Inadequate

Central and North West London NHS Foundation Trust

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

Quality Report

Trust Headquarters
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV3Y1	Campbell Centre	Hazel ward Willow ward	MK6 5NG
RV312	Park Royal Mental Health Centre	Caspian ward Pine ward Pond ward Shore ward	NW10 7NS
RV320	St Charles Mental Health Centre	Amazon ward Danube ward Ganges ward Nile Ward	W10 6DZ

Summary of findings

		Shannon Ward Thames ward	
RV346	The Gordon Hospital	Ebury ward Gerrard ward Vincent ward	SW1V 2RH
RV383	Northwick Park Mental Health Centre	Eastlake ward Ferneley ward	HA1 3UJ
RV3AN	Hillingdon Hospital Mental Health Site	Colne Ward Crane ward Frays ward	UB8 3NN

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

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

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

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 the service	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Inadequate
Are services well-led?	Requires improvement

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

We gave an overall rating for acute wards for working age adults and the psychiatric intensive care unit (PICU) of **inadequate** because:

- Although the trust had a plan to reduce the number of ligature points on the wards, the work would take some time to complete. Until this was done, patients on the ward who were at high risk of suicide would be at increased risk. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature risks on the wards in terms of the support given to individual patients who were at high risk of suicide to keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions.
- Some of the ward environments at the St Charles MHC, Park Royal MHC and the Gordon Hospital did not have clear lines of sight. There was a lack of planning of how risks in the environment would be managed on a daily basis.
- The failure to increase staffing to support increased numbers of patients on some wards put patients at risk of not having their needs met appropriately.
- The training of staff in new restraint techniques had not yet been fully implemented. This meant that staff working together on wards were not all trained in the same techniques and in line with current best practice on the use of prone restraint. At the end of the last quarter there were about 75 incidents of prone restraint a month across the trust. Until this training is complete staff were using out of date interventions that could present a risk of injury to staff and patients.
- In the event of the use of rapid tranquilisation, monitoring of physical vital signs was not always maintained until the patient was alert.
- The records relating to the seclusion of patients at St Charles MHC did not provide a clear record of medical and nursing reviews, to ensure that these kept people safe and were carried out in accordance with the code of practice.
- There were a significant number of detained patients absconding from acute wards especially from St Charles, Park Royal and the Gordon Hospital. In the 6 months prior to the inspection 82 detained patients absconded whilst receiving inpatient treatment and not when taking leave. In response to a serious incident, steps had been taken to address this at one hospital. Further review and actions were needed to reduce the risk of harm for patients using these services.
- Despite work to mitigate this, the pressure on acute beds meant that wards were often over-occupied. There was not always a bed for patients and they slept on sofas or a temporary bed was used. Patients returning from leave could not always get a bed when needed and a bed was not always available in the PICU.
- Patients were often transferred to different wards to sleep and returned to the ward during the day. This disrupted the continuity of their care and patients felt it affected their well-being.
- Privacy and dignity of patients was not always promoted. Patients were not able to make calls in private. At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity.
- Information on how to make a complaint was not always available in the PICUs and verbal complaints were not always being recognised and addressed with access to the complaints process.
- The service was not well run as contingency plans had not been in place to manage the increase in patients needing an acute hospital admission.

Summary of findings

However the staff were kind and respectful to patients and had a good understanding of individual needs. Medicines were managed well across the sites. Multi-disciplinary teams worked effectively in the care and support of patients.

The wards were aware of the diverse needs of all the people who use the service and made positive attempts to facilitate conversations about this with patients.

Staff were committed to the vision and values of the organisation and felt connected to the trust. Staff morale was good and teams worked well together.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- Although the trust had a plan to reduce the number of ligature points on the wards, the work would take some time to complete. Until this was done, patients on the ward who were at high risk of suicide would be at increased risk. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature point risks on the wards in terms of the support given to individual patients who were at high risk of suicide to keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions.
- Some of the ward environments did not have clear lines of sight. There was a lack of planning of how risks in the environment would be managed on a daily basis.
- The failure to increase staffing to support increased numbers of patients on the wards put patients at risk of not having their needs met appropriately.
- The training of staff in new restraint techniques had not yet been fully implemented. This meant that staff working together on wards were not all trained in the same techniques and in line with current best practice on the use of prone restraint. Until this training is complete staff were using out of date interventions that could present a risk of injury to staff and patients.
- In the event of the use of rapid tranquilisation, monitoring of physical vital signs was not always maintained until the patient was alert.
- The records relating to the seclusion of patients at St Charles MHC did not provide a clear record of medical and nursing reviews, to ensure that people were kept safe and these were carried out in accordance with the code of practice.
- There were a significant number of detained patients absconding from acute wards especially from St Charles, Park Royal and the Gordon Hospital. In response to a serious incident steps had been taken to address this at one hospital. Further review and actions were needed to reduce the risk of harm for patients using these services.

Summary of findings

- Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was readily accessible. Staff had been trained and knew how to make safeguarding alerts. Medicines were managed well. The wards were clean and generally well-maintained. Staff completed risk assessments and developed risk management plans to minimise risks to patients and staff. The daily 'whiteboard reviews' on the wards enabled a daily assessment of risk to be undertaken by the multi-disciplinary team.

Are services effective?

Good

We rated effective as **good** because:

Clinical staff made an assessment of patients' needs on their admission to the wards. This included an assessment of physical health needs. Where needs had been identified, these were developed into care plans so that staff knew each patient's needs. Multi-disciplinary teams worked effectively together in the care and support of patients.

Staff received appropriate training, supervision and professional development. Staff used the Mental Health Act 1983 and the accompanying code of practice appropriately. Staff had an understanding of the Mental Capacity Act 2015, and there were positive examples of their working within this to assess patients' capacity. On some of the wards they had recruited 'peer support workers' (PSW) who worked on a full or part-time basis. These were people who had experience of using mental health services. They were considered a valuable part of the team and helped other staff work with patients in a more sensitive way.

Are services caring?

Good

We rated caring as **good** because:

The staff were kind and respectful to patients and had a good understanding of individual needs. During the MDT meetings we observed patients and their relatives were encouraged to express their views. However, the involvement of patients in their care plans varied and further improvements could be made. Some positive work took place with the carers of patients, to provide support and involve them in their relatives care.

Are services responsive to people's needs?

Inadequate

We rated responsive as **inadequate** because:

- Despite work to mitigate this, the pressure on acute beds meant that wards were often over-occupied. There was not

Summary of findings

always a bed for patients and they slept on sofas or a temporary bed was used. Patients returning from leave could not always get a bed and a bed was not always available in the PICU.

- Patients were often transferred to different wards to sleep and returned to the ward during the day. This disrupted the continuity of their care and patients felt it affected their well-being.
- Privacy and dignity of patients was not always promoted. Patients were not able to make calls in private. At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity.
- Information on how to make a complaint was not always available in the PICUs and verbal complaints were not always being recognised and addressed with access to the complaints process.

The wards were aware of the diverse needs of all the people who use the service and made positive attempts to facilitate conversations with patients. The wards were able to provide a range of different treatments and therapeutic activities.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The trust had not anticipated increases in the demand for acute inpatient beds and contingency plans were not in place that preserved the safety and dignity of patients.

Staff were committed to the vision and values of the organisation and felt connected to the trust. There were local governance processes that enabled identification of where the services needed to improve. Staff morale was good and teams worked well together. Monitoring of incidents, complaints and safeguarding incidents was used to make improvements to the service. Some innovative practice took place to help improve the service that patients received.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care units (PICU) provided by Central and North West London NHS Foundation Trust are part of the trust's borough services.

The Campbell Centre in Milton Keynes has two acute wards for adults of working age: Willow and Hazel wards. They have a total of 38 beds.

Park Royal Mental Health Centre (MHC) in Brent has three acute wards for adults of working age: Pine, Pond and Shore wards. There is one 13 bedded PICU for men only called Caspian ward. The acute wards have a total of 66 beds.

St Charles MHC in Kensington has four 17 bedded acute wards for adults of working age: Amazon, Danube, Thames and Ganges. There is one 14 bedded PICU for males called Nile ward. There is a 12 bedded PICU for females called Shannon Ward.

The Gordon Hospital in Westminster has three acute wards for adults of working age: Vincent, Ebury and Gerrard wards. The acute wards have a total of 56 beds.

Northwick Park MHC in Harrow has two acute wards for adults of working age: Eastlake and Ferneley wards. The acute wards have a total of 45 beds.

Riverside MHC in Hillingdon has two acute wards for adults of working age: Crane and Frays wards. There is one PICU called Colne ward. The acute wards have a total of 41 beds. The PICU has eight beds and is for men only. Crane ward was for females only, with Frays ward accommodating males only.

