services caring?

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

Summary of findings

We rated caring as **outstanding** because:

- In February 2015 we rated the trust as outstanding for caring overall. Many of the services that were previously outstanding for caring at the last inspection were not inspected this time but there is no new information to suggest those ratings have changed.
- We have changed the rating for this key question for wards for older people with mental health problems, from requires improvement to good. This is because improvements had been made to maintain the privacy and dignity of patients, increase patient participation in care planning, and improve provision of personal lockable space for patients.
- Patients were treated with kindness, compassion and respect across the services we inspected.
- Patients and carers were supported to be involved in care decisions and also in the wider operation of the trust.
- Patients and carers were encouraged to give feedback about the services being delivered by the trust.

However:

- On the acute wards for adults of working and PICU and community mental health services for adults of working age care plans did not always include patient views and evidence of their involvement. The format and language used in care plans did not always support patients' involvement.

Our findings

Kindness, dignity, respect and support

- In February 2015 we found many examples of outstanding care, especially in the community health services. These services were not visited at this inspection.
- In February 2015, we identified that patients on the wards for older people with mental health problems did not always have their dignity maintained. In particular we observed that female patients attended mealtimes in their nightwear and with no dressing gown. At this inspection we found patients were appropriately dressed and their dignity maintained.
- In February 2015, we identified that night time checks were intrusive and patients were unable to close the observation panel from inside of their bedroom. At this inspection we saw that observation panels were kept shut on patient bedroom door to maintain dignity.
- Across all of the services we inspected we observed that patients were cared for and treated with dignity, respect and compassion. The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff.

Involvement of people in the care they receive

- We saw that patients were actively encouraged to give feedback on the services they received through a range of options including meetings and surveys. Services thought about how this feedback could be best facilitated. In most cases this was leading to improvements but in some areas further work was needed. In February 2015, on the acute wards for adults of working age and PICU we recommended the trust should promote any staff and patient feedback processes so that all people have an opportunity to be involved in the trust. At this inspection, patients were able to give feedback about the service they received through a range of options. Community meetings and daily planning meetings provided a forum for patients to contribute to the planning of activities and the day to day running of the ward. However, some patients we spoke with told us that there were no responses to some of the requests which had been raised. For example, requests for bath plugs and a remote control for the television had not been responded to after being raised at three consecutive community meetings.
- We saw many examples of patients and carers being actively involved in the planning, development and

reviewing of their care plans. However, more progress was needed in some areas. In February 2015, we recommended staff should encourage all patients to be involved in planning their care and treatment on the acute wards for adults of working age. This involvement should be clearly recorded. Across the acute wards for adults of working age, we observed that patients were involved in care planning and care reviews. However at St Charles mental health centre we identified that whilst patients were involved in care planning, this was not always documented in care plan records. At the Campbell Centre most patients we spoke with said they were not involved in their care planning. Further work was required within this service to improve this are of care delivery. In February 2015, on the wards for older people with mental health problems we identified patients were not involved in their care planning. In addition patients were not being provided with a copy of their care plan. At this inspection we found this had improved. Patients and relatives or carers were included in assessment planning and reviewing of care. Patients were provided with copies of their care plans.

- There were variations in the presentation and content of the care plans and their overall accessibility. In February 2015, on the wards for learning disabilities or autism we recommended that care plans should be in a format the was meaningful to the person, there should be a strong recovery focus and care plans should be put in practice for each person. At this inspection we found that there had been significant improvements in this area. Care planning documentation clearly reflected the patient's voice and involvement. The care plans reviewed demonstrated and individualised, holistic approach to care planning with an emphasis on recovery. On some of the acute and PICU wards and the community mental health services some care plans used terminology which was focussed on diagnosis and treatment and did not reflect the patient goals, views or wishes in line with recovery orientated practice. Further work was required to ensure care planning was person centred. Also on wards for older people with mental health problems staff were explaining and discussing care plans verbally with patients, though further work could improve the care plan presentation for patients with dementia or a cognitive impairment.
- Patients across the trust had access to advocacy services. A particular area of positive practice was the involvement of advocates in the ward rounds and MDT reviews on the wards for people with learning disabilities or autism.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as **good** because:

- In February 2015, we rated three one of the sixteen core services as requires improvement and on core service as inadequate for this key question. This led to an overall trust rating of requires improvement for this key question.
- At this inspection we inspected the one core service previously rated as inadequate and one the core services previously rated as requires improvement.
- We have changed the rating for this key question for acute wards for adults of working age and PICU from inadequate to good. This is because improvements had been made to ensure patients had access to a bed when needed and patients could return to a bed after going on leave from hospital.
- We have changed the rating for this key question for wards for older people with mental health problems from requires improvement to good. This is because improvements had been made to the management of clinically inappropriate admissions to the wards.
- In February 2015, we recommended that the areas used by patients at Hillingdon West CMHT (Mead House) be refurbished. At this inspection, we found this had improved and refurbishment had been completed.