We have inspected the services provided by Central and North West London NHS Foundation Trust (CNWL) at the Campbell Centre and St Charles Mental Health Centre (MHC) five times between March 2013 and November 2014. At the time of the last inspection, the Campbell Centre was not meeting the essential standards relating to record keeping (Regulation 20). St Charles MHC was not meeting the standards relating to patients' consent (Regulation 18), the care and welfare of patients (Regulation 9) and assessing and monitoring the quality of service provision (Regulation 10). These compliance actions were inspected as part of the comprehensive review and the requirements had been met. However, some further improvements were needed in relation to the day-to-day management of ligature risks.

Our inspection team

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of 21 people: three experts by experience, six inspectors, four Mental Health Act reviewers, five nurses, two psychiatrists and one specialist registrar. The team was split into five teams to carry out the inspection.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of 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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at thirteen focus groups.

During the inspection visit, the inspection team:

- visited all 20 of the above wards at the six hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 85 patients who were using the service, and/or their carer
- spoke with the managers or acting managers for each of the wards
- spoke with 11 modern matrons with responsibility for several of the wards
- spoke with 99 other staff members; including doctors, nurses, health care assistants pharmacists, bed manager and allied health professionals
- spoke with four advocates and received information from one other
- attended and observed five hand-over meetings
- attended and observed 13 multi-disciplinary meetings, some of which were the daily 'whiteboard' reviews.
- attended and observed three community meetings
- attended and observed one carer and users forum
- carried out five Mental Health Act monitoring visits to Willow, Pond, Nile, Amazon and Gerrard wards

We also:

- collected feedback from 66 patients/ carers using comment cards.

What people who use the provider's services say

During the inspection we spoke with 85 patients and their carers on all the wards. They were positive about their experience and felt that they received support that was appropriate to their needs.

With a few exceptions the patients spoke very positively about the support they received from the staff. They said staff were helpful, caring, listened to them and gave them encouragement and support with their needs. Patients said the staff made them as comfortable as they could when they had to sleep on the sofa or return to the ward from an overnight stay on an alternative ward. Some patients commented that improvements could be made for some staff to be more professional in their attitude, as some did not appear interested in the patients.

Some patients were not clear about why they were in hospital or why they were not able to take leave away from the ward. This was confirmed by the advocate, who felt this needed to be improved.

Most of the patients spoke of being involved in their care and support planning, though some said they did not.

We observed positive, kind and caring interactions between staff and the patients, including under challenging circumstances. Discussions between patients and staff were in private and away from other patients on the ward.

Before the inspection visit we attended fourteen local focus groups and met people who had used the acute wards and the PICU. The feedback was generally positive, although some people felt that they were discharged very quickly and some said they were moved between wards during their inpatient stay. Others felt that the challenging behaviour of others patients was not always managed well enough to make them feel safe.

At the end of the inspection we collected 66 comment cards from the wards. Apart from one, these gave positive feedback about the support people received and the caring approach of the staff. Some comments highlighted that some staff attitudes could improve. There was mixed

Summary of findings

feedback about the food, and this appeared to differ depending on which hospital site patients were accommodated. Most patients said there enough activities, but they would like more to do in the evenings.

Good practice

- In 2014 the acute care services introduced daily 'whiteboard' meetings on each ward. These were attended by a range of disciplines including the consultant psychiatrist, matron, staff nurse, psychologist, pharmacist, occupational therapist and medical trainees. The meeting provided a daily update on each patient and opportunity for professions to have daily oversight of what was happening with each patient.
- On some of the wards they had recruited 'peer support workers' (PSW) who worked on a full or part-time basis. These were people who had experience of using mental health services. They worked as part of the team and were able to provide additional insight into what is was like to be a user of services. The PSW's spoke of their role as being a 'bridge' to facilitating better working between patients and staff.
- The occupational therapy (OT) team at the Riverside Centre in Hillingdon were involved in ongoing research with a local university. This was a four year project and involved previous and current patients in research around their experience of using OT and how this had an impact on their lives.
- At the Gordon Hospital there was a homelessness prevention initiative (HPI) that supported patients admitted to a Westminster acute mental health bed that were homeless or at risk of homelessness. This project assessed and supported people to help facilitate discharge planning and reduce readmission, with the aid of peer support workers.
- Eastlake and Ferneley wards had created a therapeutic environment using a mix of service user and professional artwork. This provided areas of colour and enhanced lighting for areas with no natural light. A psychologist employed by the trust has advised on the décor.

Areas for improvement

Action the provider MUST take to improve

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

- 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.
- Staff working on the wards must be 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 provider must ensure that staffing levels 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.
- Staff must 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.

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- 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.
- Patients returning from leave must 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 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 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.

Action the provider MUST take to improve the psychiatric intensive care unit

- The trust must ensure 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.

Action the provider SHOULD take to improve

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

- 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.
- Staff at the Gordon Hospital should ensure copies of consent to treatment forms are attached to medication charts.
- 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 well-being.
- 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.
- Male staff were reluctant to interact 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.
- Staff should encourage all patients to get involved in planning their care and treatment. This involvement should be clearly recorded.
- Discharge planning should be incorporated 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.

Central and North West London NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Willow ward Hazel ward	Campbell Centre
Pine ward Pond ward Shore ward Caspian ward	Park Royal Mental Health Centre
Amazon ward Danube ward Ganges ward Nile Ward Shannon Ward Thames ward	St Charles Mental Health Centre
Vincent ward Ebury ward Gerrard ward	The Gordon Hospital
Eastlake ward Ferneley ward	Northwick Park Mental Health Centre
Crane ward Frays ward Colne Ward	Hillingdon Hospital Mental Health Site

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

The trust's systems supported the appropriate implementation of the Mental Health Act and its associated 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. The staff carried out regular audits to ensure the Mental Health Act was being implemented correctly and produce a quarterly Mental Health Act Performance Report. A Mental Health Law group met every two months to review Mental Health Act performance and trends and provided a governance structure.

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.

Detention paperwork was filled in correctly, was up to date and was stored appropriately.

There was a good adherence to consent to treatment and capacity requirements overall and copies of consent to treatment forms were attached to medication charts where applicable. However, at The Gordon Hospital the consent to treatment section on the back of the charts was not completed on any of the charts examined.

There was evidence that patients had their rights explained to them on admission to hospital. Where patients did not understand their rights, the Trust had a policy that a discussion of rights would be repeated daily for the first 14 days following detention and weekly thereafter. However, discussions of rights were not always regularly repeated following unsuccessful attempts.

Within all of the wards we visited patients had access to independent mental health advocacy (IMHA) services. Patients and staff appeared clear on how to access IMHA services appropriately.

During the inspection of St Charles MHC we found that a patient had been confined to their room. The staff supporting the patient confirmed to us that they were not allowed to leave their room. This meant the patient was being nursed in seclusion, though not in accordance with code of practice: Mental Health Act 1983. We alerted the provider to this and the patient was moved to a seclusion room.

Mental Capacity Act and Deprivation of Liberty Safeguards

During the last CQC inspection of St Charles MHC it was identified that most staff did not understand their responsibilities under the Mental Capacity Act 2005 (MCA), and there were differences in how patients' capacity was being assessed and documented. At this inspection we found that improvements had been made at the hospital and across the acute services in relation to the implementation of the MCA. Staff had received training in the MCA and were able to describe examples where patients' capacity had been assessed in accordance with this.

Capacity assessments under the MCA were recorded in the care records for specific decisions, such as the use of covert medicines and managing finances. Staff also showed an understanding of Deprivation of Liberty Safeguards (DoLS), and how this could apply to patients not detained under the Mental Health Act 1983

At Park Royal Mental Health Centre we found that work was being undertaken to review all informal patients to ensure they did not need capacity assessments in relation to specific decisions or were being deprived of their liberty without the correct authorisations in place.

Inadequate

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 **inadequate** because:

- Although the trust had a plan to reduce the number of ligature points on the wards, the work would take some time to complete. Until this was done, patients on the ward who were at high risk of suicide would be at increased risk. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature point risks on the wards in terms of the support given to individual patients who were at high risk of suicide to keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions.
- Some of the ward environments did not have clear lines of sight. There was a lack of planning of how risks in the environment would be managed on a daily basis.
- The failure to increase staffing to support increased numbers of patients on the wards put patients at risk of not having their needs met appropriately.
- The training of staff in new restraint techniques had not yet been fully implemented. This meant that staff working together on wards were not all trained in the same techniques and in line with current best practice on the use of prone restraint. Until this training is complete staff were using out of date interventions that could present a risk of injury to staff and patients.
- In the event of the use of rapid tranquilisation, monitoring of physical vital signs was not always maintained until the patient was alert.
- The records relating to the seclusion of patients at St Charles MHC did not provide a clear record of medical and nursing reviews, to ensure that people were kept safe and these were carried out in accordance with the code of practice.
- There were a significant number of detained patients absconding from acute wards especially from St Charles, Park Royal and the Gordon Hospital. In response to a serious incident steps had been taken to address this at one hospital. Further review and actions were needed to reduce the risk of harm for patients using these services.

Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was readily accessible. Staff had been trained and knew how to make safeguarding alerts. Medicines were managed well. The wards were clean and generally well-maintained. Staff completed risk assessments and developed risk management plans to minimise risks to patients and staff. The daily 'whiteboard reviews' on the wards enabled a daily assessment of risk to be undertaken by the multi-disciplinary team.

Our findings

Acute wards for adults of working age

Safe and clean environment

- The layout of most of the wards enabled staff to observe most areas. However, the female areas of the wards at St Charles MHC and the Gordon Hospital were difficult for staff to observe due their location behind closed doors and away from the reception/ office area. The male corridor on Ebury ward was not easily observable due its position. On Ferneley ward the need for further CCTV had been identified, and this was on the risk register for the ward. The staff told us that risks were mitigated by walking around the ward areas several times an hour. However, patients could be at risk where staff did not have a direct line of sight at all times.

Inadequate

Are services safe?

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

- From the last inspection of St Charles MHC it was identified that improvements were needed to the management of ligature points on the wards. Ligature risk assessments had been carried out on all the CNWL acute wards over the past few months. The ligature risk assessments identified many high and medium risks on all wards. The trust had an action plan to carry out a large programme of works that would address many of the existing risks. At St Charles MHC these were due to be completed by the end of September 2015. In the intervening period 'local management plans' had been implemented on each ward that listed the ligature risks so that staff were aware of these.
- The CNWL policy relating to the management of ligature risks detailed that control measures were required to mitigate risks from ligature points. Some ward ligature risk assessments detailed 'blanket restrictions', such as locking all the quiet rooms, lounges and bathrooms to reduce risks to people. However there was a lack of detail in the assessments and local management plans of how risks would be managed on a daily basis reflecting the needs of the patients using the service. The staff were unable to tell us how the existing ligature risks were being managed. The care plans did not clearly document how the ligature risks were managed with individual patients where there was a risk of suicide. There was a lack of clear control measures to help staff minimise or mitigate the risks to patients of existing ligature points.
- Some of the wards across the acute services were single sex wards. On the other acute wards there were separate male and female sleeping areas. These wards had 'flexible' rooms which could be sectioned off to accommodate males or females. These rooms did not have ensuite facilities but patients could use a shared bathroom that was accessed by walking down a same gender corridor. There was also a unisex bathroom near the flexible rooms and this had a lockable door. We were told that staff were extra vigilant in these circumstances. There was a separate female lounge on each ward and we saw female patients using this space during our visit. However, the television in the female lounge of Thames ward was not working, so females had to go the male lounge to use this.
- Hazel ward at the Campbell Centre had a dedicated ensuite bedroom for use with young people, under the age of 18, requiring inpatient care and treatment. This was situated off the ward, and we were informed it was only used in emergencies. The young person would be seen by their own consultant and an incident form completed about their admission to ensure relevant senior managers were informed.
- Patients told us they generally felt safe on the wards. Some patients from Thames and Danube ward said that some patients' behaviour was challenging and they did not always feel this was dealt with appropriately by staff. They said this was mainly where non-permanent staff were working and did not know how to manage situations. The concerns that patients raised with us were followed up during the inspection. Risk management plans and processes were put in place to reduce risks to patients from other patients'.
- Emergency equipment, including automated external defibrillators and oxygen were situated on the wards. They were checked regularly to ensure they were fit for purpose and could be used effectively in an emergency. The staff knew where ligature cutters were kept and told us they knew how to use them. The training records showed that staff had had training in life support techniques to enable them to respond effectively to emergencies.
- The wards we visited were clean and generally well-maintained. However, the boiler/ heating system at Park Royal MHC had been broken since December 2014. There was an action plan in place to address this issue. However, the risks presented by the temporary 'stand-alone' heaters had not been included in the ligature risk assessment of the ward.
- On some wards we were told by patients that the toilets often became blocked and were not always clean, but staff did their best to address this in a timely manner. The cleaning audits for the wards showed positive results and showed the wards were clean and hygienic. This was in line with the findings of the recent Patient Led Assessments of the Care Environment (PLACE), where the acute wards across the trust scored a minimum of 98% for cleanliness.
- Patients told us that standards of cleanliness were usually good and any shortfalls in cleaning were

Inadequate

Are services safe?

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

promptly addressed. The staff of each ward carried out regular infection control and staff hand hygiene audits to ensure that infection risks to patients and staff were minimised.

- There were call alarms in each area of the ward and staff carried a personal alarm on them at all times. At St Charles MHC the alarm sounded throughout the building, regardless of where an incident was taking place. The staff told us this was to alert members of the emergency response team to an incident. However, patients told us that the sound of the alarms made them anxious and woke them up frequently during the night.

Safe staffing

- Most of the wards we visited were fully staffed, or had minimal vacancies that were being recruited to. However, the Campbell Centre had a number of vacancies across Willow and Hazel wards including 13 vacancies for nurses and three for health care assistants. Similarly, there were a number of nurse and health care assistant vacancies at Park Royal MHC. As a result there was high use of bank and agency staff, which could put patients at risk of inconsistent care. A trust workforce plan and recruitment strategy was in place to work on addressing the vacancies.
- Staff on the wards at Park Royal MHC staff were sometimes called to assist in the health based place of safety where patients were admitted as an emergency by the police. Staff said that at night this could leave the wards short staffed while assistance was given. Additional staff were booked when patients needed one to one support or when patients were moved to other wards overnight when there was no bed available on the ward. In most cases regular bank and agency staff were being used to provide some consistency to the service and the care and treatment provided to patients.
- Most of wards we visited had more patients allocated to the beds than there were actual beds on the ward. Some patients would spend their day on the ward, but sleep on a different ward during the night. When patients returned to the ward this increased the patient numbers during the day. However, apart from the Riverside Centre in Hilllingdon, the ward managers told us that staffing levels were not increased to meet the higher number of patients on the ward. For example, on Thames ward, there was one extra bed and three patients had slept out on different wards overnight. There was also one extra patient being accommodated on the ward, with a bed made up in a lounge. However, the staffing levels had not been increased during this time. On Amazon ward an extra patient was similarly accommodated in the quiet room, and there were two patients who slept out on other wards and returned to the ward during the day. However, the ward manager told us that staffing levels had not been increased to support the extra patients. The failure to increase staffing in response to increased numbers of patients on the wards put patients at risk of not having their needs met appropriately, due to the low staffing levels.
- Patients told us that staff were visible and generally available when they needed them. However, they were very aware of the pressures that staff were under, and did not feel able to always approach staff when they needed to. Ward managers acknowledged that patients could not always take their agreed escorted leave, as there were not always enough staff to escort them. Staff tried to organise escorted leave so that as many patients as possible were able to go out as agreed, and this meant some patients went out in groups, which some patients did not want.
- Doctors told us that there were adequate medical staff available day and night to attend the ward quickly in an emergency. At night each of the hospital locations had a doctor available on site to respond to urgent needs.

Assessing and managing risk to patients and staff

- Staff completed risk assessments on the admission of new patients to the ward. These incorporated historical and known risks. This information was used to develop risk management plans. These were reviewed regularly and updated after incidents.
- Staff told us about measures put in place to ensure that risks were managed. For example, the level and frequency of observations of patients by staff were increased when required. We observed staff used appropriate de-escalation techniques to reduce patients' anxieties and potential aggression. During the inspection we observed a physically aggressive incident

on Thames ward. Staff responded promptly to this and the patient was supported on a one-to-one basis immediately to minimise risks to other patients and staff.

- Every morning a 'whiteboard review' was carried out on each ward with all members of the multi-disciplinary team. This meeting involved a daily review of each patient on the ward, assessing their current mental health and any individual risks. This meeting informed any plans for the day and ward rounds that followed on from this.
- On Willow ward at the Campbell Centre, there was a kitchen area on the ward where patients could make hot drinks. This area was kept locked and patients were allowed supervised access only, due to concern about the risks associated with unsupervised patient access to hot water. We were concerned that this was a blanket restriction and was not based on patients' individual risk assessments.
- The privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions. At The Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity as all the bathroom doors had been replaced with curtains.
- There were notices on all exits from the ward to inform patients who were informally admitted that they could leave the ward.
- The trust had a policy on the prevention and therapeutic management of violence and aggression. This had been updated in 2014 after the publication of the Department of Health guidance "Positive and Pro-active Care".
- Between 1 May 2014 and 31 Oct 2014 restraint was used trust wide on 773 ocassions. Restraint was being used mostly on the psychiatric intensive care units, acute and forensic inpatient wards. In 284 (36.7%) of these 773 incidents, patients were restrained in the prone position. In 319 (41.3%) of the 773 incidents of restraint rapid tranquilisation was administered. The number of prone restraints was being closely monitored by the trust through a restrictive interventions group. However at the end of the last quarter (December 2014) the number of prone restraints remained at around 75 a month which is a high figure. The trust had a strategic action plan on restrictive interventions and had set a target to reduce the use of all forms of restraint by 50% in 18 months.
- Physical intervention training was delivered by an in-house tutor team and the model used was the general services association. The training focused on verbal de-escalation techniques but also teaches techniques to safely restrain patients in the supine position. At the time of the inspection over 200 staff had been trained in the supine position however these were staff from across the wards. They were not able to always use this revised training as they could be working with people who had not had been taught the new technique.
- Immediately after the inspection the trust said they had developed a plan to accelerate the delivery of training of restraint in the supine position to the remaining staff that required this update. The trust had secured an external training venue and had brought in additional trainers to deliver this. This additional training would be commencing in April 2015 and was scheduled for completion in June 2015. Whilst this new technique is expected to support a reduction in prone restraint, wider work was also being undertaken via the trust's strategic action plan to support a reduction in all restrictive interventions. Areas known to be high users of all forms of restrictive practices would be prioritised with a particular emphasis on de-escalation and alternatives to physical interventions and enforced medication. The trust said that as part of this training package, all staff will receive an introduction to positive behaviour support planning and advanced directives.
- Across some wards we looked at the records kept after patients had been given rapid tranquilisation to manage violent behaviours. The National Institute for Health and Care Excellence (NICE) guidance states that the vital signs of patients should be monitored until they are alert. However, the records of monitoring following rapid tranquilisation (RT) we reviewed did not show that this always happened. In some cases staff recorded the patient was asleep, with no records of monitoring taking place. We found examples where the reason for administering RT was not always recorded. Whilst there was some monitoring of physical checks for up to four hours post rapid tranquilisation, this was not consistently being carried out and patients were at risk

where staff did not monitor and record their state of physical health. In some situations a medical review was not carried out until the next ward round, which was some days later, or the doctor was not notified of the use of RT until the following day. This lack of monitoring put patients' physical health at risk.

- The seclusion room at St Charles MHC was situated away from the acute admission wards and in between the two psychiatric intensive care units (PICUs). The staff told us that if their ward had a patient in the seclusion area then they would provide the nursing support to the area. The records relating to the seclusion were included within the daily progress notes and did not provide a clear record of medical and nursing reviews, in accordance with the code of practice. There was no separate 'at a glance' record to ensure medical reviews took place at the correct times. Recording in the progress notes meant that reviews that took place were not always recorded contemporaneously, and the timings of the start and end of seclusion and reviews were not always recorded. This put patients at risk of not having their needs reviewed appropriately whilst in seclusion.
- One seclusion room at Park Royal Mental Health Centre had a 'blind spot', where staff could not safely view the patient at all times. At Northwick Park the seclusion room had no clock. There had previously been a clock but it was removed as the fixture it hung from was considered a ligature risk. The clock was reinstalled and was ligature risk free by the end of our visit.
- Park Royal MHC had two seclusion rooms and also the highest rate of seclusions of any of the other acute in-patient sites. Of a total of 1257 episodes of seclusion across the acute and PICU services over the past three years, 988 of these were at Park Royal. The trust was aware of this and informed us that the local care quality group and restrictive interventions group were monitoring the seclusion and other restrictive interventions used at the hospital to benchmark against other services, examine seclusion incidents and extract learning from these.
- Between the 1 September 2014 and the 28 February 2015 there were 247 incidents of patients detained under the Mental Health Act who were absent without leave. These were mostly from acute inpatient wards and the numbers were St Charles 57, Hillingdon 43, Park Royal 40 and the Gordon Hospital 30. Thirty three percent (82) of these were incidents of patients who had absconded whilst residing on the ward. The three sites with the most incidents of patients absconding from the ward were St Charles 21, Gordon Hospital 17 and Park Royal 12 incidents. Just prior to the inspection a patient who was detained absconded from Gerrard ward at the Gordon Hospital and sadly taken their own life. The trust had taken the step of ensuring a member of staff was placed in the reception area by the ward at all times. However, there was one occasion when we arrived at the reception and there was no member of staff present. The reception desk was raised, which made it difficult for staff to have a full view of the door especially if there was someone standing at the reception desk blocking their view. The layout of this area also meant that if a patient tried to leave the ward it would be hard for nursing staff to try and stop them. The three sites where most detained patients were absconding must be reviewed and action taken to reduce the risk of harm for patients using these services.
- Staff had received training in safeguarding vulnerable adults and children.The staff we spoke with knew how to recognise a safeguarding concern and how to escalate this to ensure it was reported appropriately. Staff were aware of the trust's safeguarding policy and could name the safeguarding lead. They gave us examples of safeguarding referrals that had been made. These showed that safeguarding concerns were alerted promptly in response to allegations or incidents that had occurred. In the office areas there were flowcharts on display of how to raise any safeguarding concerns, to remind staff of actions they needed to take.
- Appropriate arrangements were in place for the management of medicines. We reviewed the systems for the storage and administration of medicines on several of the wards we visited. Medicines were stored securely. Temperature records were kept of the medicines fridge and clinical room in which medicines were stored, showing that medicines were stored appropriately to remain fit for use. The records relating to the administration of medicines were accurate. Wards regularly audited medicine records to ensure recording of administration was complete. The pharmacy team sent out regular newsletters to the wards to remind staff of good practice in the management of medicines on the ward.

Inadequate

Are services safe?

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- There was ongoing pharmacy review and management of the medicines on each ward. The use of 'as required' (PRN) medicines was reviewed at each ward round. Any medicines errors were addressed with staff and used as learning for the rest of the staff team to prevent recurrence. However, in the Milton Keynes wards we found there were more medicine errors reported, which could have been related to the high use of agency staff that were not always familiar with the systems of the wards.
- Patients were provided with information about their medicines. Pharmacist and ward staff discussed changes to patients' medicines, and mental health medicines information leaflets were available for people. Most patients we spoke with confirmed they had received information about medicines and knew what they were for.
- For patients who wanted to see their children, this was considered with partner agencies and risk assessed to ensure it was in the child's best interest. A separate family room away from the ward was available for visits.

Track record on safety

- In the last year there had been five serious untoward incidents involving working age adults. One of these had been a death on an inpatient ward St Charles MHC through the use of a ligature point. One incident at the Gordon Hospital was as a result of a patient leaving the hospital and taking their life. These were being investigated at the time of the inspection, and measures had been taken to prevent recurrence.
- There had been a number of safeguarding incidents across the wards which related predominantly to aggressive incidents between patients. The wards took action in response to these to ensure that management plans were updated to prevent recurrence. Additional support was provided to patients to help them manage their anger and stay safe.

Reporting incidents and learning from when things go wrong

- The staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and modern matron and forwarded to the trust's clinical safety team, who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.
- Local incidents and learning from these was evident in the wards we visited, where improvements had been made as a result of incidents that had occurred.
- At St Charles MHC improvements were made in response to incidents. For example, more thorough searches of patients were made when returning to the ward to ensure they were not carrying any items that could be used as potential ligatures. At the Riverside Centre in Hillingdon action had been taken in response to learning from incidents including medicines errors. At Park Royal MHC, single sex wards were introduced in response to safeguarding concerns. Following a sudden increase in incidents at the Campbell Centre a root cause analysis of incidents took place and identified that more social and therapeutic activities were needed in the evenings to keep patients occupied. This was subsequently introduced on the wards.
- Some managers told us they were made aware of incidents that had occurred on other wards at weekly meetings of ward managers and the modern matron. However, the staff on the wards had limited awareness of incidents that had occurred outside of their ward areas, or of the learning from these. Despite this, we did see on some wards a folder that contained details of incidents that had occurred in the trust and the learning from these.
- Following incidents, staff were offered support from their line managers and peers. Staff reported feeling supported by their team and able to discuss incidents and any difficult feelings that arose as a result. Reflective practice sessions for staff took place fortnightly on each ward with a psychologist.

Psychiatric intensive care units (PICU)

Safe and clean environment

- All four PICUs had had a ligature risk assessment. This identified work that was needed, including removing high risk ligature points in the ensuite bathrooms and

communal bathroom on Shannon and Nile wards. This work was scheduled for the week following our inspection. Caspian and Colne wards also had plans to carry out work.