However:

- Whilst there was clear information displayed throughout the services visited to explain to patients and carers how to make a complaint, informal verbal complaints were not being recorded and so it was not possible to ensure these had been addressed or to look at themes and areas for learning.

Our findings

Access and discharge

- The trust had undertaken a large piece of work to ensure access to an inpatient bed on the acute wards for adults of working age. Bed management across the inpatient sites had improved considerably since the last inspection and was closely monitored by the trust. Further work was needed to improve the timelines of discharges and to reduce the number of patients waiting more than four hours once they had been clinically assessed as needing an inpatient bed, especially at weekends.
- In February 2015, we identified there were significant pressures and challenges on the acute admission pathway. In addition we identified that improvements were required to ensure patients had a designated bed when they were admitted and when they returned from leave. At this inspection there had been significant change and improvements to manage this process. Patients were no longer sleeping on couches. The trust had introduced weekly bed management meetings across all boroughs to ensure that admissions, discharges, and bed capacity was regularly reviewed and discussed. These meetings included staff from acute admissions wards, community recovery teams, homeless services, and primary care liaison nursing teams and early intervention in psychosis teams. These regular meetings meant that the admission, treatment and discharge of patients was monitored and where possible patients were discharged promptly to ensure beds were available.
- The trust had introduced single point of access service (SPA) service. This operated a one-stop entry point into adult secondary community based mental health for patients living in the North West London boroughs of Brent, Harrow, Hillingdon, Kensington & Chelsea, and Westminster. The service received and triaged crisis referrals and assessments and supported identification of early assessment and prompt admission to acute inpatient wards if required. As part of a redesign of services, the SPA referred patients to the home treatment teams for assessment and gatekeeping of inpatient admissions.
- The trust was reviewing each incident where a patient waited more than four hours from the point at which they were clinically assessed as needing an inpatient bed. There were 22 breaches in July, 14 breaches in

Good

Are services responsive to people's needs?

August and 35 breaches in September 2016 all for adult patients. Just under half of these breaches were at the weekend. Where the breach was over 12 hours there was a common theme about the time taken to place the patient in the independent sector. The trust reviewed the learning from each case but recognised there was still more work to do to improve prompt access to an inpatient bed.

- Between 1 March 2016 and 30 August 2016 there were a total of 145 delayed discharges from the acute wards for adults of working age and PICU service. The ward with the highest number of delayed discharges was Vincent Ward with 30, followed by the Campbell Centre with 24. The trust was working to improve the discharge of patients. Each inpatient centre had a discharge co-ordinator although how they performed this role varied between geographical areas. Throughout the inspection there were many examples of ward staff working closely with other trust teams and external organisations to facilitate the discharge of patients. For example, the Riverside MHC had a dedicated staff member within the housing department to ensure prompt patient referrals from the wards
- The trust was focusing on patients who had longer lengths of stay of over 60 and 100 days and were making progress with some individual patients. This was monitored at the bed management meeting and there was still more work to do improve delayed discharges.
- In February 2015, we identified on the acute wards for adults of working age and PICU that the trust must take steps to reduce the number of times that patients are moved to other wards to sleep for non-clinical reasons. In addition, where it is unavoidable, staff must ensure that a thorough handover takes place to promote continuity of care. Patients must only be moved at reasonable times so that they are not adversely affected. At this inspection we found this had improved and this was not taking place, patients were no longer being moved to other wards to access a bed.
- In February 2015, we identified on the acute wards for adults of working age and PICU, that the trust must ensure that contingency plans were in place for when the numbers of patients needing a bed increases above the beds available. At this inspection we found this had improved.
- Within the PICU wards beds were available to provide intensive care if needed. The occupancy levels on the PICU wards between 1 March 2016 and 30 August 2016 was below 90% with the exception of Colne ward where it was 92%.
- In February 2015, we identified on the wards for older people with mental health problems that Redwood ward must not provide beds for working age adults who were not clinically appropriate for a service for older people. At this inspection we found this had improved. Patients were not being admitted onto the wards for older people when they were not clinically appropriate. Improvements in the bed management of the acute wards for adults of working age and PICU had prevented inappropriate admissions to these wards.
- Across the community based mental health services for adults of working age, urgent referrals were discussed at the daily zoning meetings. Doctors within the teams could review urgent referrals. All the teams had a duty system to enable the team to respond to urgent telephone enquiries from health professionals and deal with emergency situations. The duty worker was also able to see patients quickly if required.
- The trust was not meeting the agreed target of 28 days for routine referrals to assessments, although this was improving. From November 2016 to April 2017 average routine referral to assessment waiting times was 31 days across all services. The average number of days was fluctuating between months. At the end of April 2017 the average waiting time was 31 days which was a drop from March 2017 where the average was 37 days. Across the eight services, North Hillingdon CMHT had the highest average waiting time over the six months at 47 whilst North Brent CMHT had the lowest average of 25 days. Breaches to the trust targets were monitored by each team and reported on at service and divisional level.
- Each team monitored the referral to assessment waiting times, where shortfalls were identified in meeting target times action plans were in place. For example, in the East and West Harrow CMHTs there was a management plan in place to address non-compliance with the target time by reviewing the teams' management referral process, training administration staff and telephoning new referrals before their appointment to confirm attendance. In the Brent CMHTs there had been an in-

depth review of the non-compliance with the CCG urgent pathway targets. Improvements had been made in the North Kensington and Chelsea CMHT in the timeliness of assessments and 81.8% of routine referrals were seen within 28 days in April 2017, an increase from 25% in January 2017.