- All four PICU wards were single sex and complied with guidance on same-sex accommodation.
- The emergency equipment in all four wards was accessible to staff. It was checked daily and the emergency medication was in place and in date.
- Colne ward did not have a seclusion room. Caspian ward had a recently refurbished seclusion room and a de-escalation room. Staff told us that when using the de-escalation room a member of staff stayed with the person and the door was not locked. Shannon and Nile wards had shared use of a seclusion suite along with the rest of St Charles MHC.
- All the services we visited were clean, had reasonable furnishings and were well maintained.
- Staff were provided with portable alarms. The alarm system identified where the staff member who needed help was located. Staff from adjoining units helped as needed.

Safe staffing

- The trust had reviewed the staffing levels of the PICUs. During the day on Caspian ward there were three qualified nurses and two health care assistants (HCA), and at night two nurses and one HCA. On Shannon ward there were four nurses and two HCA's during the day. Additional staff were booked if patients need one to one support, which happened frequently. On Nile and Shannon wards admissions were temporarily suspended if four patients required one to one observations.
- The staffing levels on duty normally reflected the planned rota of staff. The exception being when a staff member was unable to work at the last minute.
- There was an active ongoing programme of recruitment involving measures such as close work with the local university. The staffing levels were maintained using bank and agency staff. Permanent staff covered the usual shifts but bank and agency staff were needed for one to one work.
- Bank staff were usually known and familiar with the service. Agency staff had to complete an induction that when they worked in a unit for the first time. There was an induction checklist and description of expectations that was given to new staff.
- Staff, including qualified staff were mostly present in communal areas of the ward and available to patients.
- Each patient had a named nurse and associate worker. The goal was for patients to have an individual session with their named worker at least once a week and this was being achieved.
- Patients on Caspian ward had access to regular leave and activities and these were rarely cancelled due to staffing, although a change in time might be negotiated with the patient if needed. Patients on Nile and Shannon ward were rarely granted Section 17 leave. They had access to a good range of activities.
- All staff had to complete training on physical interventions which was refreshed on a three yearly basis. There were enough staff on the wards to carry out these interventions.
- Patients had up to date risk assessments that were reviewed regularly. Staff on Colne ward showed a thorough understanding of relational security.

Assessing and managing risk to patients and staff

- Patients' needs were regularly reviewed and if additional staff were needed for closer observation this was provided. Searching of patients happened very rarely and was based on individual risks. This was negotiated with the patient as part of their care plan and risk assessment.
- Staff were aware that the trust had begun training staff in supine restraint, but prone restraint was continuing to be used until all ward staff had been trained in the new method. Training was updated and everyone had refresher training every three years. Staff were skilled in de-escalating incidents. Almost all Shannon ward staff had been re-trained in supine restraint.
- Safeguarding training was part of the mandatory training. Staff knew how to recognise abuse, who the

Inadequate

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safeguarding leads and safeguarding authority were. Managers said that they would discuss potential safeguarding issues with the local authority safeguarding team where needed.

- Medicines were well managed on the site including the storage and dispensing. The pharmacist visited the sites twice a week but there were arrangements to obtain medication on the other days if needed. The pharmacist said they were involved in complex prescribing decisions. They also provided regular training to staff. They regularly undertook clinical audits relating to medication.
- There were rooms available off the ward for patients to meet with families that included young children.

Reporting incidents and learning from when things go wrong

- Staff all knew how to report incidents.
- All incidents were reported as necessary.
- While staff knew about incidents that had taken place within the site they did not know about incidents occurring across the division or wider trust. They were aware that incidents resulted in safety alerts and were in bulletins provided by the trust. Feedback on incidents was a standing item on the care quality meeting agenda. The meeting was attended by ward managers. It was also a standing item discussed at the monthly management meeting. The modern matron said this was also discussed at matron meetings and the divisional director monitored this across the division.
- Staff received full support after a serious incident. This included seeking medical advice where necessary. Staff were provided with a debrief meeting and opportunities to review incidents during reflective practice. Access to occupational health and counselling services was available when needed.

Are services effective?

Good

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Summary of findings

We rated effective as **good** because:

Clinical staff made an assessment of patients' needs on their admission to the wards. This included an assessment of physical health needs. Where needs had been identified, these were developed into care plans so that staff knew each patient's needs. Multi-disciplinary teams worked effectively in the care and support of patients.

Staff received appropriate training, supervision and professional development. Staff used the Mental Health Act 1983 and the accompanying code of practice appropriately. Staff had an understanding of the Mental Capacity Act 2005, and there were positive examples of their working within this to assess patients' capacity. On some of the wards they had recruited 'peer support workers' (PSW), who worked on a full or part-time basis. These were people who had experience of using mental health services. They were considered a valuable part of the team and helped other staff work with patients in a more sensitive way.

Our findings

Acute wards for adults of working age

Assessment of needs and planning of care

- Patients' needs were assessed and care was delivered in line with their individual care plans. The care records showed that people were assessed on admission to the ward and care plans implemented in response to their assessed needs.
- The trust set itself a target of the records showing that all patients had a medical and nursing physical health assessment on admission to the wards. Care records showed this was happening and each patient's physical health needs were assessed by medical and nursing staff. Where a physical health need had been identified, care plans had been implemented to ensure they were addressed, along with plans for routine monitoring. An example of this was where patients had long term conditions such as diabetes, and care plans were developed to enable the patient to maintain as much independence as possible with this, whilst being monitored by staff.
- Physical health checks of all patients were carried out through a system of weekly weight, blood pressure, pulse and temperature monitoring. The staff that carried out these checks were aware of the safe parameters and said they would raise any concerning physical observations with nursing staff or the ward doctor.
- At the last CQC inspection of St Charles MHC we identified there was a lack of individualised care planning and assessed needs had not always been planned for. During this inspection we found some improvements had been made to the care planning to ensure these were more personalised, holistic and recovery-orientated. However, more information could be provided in relation to patients' individual preferences in their care. The care plans were reviewed on a regular basis and updated as appropriate.
- The care records were stored on the provider's computerised care planning system. Access to the system was through staff identification card and password login, which ensured confidential information was maintained securely. The computerised records meant that information was available to doctors and nurses as patients moved between services. From the last inspection of the Campbell Centre there were concerns raised with regard to record keeping. At this inspection we found that improvements had been made to ensure records were appropriately maintained.

Best practice in treatment and care

- The National Institute for Health and Care Excellence (NICE) guidance was followed in relation to the management of and prescribing of medicines. The psychological therapies provided were in accordance with those recommended by NICE, such as cognitive behavioural therapy, living with psychosis and mental health recovery. At the Riverside Centre in Hillingdon we found that work took place with the relatives of some patients to support them with their relative whilst in hospital, and when discharged.
- We found that access to psychological therapies as part of patients' treatment varied between different wards. Psychologists were part of the ward teams and provided

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input to the care people received. However, they were not always full-time. For example, at The Gordon Hospital there was a part-time psychologist that worked across three wards. This meant that not all patients received direct support from psychologists. We were informed that decisions about who received psychological therapies was not always based on clinical need as there were not enough psychologists available.

- The acute wards were based in mental health centres within the grounds of acute (physical health) hospitals or were close to them. This meant that staff could access support promptly in the event of a physical health emergency. Each ward had a ward doctor to oversee patients' physical health needs, and on a day-to-day basis this was monitored by ward staff. Regular physical health checks were taking place where needed.
- On admission to the wards the staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- The occupational therapists (OT) used the model of human occupation screening tool with patients. They assessed patients within the first 72 hours of their admission, to see if they required any OT support during their stay.
- The acute wards used a number of measures to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis. On all the wards we visited we saw examples of audits of care plans, medicine records, explanation of patients' rights, physical health checks and incidents. Information from completed audits was used to identify and make changes needed to improve outcomes for patients.

Skilled staff to deliver care

- The staff working on the acute wards came from a range of professional backgrounds including nursing, medicine, occupational therapy and psychology. Some wards had activity co-ordinators to support people with in-house and external activities. The pharmacy team also provided support to the wards.
- On some of the wards 'peer support workers' (PSW) had been recruited. PSWs worked on a full or part-time basis. These were people who had experience of using mental health services. They worked as part of the team in the support of patients, and carried out the same role as health care assistants, but were able to provide additional insight into what it was like to be a user of services. The PSWs we spoke with described their role as being a 'bridge' to facilitating better working between patients and staff. They were part of the team and involved in training and support sessions, along with the rest of the staff team. The other staff valued their input and said they learnt a lot from the PSWs, that helped them work with patients in a more sensitive way. However, most of the patients we spoke with were unclear about the role of the PSWs, and did not feel this had been clearly communicated to them.
- Staff received appropriate training, supervision and professional development. The training records held on the wards showed that staff had were generally up to date in training relevant to their role, including safeguarding adults, fire safety, basic life support, infection control and therapeutic management of violence and aggression. New staff had a period of induction before being included in the staff numbers. Through the IT systems the ward managers were able to monitor staff progress in completing their training. The training helped to ensure staff were able to deliver care to patients safely and to an appropriate standard.
- Some staff told us about examples of continuing professional development they had undertaken. This included undertaking degrees and diplomas in areas relevant to their work. They were supported by the trust to undertake further learning and develop themselves professionally. On some wards bespoke training was provided, such as at the Campbell Centre where specific training was provided to staff in personality disorders and risk behaviours to meet the needs of a significant group of patients on the ward.
- Most staff told us they received clinical and managerial supervision every month, where they were able to reflect on their practice and incidents that had occurred on the ward. However, some staff told us that this could be cancelled when the wards were very busy. Fortnightly reflective practice took place across the wards, facilitated by a psychologist.