The facilities promote recovery, comfort, dignity and confidentiality

- In February 2015, we recommended the trust should provide individual lockable space for patients to keep their possessions safe on the acute wards for adults of working age. At this inspection we found this had improved. Patients had access to lockable spaces to store individual possessions safely.
- In February 2015, we recommended the trust should address the sound of the alarms at St Charles MHC in the acute wards for adults of working age. At this inspection we found this had improved and patients were not being disturbed by alarms sounding across the wards.
- On the wards for older people with mental health problems the environments were clean, comfortable and welcoming. However the wards did not consistently provide a dementia friendly environment to support patients with cognitive impairment. The trust had identified further work could be done to improve the environment on these wards. An action plan had been put in place to make improvements .This included changes to facilitate orientating patients to time and place, sensory stimulation and more pictorial prompts and signs
- In February 2015, we recommended the rooms used to meet patients at Mead House (Hillingdon CRT) were refurbished so that it was a pleasant environment for patients to use. At this inspection we found this had improved and the environment was pleasant and welcoming. Overall the environments across all the community teams we inspected were pleasant, welcoming and well furnished.
- At this inspection, all of the community mental health teams we visited were welcoming, clean environments. There were adequate rooms and space for patients to meet with staff to maintain privacy and dignity. However, some patients reported that there were dignity and privacy concerns in the reception area of the building which housed the East and West Harrow CMHTs. Patients said that other patients could hear them when they discussed confidential matters with the receptionists, because there was not enough space between the desk and the seating area. The reception area was small and meant that other people could easily hear patient information.
- In February 2015, we identified that the privacy and dignity of patients was not always promoted for patients in a shared rooms at the Campbell Centre due to measures to manage ligature risks. At this inspection we found that improvements had been made. The trust had made improvements to the environments in the shared rooms and replaced curtains with doors. This addressed the privacy and dignity of patients.
- Overall the trust worked to meet the dietary needs of patients on the acute wards for adults of working and PICU. However, patient feedback on the quality of food was mixed. Patients had access to a variety of menu options. Some patients we spoke with at Northwick Park MHC said that the food provided did not meet their cultural and religious needs and at St Charles MHC some patients commented the food was of poor quality.
- On the wards for older people with mental health problems patients were not effectively supported with information to make decisions about food choices during meal times On Redwood, Kershaw wards and Beatrice Place menus were available in small print only. Pictorial menu descriptions or easy read explanations which could help people with cognitive impairments to understand what was available were not provided.
- On the acute wards for adults of working age and PICU a programme of therapeutic activities was available for patients to engage in throughout the week. Overall patients spoke positively about the activities provided. However, the majority of patients we spoke with said there were few or no activities taking place at the weekends. Some action had taken place to provide activities throughout the week. However further work was required to improve access to activities at weekends for patients on the wards.
- In February 2015, we recommended the trust should ensure that scheduled activities take place for patients as planned. At this inspection we found this had improved. The service provided an extensive

programme of activities which met the individual needs and preferences of patients. Each patient had an individual activity schedule which involved one to one and group activities within the service and in the community. The activities programmes were person centred, and took place regularly.

- On the wards for older people with mental health problems patients could access a range of activities and groups to support their care and recovery. These included drama therapy, art therapy, exercise, cooking, music and reading groups on the ward. Activity co-coordinators and occupational therapy staff provided activities. At Beatrice Place, we saw that patients participated in a sensory stimulation group using music therapy. TOPAS ward employed occupational therapists to work at weekends. Weekend activities were also provided for patients.
- On the wards for people with learning disabilities or autism patient extensive programme of activities which met the individual needs and preferences of patients. Each patient had an individual activity schedule which involved one to one and group activities within the service and in the community. Patients spoke positively of the activities that they took part in such as the community leisure group, reading and writing group and the social drop in group.

Meeting the needs of all people who use the service

- On the acute wards for adults of working age and PICU patient's religious and spiritual needs were supported. Local faith representatives visited the service or staff supported patients to attend places of worship in the community where appropriate. However, the faith room at Park Royal MHC was bare and contained no materials such as religious or spiritual texts to support patients' spiritual needs.
- In February 2015, we recommended the wards for people with learning disabilities or autism should ensure that patient should receive the support they need to practice their faith if they wish to do so. At this inspection we found this had improved. Staff supported patients to practice their faith and requested faith leaders to meet with patients when required. The service had a multi-faith room and staff supported patients to meet their religious and cultural needs.
- In the community based mental health services for adults of working age staff were aware of community groups who could offer support to patients from diverse backgrounds. In the North Kensington and Chelsea CMHT we saw that staff referred BME patients to a specific BME resource service at a local charity. In the Brent Early Intervention Service care records detailed that written communication to a patient had been translated into their own language.
- On the wards for older people with mental health problems we saw positive practice at Beatrice Place with staff proactively supporting patients from different cultural and religious backgrounds. This included using phrases and greetings in the person's language. These were developed in care plan with the support of patient's relatives. Also the unit went the extra mile to support patients religious and faith needs.
- Across the services inspected we found that teams had access to patient information leaflets in a wide range of languages. These could be printed off from the trust intranet.
- The trust had an excellent range of medicine information available to patients. There was a comprehensive range of patient information leaflets for all commonly prescribed medicines. These were available in other languages, large print, Braille and audio format on request.
- Staff were able to access interpreters to translate for patients with different language needs. For example this was often used to explain patient rights following detention under the Mental Health Act
- All of the services provided disabled access for patients with mobility needs.

Listening to and learning from concerns and complaints

- Information on how to complain was provided in the inpatient wards and in community services. In the teams we inspected, this information was displayed clearly for patients and relatives or carers.
- On the wards for people with learning disabilities or autism a complaints procedure was displayed on each ward and throughout the service. This was available in an easy read pictorial format. Patients could request

Good

Are services responsive to people's needs?

advocacy support if they wanted to make a complaint. Complaints could be raised with the staff on the ward, at the weekly patient group and during one to one sessions.

- In February 2015, we identified the trust must ensure information was available to inform patients how to make a complaint across the wards for adults of working age and PICU. In particular the trust must ensure verbal complaints are addressed and, if needed, patients and carers have access to the formal complaints process. At this inspection we found this had partially improved, and information on how to make a complaint was available to patients. However, we found the system to collate and follow up on informal verbal complaints had not significantly improved on acute wards and wards for older people. Further work was required to ensure that verbal complaints are followed up and the actions of verbal complaints collated and evidenced. This was a particular concern on the PICU wards in Brent following patients raising concerns in community meetings and informal complaints. This was a continuing breach of regulation.

Good

Are services well-led?

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

Summary of findings

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

- In February 2015, we rated all but one of one of the sixteen core services as good for well led. The exception was wards for adults of working age and psychiatric intensive care units (PICU); which we rated as requires improvement for this key question. Following this most recent inspection, we changed the rating of well led for acute wards for adults of working age and PICU to good. This means that all seven community health core services and nine of the ten mental health core services are now rated as good for well led. The wards for people with a learning disability or autism are rated as outstanding for this key question.
- The trust had a skilled and experienced leadership team who were committed to providing high quality services.
- There were clear strategies in place which put the patients and carers at the centre of the work of the trust, whilst addressing the financial challenges.
- The leadership team were cited on the risks facing the trust and had robust action plans in place to address these areas.
- Patients, staff and external stakeholders were actively engaged in the trust. Further developments in carer engagement were being promoted.
- The trust welcomed innovation and was introducing a systematic approach to quality improvement.

Our findings

Leadership capacity and capability

- The trust had a stable executive leadership team. The chief executive had been in post for over 10 years. The most recent appointment was the chief finance officer who joined in 2016. The executive leadership team had a detailed knowledge of the trust.
- The chief executive was also 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.
- The trust board was experiencing some change but this was being carefully managed. There were eight non-executive director posts including the chair. The chair had been in post since January 2013. Two non-executive directors had been appointed for a second term to provide stability for the board. Two non-executives had just been appointed. There was one non-executive board vacancy that was in the process of being filled.
- The non-executives had a wide range of skills and experience at a strategic level from careers in a range of sectors. They did not include someone with a clinical background, although there were members with experience as a carer or other personal interests relating to the services provided by the trust. The chair was conscious that the composition of the board did not represent the diverse communities supported by the trust and the need to try and increase the number of directors from a BME background.
- A recently appointed non-executive director confirmed they were receiving an in-depth induction to prepare them for their role. Non-executive directors had ongoing support to enable them to have the capability to undertake their role. This included pre-board seminars, separate meetings for non-executive directors with an annual overnight event and access to external conferences.
- Non-executive directors demonstrated at the board meeting that they had a good knowledge of the trust and were well prepared for the meeting. They provided appropriate challenge where needed, although it was recognised that this will develop further once the recently appointed non-executive directors gain knowledge and confidence in their roles.

Good

Are services well-led?