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- At the time of the inspection, senior staff told us that they were addressing performance issues with a number of staff, and were supported by the human resources team from the trust.

Multi-disciplinary and inter-agency team work

- During the inspection we observed three handover meetings between the morning and afternoon shifts on the wards. These were unhurried, detailed, and provided a clear picture to the oncoming staff of the current needs of each patient and any areas of risk or concern that staff needed to be aware of.
- Every morning, on each ward, there was a multi-disciplinary team (MDT) 'whiteboard' meeting, where the team reviewed each patient's needs daily. Pharmacists attended these on different wards each day. We observed five of these meetings. They enabled all the team to review each patient and discuss important issues or events that had occurred during the previous 24 hours, as well as ongoing needs. Some members of the MDTs told us they found the meetings very beneficial. We observed at these meetings that the MDT worked well together and all participated in discussions about the patients.
- Staff spoke positively about the MDT and felt that everyone was on the same level, working together to meet patients' needs. They felt listened to and could approach colleagues for advice when needed.
- The trust had recently introduced a new IT system of care recording to make these multi-disciplinary in approach. We found some were multi-disciplinary but further work was needed to embed this with all the MDTs. Nurses were expected to input their information onto the care plan even when decisions had been taken by other members of the MDT. The expectation for nurses to do this is not in the spirit of the system and could lead to inaccurate professional judgements being recorded.
- We observed six MDT meetings and found they were effective in sharing information about patients and reviewing their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- Staff spoke of positive links with local authority staff and care co-ordinators of patients. Patients were able to access their GPs in the community. For example, the homelessness prevention initiative at the Gordon Hospital worked closely with external organisations including homeless charities, housing options and embassies. The MDT worked closely with external agencies such as drug and alcohol services, CAMHS, debt management and volunteering organisations in arranging support for patients being discharged from hospital.

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

- Staff showed a good understanding of the Mental Health Act (MHA), code of practice (CoP) and guiding principles. Staff completed training on the MHA.
- The use of the MHA was good in the wards. The documentation we reviewed in detained patients' files was generally compliant with the Act and the CoP.
- Patients' medication administration records on all the wards had consent to treatment forms attached for those patients detained under the MHA. However, at the Gordon Hospital the consent to treatment section on the back of the charts was not completed on any of the charts examined.
- While reviewing the medication charts on Ebury ward, we found one case of where the patient had consented to the treatment, there was no legal authorisation covering the time period. This was rectified immediately when brought to the attention of the consultant. Managers told us that the patient would be informed, and that incident, safeguarding and initial management reports would be completed.
- During the inspection of St Charles MHC we found that a patient had been confined to their room. The staff supporting the patient confirmed to us that they were not allowed to leave their room. This meant the patient was being nursed in seclusion, although not in accordance with CoP. We alerted the provider to this and the patient was moved to a seclusion room.
- Staff said that patients had their rights explained to them on admission and routinely thereafter. However, not all patients we spoke to were aware of their rights.
- Staff spoke positively of the support they received from the Mental Health Act law office regarding advice on the MHA and the Mental Capacity Act MCA

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- An independent mental health advocacy (IMHA) service regularly visited the wards. There were notices with information about the IMHA service on each ward. The service could be contacted by staff and patients directly during visits or by telephone on the publicised number.

Good practice in applying the Mental Capacity Act

- During the last CQC inspection of St Charles MHC it was identified that not all staff understood their responsibilities under the Mental Capacity Act 2005 (MCA), and there were differences in how patients' capacity was being assessed and documented. Our findings from this inspection were that improvements had been made at the hospital and across the acute services in relation to the implementation of the MCA. Staff had received training in the MCA and were able to describe examples where patients' capacity had been assessed in accordance with this.
- Capacity assessments under the MCA were recorded in the care records for specific decisions, such as the use of covert medicines and managing finances. Staff also conveyed an understanding of Deprivation of Liberty Safeguards (DoLS), and how this could be an issue for people not detained under the Mental Health Act 1983.
- At Park Royal Mental Health Centre we found that work was being undertaken to review all informal patients to ensure they did not need capacity assessments in relation to specific decisions or were being deprived of their liberty without the correct authorisations in place.

Psychiatric intensive care unit (PICU)

Assessment of needs and planning of care

- All patients had comprehensive assessments in place.
- Each patient had a full physical health assessment as part of their admission and we saw ongoing monitoring of physical health problems.
- Care plans were up to date, holistic and recovery orientated.

Best practice in treatment and care

- Individual health conditions were being managed appropriately. There were staff that were designated smoking cessation leads to support patients to reduce their smoking.
- All the patients were assessed using HoNOS and these were updated for care programme approach (CPA) reviews.
- A range of audits took place. These included audits to ensure care plans and risk assessments were up to date. Managers and team leaders had also completed audits to ensure supervision and appraisals were up to date. There were also medication audits.

Skilled staff to deliver care

- There was a strong multi-disciplinary team. In addition to medical and nursing staff there were psychologists, occupational therapists and pharmacists, and art, drama and music therapists. On Colne Ward there was only one hour of OT input per week due to an inability to cover the maternity leave of their OT.
- All staff completed an induction and mandatory training. Staff and their managers were reminded when this needed to be refreshed. The aim was for all staff to have management supervision once a month and this mostly happened. All the staff had an annual appraisal.
- Staff were positive about the training they could access. There was local training provided by team members and also training provided by the recovery college. Staff spoke very positively about opportunities for continuous professional development and access to leadership training.
- Staff performance issues were addressed through ongoing supervision.

Multi-disciplinary and inter-agency team work

- There were a range of multi-disciplinary meetings. These include ward rounds, CPA reviews and other meetings to discuss particular issues. We observed two ward rounds and these showed good multi-disciplinary working where everyone participated. They also demonstrated that staff knew individual patients very well.
- Regular handovers took place between shifts which enabled the sharing of essential information.
- Staff ensured that care coordinators were invited to CPA reviews and kept them updated through email and phone contact.

Are services effective?

Good

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.

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

- Staff showed a good understanding of the Mental Health Act, code of practice and guiding principles.
- There was a good adherence to consent to treatment and capacity requirements overall and copies of consent to treatment forms were attached to medication charts where applicable.
- We saw good documentation of mental capacity assessments within patients' care records.
- Patients had their rights explained to them on admission and regularly thereafter. We saw that where people were unable to understand their rights due to seriousness of their illness this was repeated more regularly.
- Staff told us that they had received support and legal advice on the implementation of the Mental Health Act and the Mental Capacity Act.
- All MHA paperwork had been filled in correctly, was up to date and stored appropriately.
- An IMHA service visited the wards once a week as a minimum and made additional visits to support patients at specific meetings such as CPAs and ward rounds. There were notices with information about IMHA services on each ward. The service could be contacted by staff and patients directly during visits or by telephone. We met the IMHAs for Colne Ward, Shannon and Nile Wards.

Good practice in applying the Mental Capacity Act

- Staff training on the MCA was mandatory.
- We saw good documentation of mental capacity assessments within people's care records.

Staff had a good understanding of the MCA and best interest meetings took place as needed.

Good

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 **good** because:

The staff were kind and respectful to patients and had a good understanding of individual needs. During the MDT meetings we observed patients and their relatives were encouraged to express their views. However, the involvement of patients in their care plans varied and further improvements could be made. Some positive work took place with the carers of patients, to provide support and involve them in their relatives care.