- Succession planning had been carefully considered by the chair and chief executive and senior staff had access to bespoke plans for their development and career progression.
- The trust provided a range of leadership development opportunities. One was targeted at new front line managers to provide them with skills and a network of support. Senior clinical leaders participated in the Imperial leadership training course. The trust was working on pulling together all the initiatives to have a more robust talent management strategy to ensure they were meeting everyone's needs. Team and ward managers commented favourably about the access to leadership development opportunities. Divisional and borough directors described the range of opportunities they had including mentoring and coaching, attending conferences and more bespoke leadership development courses.
- The Trust was in segment 2 of the NHS Improvement Single Oversight Framework linked to the rating of requires improvement from the last comprehensive inspection.

Vision and strategy

- The trust had a clear vision and values. The vision was 'wellbeing for life for everyone'. The values were that we should all experience and express every day, encompassing compassion, respect, empowerment and partnership. These had been developed in partnership with patients, carers, staff and a wide range of stakeholders.
- The vision and values were underpinned by clear strategic objectives to provide high quality care and best outcomes for patients, and to be operationally sustainable and financially viable.
- The trust had a five year plan which provided the strategic priorities for the trust and annual operational plans.
- A trust clinical and quality strategy was just being completed. This had been produced in consultation with clinicians, patients and carers at an event with external stakeholders. It described how patients and carers will be at the centre of the work carried out by the trust in line with the trusts quality priorities.
- External stakeholders, governors, patients and carers were also involved in the preparation of the annual quality account which agrees the quality priorities for the year ahead and reviews progress with achieving the priorities from the previous year.
- Staff were supported to understand the visions and values through the internal communication strategy. Information was available on the intranet, posters and was the basis of trust communications.
- The visions and values of the trust were understood by staff throughout the trust and they were able to articulate how these related to their work within the organisation and the care delivered to patients.
- Staff were aware of the need to deliver high quality care whilst also delivering a very challenging savings plan. For the year 2016/17 the trust had achieved its end of year planned deficit of a £1.1m subject to this having an external audit review. The trust had also reduced the spend on agency staff in the last year by £10m. A savings total of £30m (6%) had been identified for 2017/18.
- At the time of the inspection the trust was working to transform services. Also divisions were identifying further cost improvement schemes. These were presented to the medical and nursing director and if the impact on patient care was detrimental, the scheme would be refused.
- The trust was participating in a Lord Carter pilot review in some of its community services to look at comparative costs, opportunities to save money and improve care.

Culture of the organisation

- In the 2016/17 national NHS staff survey, the trust had a staff engagement score of 3.83 which was above average when compared to other similar trusts. This was a very similar result to the previous year. There were five areas where further improvements were needed. These included staff working extra hours, recent experiences of violence, recent experiences of bullying and harassment, opportunities for flexible working and access to services for health and well-being. Seminars were being arranged to discuss how improvements could be made.

Good

Are services well-led?

- Staff who were interviewed during the inspection, were generally very positive about their experiences of working for the trust and said that the culture was very open and they felt able to raise concerns without fears of retribution.
- The trust leaders placed a high priority on being visible and approachable. This was a challenge as the trust was very large, geographically spread and provided a wide range of services. All the board members regularly visited services. The non-executive directors had a programme to ensure they went to a variety of services and they wrote up these visits and fed back any concerns to the board. They described how staff were very open and willing to discuss any challenges they were experiencing. They were also thoughtful about how to best speak to patients and get their feedback during these visits. Executive directors also undertook visits including out of hours. This included a back to the floor initiative where 50 senior staff each worked in 3 areas and at the end came together to review the lessons learnt. Staff felt senior staff were accessible.
- A non-executive director was the trust lead 'speak up guardian'. In addition five staff side representatives were also 'speak up guardians'. They had received some initial training and guidance and wore a badge showing their role. This had been publicised throughout the trust using the intranet and posters. It was too early to see if they were used much by staff.
- The trust also had a whistle-blowing process. In the previous 12 months the trust had received and investigated 8 whistle-blowing concerns. These had been raised in a number of ways, although the most frequent was to write to the chief executive. Following an investigation, the lessons learnt had been considered.
- External stakeholders had described the culture of the trust as open and transparent.
- The trust worked closely with the trade unions with meetings taking place every 4-6 weeks and joint policy groups in place including one to look at actions from the staff survey.
- Staff performance issues were addressed appropriately. In the last year there were two cases of staff dismissed for bullying, which demonstrated the trusts commitment to address inappropriate behaviour.
- The trust recognised that they need to make improvements in terms of their workforce race equality standard (WRES). A WRES action group had been set up chaired by the chief operating officer. They were focusing on four areas. These were to increase the percentage of BME staff at band 8 posts and above; increase the likelihood of BME staff being appointed after shortlisting; decrease the likelihood of BME staff entering formal disciplinary processes and increase BME staff believing the trust provides equality of opportunity. They were working on several developments including the roll out of unconscious bias training, having BME staff on interview panels, reviewing dismissals and promoting BME role models and supporting BME staff to have the confidence to apply for jobs. Much of this work was still at an early stage.
- The trust had a number of networks promoting the diversity of staff. This included the BME network which was being supported to develop further. There were also networks for LGBT staff, a disability network, staff who are carers' network and staff with lived experience.
- An occupational health service was available promoting the health and well-being of staff. A new 'staying well at work service' was being piloted to support staff who needed assistance with their mental well-being to signposted them to appropriate services.
- The trust also provided a bursary to encourage staff to come up with ideas to promote health at work. Lots of teams had come up with ideas and a panel was being convened to decide which ideas to fund.
- The trust was aware of the challenges for staff based linked to staff vacancies. At the time of the inspection these were at 13.8% with turnover at 15.6%, sickness at 3.2%. The completion of appraisals was at 86%. The trust was using initiatives such as golden handshakes for new staff and relocation allowances to support the recruitment and retention of staff. A trust workforce board had been established and was chaired by the chief executive to oversee this work and progress was carefully monitored by the board. It was recognised that further work was needed on retention. A rotation programme had been implemented for qualified nursing staff to enable them to work across a number of services and develop their skills and experience. At the time of the inspection 175 nurses were taking part in this programme.

Good

Are services well-led?

- Staff success was recognised, with an annual staff awards ceremony and also monthly awards. The trust also had long service awards for staff.

Governance and management

- The trust had robust governance structures in place. This meant that from ward to board there was a good understanding of the challenges facing the trust. Areas for improvement were recognised and work was done to make these changes. An integrated dashboard monitored key areas of performance and identified trends across the three divisions and the trust as a whole. In the acute wards and PICUs we saw that improvements had been made to the oversight of bed management across the trust which had been identified as an area for improvement at the previous inspection in February 2015.
- The papers for the board and the quality and performance committee were contained clear summaries and detailed information.
- There were three divisions in the trust each with a divisional director and medical and nursing director. The three divisions each had responsibility for a number of boroughs and other specialist services. This helped to facilitate joint working with clinical commissioning groups and local authorities.
- There was a clear accountability structure for each division. At a directorate level assurance took place through a quarterly executive review meeting led by members of the senior executive team. These meetings considered all aspects of the directorate's operational performance and discussed plans for the directorate going forward. A representative from the division also attended the quality and performance committee which was a sub-committee of the board. Divisions were clear about issues which needed to be escalated to the executive team and other stakeholders when they arose. Similarly boroughs were accountable to the divisions.
- There was also effective sharing of information and learning across the divisions. For example there were regular meetings of divisional leads, a nurse forum and other clinical networks, peer reviews of services across divisions and a learning disability network of champions.
- Where these systems identified services which needed additional support, an improvement board was put in place as was seen in the trusts offender care services.
- The non-executive directors were also clear about their areas of responsibility. They chaired the board sub-committees. One or two non-executive directors were aligned to each division and the division informed the non-executive director of key issues facing the division.
- At a ward and team level front line managers were also clear about their responsibilities and felt they were given sufficient autonomy and also support to perform their roles.
- The trust recognised the importance of having a strong programme of quality assurance. This included clinical and non-clinical audits, using feedback from patients to drive improvement, embedding learning from serious incidents and complaints and assuring compliance against NICE clinical guidelines. These were seen working well as part of the inspection.
- The trust has clear structures and procedures for ensuring the implementation of the Mental Health Act and Mental Capacity Act reflected good practice. Despite the size of the trust, the mental health law team had a presence on each inpatient site and also spent time in community settings. The director of nursing was the executive lead for mental health law and oversaw the work of the mental health law team. The use of both acts were monitored and reported to the Mental Health Law committee.
- In February 2015, the trust had just brought in the fit and proper person policy and procedures. The records of six directors were reviewed and a few checks were not yet in place, although we were assured these were completed after the inspection. This time we looked at eight records and they were all complete.

Management of risk and performance

- The trust had clear risk management processes in place, with risks collated and reviewed at different levels of the organisation to ensure action plans were in place. These fed into the trust risk register which included the seven top risks, the assurance and action plans. These were reviewed by the quality and performance committee and the board. The current concerns identified by the

latest core service inspections such as staff vacancies, IT infrastructure and varying quality of data at a team level were reflected in the risk register and actions to address them were in place.

- Following the publication of the Mazars review the trust established a central mortality review group. The group met monthly and was chaired by the medical director and included clinical membership from all divisions. The group was also attended by an older adult psychiatrist, end of life clinical network lead and clinical director for learning disability services. Commissioners were also represented at the meeting and a service user governor brought lived experience to the forum. Deaths were reviewed using the Confidential Enquiry into Stillbirths in Infancy (CESDI) Framework. This involved a review of the patient record, multi-disciplinary team discussion and also allowed staff to take into account feedback from carers. The new process was being applied to all relevant deaths that had been reported since December 2016. A number of learning events had taken place across the trust which has included sessions to front line clinical staff on the importance of this work and how to implement the framework. The initial focus had been on mental health and learning disability services but this was being extended to community services using a sampling approach.
- The emergency planning & business continuity plan was reviewed on an annual basis by the board. In the latest plan for 2016/17 the trust was compliant with 49 out of the 51 standards. For the remaining two, plans were in place to increase training and exercising to test the plans.