Our findings

Acute wards for adults of working age

Kindness, dignity, respect and support

- We observed positive, kind and caring interactions between staff at all levels and the patients, including during challenging circumstances. Discussions between patients and staff were in private and away from other patients on the ward. However, improvements were needed on Pond ward where we were informed that following a safeguarding investigation male staff were reluctant to interact with female patients due to the fear of potential allegations being made against them.
- With a few exceptions patients spoke very positively about the support they received from the staff. They said that staff were helpful, caring, listened to them and gave them encouragement and support with their needs. Patients said the staff made them as comfortable as they could when they had to sleep on the sofa or return to the ward from an overnight stay on an alternative ward. Some patients commented that improvements could be made for some staff to be more professional in their attitude, as some did not appear interested in the patients. On Frays ward some patients reported concerns about the way a staff member spoke to them, and we reported this to the modern matron at the time of the inspection.
- Information relating to patients was confidentially stored on the computers. However, we identified on Crane and Frays wards that information relating to productive wards was on display on the wards. This detailed different incidents that had occurred on the ward, such as rates of violence and aggression. Whilst patient names were not displayed, the information could potentially be identifying to other patients and visitors to the ward.
- Some patients were not clear about why they were in hospital or why they were not able to take leave away from the ward. This was confirmed by the advocate, who felt patients needed more information about this.
- The staff conveyed a caring approach when talking about patients and had a good understanding of their individual needs. Staff interacted with patients in a caring and kind way. When patients became anxious or aggressive staff responded promptly and de-escalated situations by speaking calmly and giving reassurance.

The involvement of people in the care that they receive

- When patients arrived on the ward they were shown around and provided with a welcome pack. The pack included information about the staff and different treatments they might be offered.
- During the MDT meetings we observed patients and their relatives were encouraged to express their views. Where people or their relatives were not happy about the decisions made, these were discussed and reasons given for actions.
- Patients' care plans varied in how much they demonstrated the involvement of patients in their care planning. We found that some used direct quotes from the patient, whereas others were written in the first person, or were a set of instructions to the patient, so it was not always clear how people were involved. There were opportunities to improve this across the services. Most patients' spoke of being involved in their care, and that the wards were good at trying to involve their families, where they had agreed to this.
- There was a service user involvement project called 'different voices' that was delivered through the 'advocacy project'. This project provided opportunities for former patients to be service user representatives who supported staff recruitment, provided feedback to the trust from various service user meetings, and conducted various surveys. For example, surveys were conducted about sexual safety and the admission

Good

Are services caring?

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

process. At the Riverside MHC in Hillingdon ex-patients helped co-facilitate some of the occupational therapy groups, which helped to role-model and support patients to be involved.

- Information about local advocacy services and independent mental health advocates was on display in the wards. Patients were aware of the days and times that advocates visited the ward, and staff supported patients with referral to the service, when they requested.
- Patients were encouraged to involve relatives and carers in care planning and attending meetings in relation to their care and treatment. We saw work with relatives took place at different sites. At the Campbell MHC work took place regarding family consultation meetings. At the Riverside MHC in Hillingdon specific work took place with families around supporting them with their relative. On some of the sites monthly carers meetings took place. Carers said they appreciated these meetings. Some patients felt the involvement of relatives could be improved. This was supported by the advocate we spoke with, who said that the timings of ward rounds or care review meetings often changed, without adequate notice given to relatives and advocates of patients, to ensure they could attend to support the patient. We heard from a number of carers and relatives before the inspection about how they did not feel they had been appropriately involved such as not being involved in assessments, not invited to meetings or having meeting times changed.
- The wards held community meetings with patients to gather their views about the ward. Minutes of the meetings were displayed to remind patients and staff of what had been discussed. Some of the feedback we received from patients at St Charles MHC was that community meetings did not take place regularly, and this was confirmed by staff and the lack of records or minutes of meetings.

Psychiatric intensive care unit (PICU)

Kindness, dignity, respect and support

- We observed positive, kind and caring interactions between staff and the patients. Staff were respectful, for example, knocking on doors before entering bedrooms.
- With very few exceptions patients spoke very positively about the support they received from staff.
- Staff knew patients well and were able to support them confidently and consistently.

The involvement of people in the care that they receive

- Staff described how new patients were introduced to the ward. This often had to take place gradually as patients were sometimes very unwell on their arrival. This would include showing them around and introducing them to staff and some other patients.
- Patients were routinely involved in their care planning, ward rounds and CPA reviews. Most patients told us that they had a copy of their care plan and we saw these were mainly written in clear and accessible language.
- Each PICU had access to a local IMHA service. An IMHA visited the sites once a week and more frequently if needed.
- Families were routinely invited to review meetings. Rooms were available for relatives to see people in private. Families and carers also had access to courses at the recovery college.
- Each ward had a weekly community meeting and these are well attended. At the meeting decisions were made about the arrangements for the day.

Are services responsive to people's needs?

Inadequate

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

Summary of findings

We rated responsive as **inadequate** because:

- Despite work to mitigate this, the pressure on acute beds meant that wards were often over-occupied. There was not always a bed for patients and they slept on sofas or a temporary bed was used. Patients returning from leave could not always get a bed and a bed was not always available in the PICU.
- Patients were often transferred to different wards to sleep and returned to the ward during the day. This disrupted the continuity of their care and patients felt it affected their well-being.
- Privacy and dignity of patients was not always promoted. Patients were not able to make calls in private. At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity.
- Information on how to make a complaint was not always available in the PICUs and verbal complaints were not always being recognised and addressed with access to the complaints process.

The wards were aware of the diverse needs of all the people who use the service and made positive attempts to facilitate conversations with patients. The wards were able to provide a range of different treatments and therapeutic activities.

Our findings

Acute wards for adults of working age

Access and discharge

- The most significant area of concern from the inspection related to acute care pathway for mental health services. In the six months between the 1 April 2014 and 1 September 2014 the average mean bed occupancy for the acute beds on each site was as follows: St Charles 108%, the Gordon Hospital 103%, Park Royal 113%, Northwich Park 106% and the Riverside Centre in Hillingdon 108%. In December 2014 the trust closed one further acute mental health ward, Mulberry South ward at the South Kensington and Chelsea Mental Health Centre. The trust said they had delayed this closure for several months in response to bed pressures.
- The trust told us that due to these exceptional pressures they were now placing a few patients in the independent sector and buying beds from another trust. This arrangement had started shortly prior to the inspection.
- All the wards we visited were full and the majority of patients on the wards were detained under the Mental Health Act 1983. With the exception of one ward, the wards were operating with over-occupancy. On Thames ward there were 21 patients allocated to the 17 beds. Crane ward had 27 patients (four patients on leave) allocated to 18 beds, plus one extra patient accommodated in a quiet lounge. Frays ward had 23 patients allocated to 18 beds. An extra bedroom had been created on Amazon, Ganges and Crane wards, through converting a quiet lounge into a bedroom. In some cases these were a long way from toilet/ bathroom facilities, which patients had to ask to use, due to these being kept locked.
- As a result of the over-occupancy of wards, beds were not always available for patients on their return from leave. For the first two months of 2015 there were 68 occasions across the acute and PICU wards when a bed was not available to patients in need of these, or there were delays to a patient receiving a bed. The highest number of these occurred on Thames ward, where there were 18 occasions, and on Danube ward there were 10 occasions when a bed was not available.
- Overall, between November 2014 and January 2015 there were a total of 57 occasions where patients did not have a bed to sleep in and slept on the sofa or in the quiet room on a temporary bed. Some incident reports showed that a patient was kept in the 'place of safety' (136 suite) for two nights. One person had also spent 32 hours in the assessment area at St Charles MHC when no bed was available on Danube ward.
- There were frequent moves between wards for some people for non-clinical reasons. Between November 2014 and January 2015 there were 85 occasions across the acute wards where patients slept on a ward other that the one they were admitted onto. The highest

Are services responsive to people's needs?

Inadequate

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

number of these occurred at St Charles MHC where during this period there were 38 occasions when patients slept on another ward. Other data submitted by the trust showed that for the month of February 2015, there were 167 occasions when patients slept out on another ward.