Management of information

- At the time of the inspection the trust was experiencing difficulties in the roll out of their IT infrastructure and as a result the delivery of a new patient record system. This had been highlighted on the risk register and clear actions were in place including extremely close monitoring of the implementation of the contract with the company providing this service. The inspection found there was some impact on patients and staff, although the trust had tried to minimize this as far as possible. For example in one community team the new telephones were not working well and it was not possible to put through calls from the reception to other members of the team. This was causing problems with patients having difficulty in getting through when they called the team. The trust was working to correct these problems and in the meantime had arranged for additional staff to assist. Where the new patient record system could not be implemented staff were continuing to use the old one. In areas where the IT changes had taken place staff were generally very positive and they had been provided with training and support to learn the new systems.
- The trust was also implementing a new business intelligence tool. Once this is fully implemented this will provide information at a ward and team level to support the clinical delivery of the service. For example teams will know on an individual named basis which patients need to have their care programme approach meeting or to be followed up within seven days of being discharged. It will also show how many patients each care co-ordinator has on their caseload. At the time of this inspection some team managers were not able to provide this information with confidence, however the new system when implemented will address this.
- The non-executive directors felt confident about the quality of the data at a board level. They said it was reliable, accurate and timely. Divisions had a good knowledge of services and could challenge data that did not look correct.
- The information provided at the board meetings provided a holistic overview of performance and covered clinical, operational and financial matters.
- The trust Integrated board performance report contained key data for divisions and the trust as a whole and this was easy to follow and showed the trends in the data, for example monitoring the reduction in restraint and prone restraint.

Engagement and involvement

- The trust engaged well with staff, patients, carers and a wide range of stakeholders. This was challenging due to the size and complexity of the trust. The recovery college was universally praised and reflected the co-production work between all the engaged parties leading to a range of highly valued learning opportunities.
- The trust engaged effectively with staff and had a sophisticated communications strategy. Information

was provided through a range of mediums including a 'three minute read', newsletters, magazine, CEO blog and three key messages after the executive board meeting. Recent initiatives included the clinical message of the week. The trust also used on-line forums for staff to discuss topics and share good practice.

- Individual divisions had responsibility for sharing key information with staff through divisional and team meetings. This included learning from incidents and complaints. Each division also had their own communication strategy and local leaders used a range of methods to communicate with staff including emails, social media and direct contact.
- Senior leaders were very visible and gave staff the opportunity to raise issues. Structured programmes of visits took place during the day and night. Meetings took place at a range of venues to allow staff to see different parts of the organisation. Listening events took place at borough and team levels.
- Work took place with specific groups of staff, for example listening events with junior doctors had led to some improvements in rooms used by doctors whilst working on – call..
- Governors felt very engaged in the work of the trust and well supported. They had quarterly council of governors meetings, an annual away day with the board, tea with the chair and learning sessions. Examples of their work included, helping to select the non-executive directors, participation in a range of advisory panels and visits to services.
- The trust engaged well with patients. There was a trust wide patient reference group to oversee the engagement work. The trust also used the results of the friends and family test to gain trust wide feedback. Healthwatch spoke positively about the engagement work, although they said that opportunities for participating could be promoted more widely.
- Divisions had their own engagement strategies, reflecting the patients using their services. For example in sexual health services, extensive feedback had been gathered and used to improve services through feedback cards completed after clinic appointments.
- Patients were involved in consultations on areas such as revising care plans and reducing restrictive practices. They were also involved in consultations about service transformations.
- A patient or carer story was presented at each board meeting sharing positive and negative experiences.
- The trust was making excellent progress in the recruitment of peer support workers with over 40 people in post. They carried out a wide range of roles supporting patients and contributing to service improvements.
- There were many examples of patient engagement in individual services. For example in CAMHS the young people helped co-produce the website and review operational tools such as the leaflets and letters used by the service. There were also mental health services where patients were co-producing art work in partnership with local artists.
- The trust recognised that there was further work to be done on involving carers. A carers council had been established. The trust was starting to implement the triangle of care. Healthwatch said more could be done to ensure carers had a carer assessment.
- The trust had a list of patients and carers trained to help with staff interviews.
- There were a wide range of initiatives in place to support carers throughout the trust at a ward, team or borough level. For example in Harrow there was a carers surgery to provide support for carers.
- The trust was engaged with a wide range of stakeholders. For example staff were actively involved in the work of three sustainability and transformation plans (STPs). This engagement took place at a director level, divisional and borough level. The trust was also actively engaged in the development of accountable care partnerships, such as the one in Hillingdon where they were working with the acute trusts, GP federation and third sector providers. External stakeholders spoke positively about the quality of this engagement work.

Learning improvement and innovation

- The trust participated in a range of research, though recognised this could be developed further especially for mental health services. A director of research had

been appointed and a conference looking at research had been planned later in the year. The trust was linked with Imperial College London for some existing research and also worked collaboratively with other trusts. The trust's sexual health services were undertaking a range of research and acted as a host for research in other trusts.

- The trust participated in a number of Royal College of Psychiatrists' accreditation schemes. This included the schemes for memory services (three teams accredited); psychiatric liaison services (three teams accredited one as excellent); eating disorders (one team); learning disability wards (one ward); working age adult wards (two wards); ECT (two services accredited one as excellent); perinatal inpatient and community (one service); inpatient CAMHS (one ward); rehabilitation wards (four wards).
- The trust had a director of improvement and was focussed ion continuous improvement and innovation. There was a culture where staff and patients felt able to develop innovative schemes throughout the trust. There was also an innovation fund where teams could present bids for funding for new ideas that would improve patient care.
- The trust had recognised the need to implement a systematic approach to quality improvement and they had just signed up with a provider and the process was starting.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not provided in a way that ensured that assessments of needs and preferences of the service user were carried out and that these needs were met. **Community based mental health services for adults of working age** Care and treatment was not provided in a way that ensured that assessments of needs and preferences of the service user were carried out and that these needs were met. Care plans were not person centred at North Kensington CMHT. At Brent CMHT, care and treatment was not carried out in accordance with the care plan and care plans did not always include identified needs. Waiting lists for psychological therapies were very long. In some teams service users were waiting up to 24 months to be seen. Some patients in the North and South Brent CMHTs had not had regular contact with a care co-ordinator for a significant period of time. This placed them at risk of not having their assessed needs met. This was a breach of regulation 9(1)(2)(3)(a)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

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

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

The trust had not ensured that patients were

appropriately assessed and that the welfare and safety of patients was maintained.

The reasons for the administration of rapid tranquilisation, and the reviews of patients' physical health, including vital signs, following rapid tranquilisation were not always demonstrated to ensure patients were not at risk.

Whilst improvements had been made in this area, we found gaps in the monitoring and recording of patients physical health following RT.

This requirement was stated in the last inspection In February 2015, and is a continuing breach.

Risk assessments did not include details about risk and there was no information in care records on how the risks were to be managed.

This was a breach of Regulation 12 (1)(2)(a)(b)(g)

Community based mental health services for adults of working age

Care and treatment was not provided in a safe way for service users.

Risks were not always assessed, assessments lacked detail and management plans did not address identified risks.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12 (1)(2)(a)(b)(c)(e)

Crisis services and health based places of safety

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. Delays in accessing inpatient beds when required meant that people had to be supported in health based places of safety and bed management lounges for extended periods of time.

This was a breach of regulation 12 (1)(2)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

The trust was not providing care or treatment in a way that minimised acts which involved the use of control or restraint.

The number of incidents of prone restraint and the use of restraint across the service were significant.

Further work was needed to reduce variations in the use of restraint between different trust inpatient services.

This was a breach of Regulation13(4)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Requirement notices

Community based mental health services for adults of working age

Premises and equipment used by the service provider were not suitable for the purpose for which they were being used.

Staff were at risk because the Milton Keynes CMHT did not have an alarm system and staff did not carry personal alarms when seeing patients.

This was a breach of regulation 15(1)(c)

Crisis services and health based places of safety

People were not being protected against the risks associated with unsafe or unsuitable premises.

People using the place of safety at the Gordon Hospital and Park Royal had to pass through other parts of the hospital rather than accessing the service through a separate entrance which could compromise their privacy and dignity.

Interview rooms at St Charles hospital did not maintain the confidentiality of people using the service.

This was a breach of regulation 15(1)(c)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Long stay rehabilitation mental health wards** The trust did not have an effective system to inform people of how to make a complaint.

This section is primarily information for the provider

Requirement notices

There was a lack of information in some rehabilitation services to inform people how to make a complaint.

There was not a central register of verbal complaints and it was possible that where patients wanted a formal response to their complaint this was not happening.

This was a breach of regulation 16(1)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Acute wards for adults of working age and psychiatric intensive care units** The trust was not ensuring that accurate, clear contemporaneous records of service users care and treatment were being maintained. Records of physical restraint of patients were not always complete and accurate. This was a breach of Regulation 17(2)(c) **Wards for older people with mental health problems** The trust had not ensured that staff on Kershaw ward had an understanding of the policy on reporting incidents and reporting restraint in relation to personal care. This was a breach of regulation 17 (2) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Community based mental health services for adults of working age

Staff were not receiving appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The trust must ensure that all non-clinical staff undertake basic life support training and all staff undertake fire safety mandatory training.

This was a breach of Regulation 18(2)(a)