- Some patients were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. We were informed they were always escorted by a qualified nurse. Patients told us that sometimes they were moved very late at night, for example at around midnight, and had to return to the ward by 6:30am the following morning. This was confirmed to us by staff, although they said they attempted to move patients after they had received their evening medicines, between 9:00pm and 10:00pm. Patients told us that when they refused to move they were accommodated on sofas on the wards.
- The wards that patients transferred to was a substance misuse ward, older people's ward or rehabilitation facility. However, a patient from Frays ward slept overnight in a psychiatric intensive care unit (PICU) despite there being no clinical need requiring this. This meant there would not always be a bed available in the PICU when a person required more intensive care. The moving of patients between wards impacted on the continuity of care they received and patients reported this as being disruptive to their care and well-being.
- On Danube ward a patient had spent eight consecutive nights on a different ward, followed by a further thirteen on another ward. The patient had spent the majority of their admission sleeping on a different ward from that to which they were admitted. Another patient had spent ten consecutive nights on a different ward, whilst another had spent five consecutive nights away from the ward. On Thames ward a patient admitted on 31 January 2015 had spent every night of their admission on another ward, which was 24 consecutive nights.
- The bed management team met weekly to review the bed situation and to establish reasons for any delays to patients being discharged. Daily bed management reviews took place on each ward to review the current bed management and identify patients who were ready for discharge. However, staff told us that the majority of discharges were delayed due to social, immigration, funding or housing issues.
- We observed that discharge planning took place in the daily whiteboard reviews and in ward rounds. However, the discharge planning was not always evident in the care records.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had a number of rooms for use, including quiet lounges, therapy rooms, clinic rooms and access to a faith room. There was equipment available to support patients to occupy their time, such as books, games, art equipment and computers. However, due to the bed pressures the quiet lounges on Ganges and Amazon wards had been set up as extra bedrooms.
- Patients were not able to make telephone calls in private. This was because the phone booths on the wards were kept locked, due to ligature concerns, and they were only opened under the supervision of staff. Where there was no payphone for people to use, such as on Crane ward, patients had to use the office phone and stand in the corridor, which meant their calls were not private.
- At the Campbell Centre there were shared bedrooms of up to four patients. The four patients shared a bathroom leading off the bedroom. The bathroom doors had been removed and only a curtain was in place to provide a level of privacy. Patients were not happy with this arrangement and told us they were often interrupted when using the bathroom and that other patients walked in regardless of the curtain. This meant their privacy and dignity was compromised.
- Each ward had access to outside space, though this was timed so patients could be supervised by staff when using these areas, to minimise risks. Patients were not able to access outside areas when they wished. Due to the location and structure of the Gordon Hospital there were limited hospital grounds and direct access to outside space was limited.
- Patients gave mixed feedback about the food provided. At the Riverside MHC in Hillingdon patients were positive about the food. However, at St Charles MHC, people were less positive and said they lacked choice and adequate portion size. This corresponded with the recent PLACE findings, where the site scored the lowest on the quality of food overall, when compared with the other acute mental health centres.

Are services responsive to people's needs?

Inadequate

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

- On some wards people were able to make their own drinks when they wanted. However, these facilities were not available on all wards and on some wards patients had to request drinks from staff. Snacks were available outside of mealtimes, such as fruit and biscuits and sandwiches could be prepared on request.
- Patients were not always able to securely store their possessions due to a lack of lockable storage in the bedrooms, or where they were in place, they were damaged. Some patients on different wards told us that personal items had gone missing from their rooms, as they were not allowed a key to their rooms. The staff confirmed that patients were not issued with keys, due to these having gone missing previously. They said that they would lock patients' bedrooms on request, or small personal items could be stored in the ward safe.
- Activity programmes were on display on the wards. Occupational Therapists (OT) were part of the ward team and were part of the daily whiteboard reviews to identify patients that would benefit from OT support, such as where there were plans for discharge.
- There were differing levels of activities provided across the wards. Feedback from patients and staff was that activities took place and were rarely cancelled. Some wards had dedicated activity co-ordinators who were present on the wards throughout the seven day period and some evenings, whilst others were present only during the working week. Some patients we spoke with said they did not feel there were enough activities provided, or those that were did not interest them. On Crane ward we saw that attempts had been made to support patients to occupy themselves during their stay. This was through the development of a poster detailing low-key ways of keeping occupied outside of the structured activity programme. Ideas to keep patients busy included accessing the on-site library, playing pool, attending to personal care, listening to music and doing laundry. The on-site Tamarind Centre at Park Royal provided a larger space for activities and had a social café.
- OTs had developed written information to inform new patients of activities they could be involved in, and ways of giving input into activities patients would like.
- Eastlake and Ferneley wards had created a therapeutic environment using a mix of service user and professional artwork. This provided areas of colour and enhanced lighting for areas with no natural light. A psychologist employed by the Trust has advised on the décor.

Meeting the needs of all people who use the service

- A number of the wards we visited were purpose-built and had facilities for people with mobility needs. In all hospital sites the different floors could be accessed by a lift.
- The staff respected patients' diversity and human rights. Staff received training in equality and diversity as part of their mandatory training. The geographical area covered by the acute care pathway of CNWL was highly diverse with different cultures, religions and languages spoken. The services within the Riverside MHC at Hillingdon were close to Heathrow airport and so accommodated people of different nationalities who had just arrived in the country, or were found living within the airport. In all the services the staff spoke of how they met individual communication needs. Staff had access to interpreters to support patients at meetings and used computer-based communication tools with patients on a day-to-day basis. In the services there were photographic versions of the activity timetable to enable patients to view what was available. Some local faith representatives visited patients on the ward, whilst others could be contacted to request a visit, or patients could be escorted to local places of worship.

Listening to and learning from concerns and complaints

- Most of the patients we spoke with said they knew how to raise a complaint, or would discuss any concerns with the ward manager. Information on how to make a complaint was displayed in the wards, as well as information on the patient advice and liaison service (PALS) and independent advocacy services.
- Where complaints had been received by the ward, these were logged onto the 'complaints tracker', which was overseen by the matron, to ensure that concerns were investigated and responded to. At St Charles MHC some complaints were overdue for a response, and these had been flagged as needing action. However, at the Gordon Hospital staff told us verbal complaints were handled at ward level and recorded in progress notes, and there

Are services responsive to people's needs?

Inadequate

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

was no central recording process to log and monitor these complaints. Formal complaints sent directly to the trust were responded to and we saw examples of these during our visit

- The staff told us they tried to address patients' concerns informally as they arose, though they were aware of the formal complaints process and knew how to signpost people to PALS when needed.
- The ward managers showed us where learning from complaints was discussed at team meetings and changes had taken place as a result, such as in relation to food and customer care.

Psychiatric intensive care units (PICU)

Access and discharge

- Ward managers and staff confirmed that patients were not moved between wards during their admission unless there was a clinical need.
- We saw that some patients were waiting for a transfer to acute wards. One patient had been on Nile Ward since mid-2014 and was very frustrated by the delay in transfer of care. This could have had an impact on their recovery.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had areas for activities, therapies and meetings.
- Each ward had space for patients to meet with relatives and there were also meeting rooms.
- Patients had access to a pay phone.
- Each ward has access to outside space and patients were able to smoke outside at set times.
- Patients and staff told us there was a good choice of meals which also catered to individual religious or dietary needs. The main issue raised by patients was the small portion sizes. Ward managers told us this was an ongoing issue that they were addressing this with the catering service. Patients could order take-away meals at the weekends.
- Patients had to ask staff if they wanted a hot drink. Snacks such as toast and sandwiches were available on request. Bowls of fruit were available. Patients bought food at the local supermarket and this was stored for them in the fridge in labelled containers.
- Patients could personalise their bedrooms which they did to varying degrees.
- Patients had to ask staff to lock and unlock the doors on their behalf. This meant that doors were sometimes left unlocked and possessions went missing although these were sometimes found. There were secure lockers for storage of patient possessions.

During the week there was a good range of therapeutic activities available on a group basis on the wards. At the weekend there were less structured activities and these were provided mainly by the nursing staff. In the evenings there were leisure activities such as games and DVDs in the wards. Patients were generally satisfied with the range of activities available. Patients and staff spoke very positively about the courses provided by the recovery college.

Meeting the needs of all people who use the service

- Ground floor accommodation that was accessible to patients with physical disabilities was available in each of the services.
- The trust had access to interpreting services and where people needed this service it was very accessible. There was also access to leaflets in different languages.
- Food was available to reflect people's religious and cultural choices when this was requested.
- The wards had links with local religious groups, and there were local places of worship in the areas where the hospitals were situated that patients could go to.

Listening to and learning from concerns and complaints

- Most patients said they did not know how to complain. We did not see posters or information explaining the process in the services.
- Staff said that they generally tried to respond to verbal complaints immediately to sort them out. They said that this would be put in the patients' daily record which was held electronically.

Are services well-led?

Requires improvement

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 **requires improvement** because:

- The trust had not anticipated increases in the demand for acute inpatient beds and contingency plans were not in place that preserved the safety and dignity of patients.

Staff were committed to the vision and values of the organisation and felt connected to the trust. There were local governance processes that enabled identification of where the services needed to improve. Staff morale was good and teams worked well together. Monitoring of incidents, complaints and safeguarding incidents was used to make improvements to the service. Some innovative practice took place to help improve the service that patients received.

Our findings

Acute wards for adults of working age

Vision and values

- The trust's vision and strategies were on display in some wards. Staff felt connected with the trust and its values and spoke of demonstrating their commitment to these in their day-to-day work with patients.
- Staff said they had good links to the service director and were able to communicate directly with them. Some staff spoke of feeling very connected to the trust board and were able to identify the names and roles of different board members, some of whom had visited the wards.
- The modern matrons had a presence on the wards and staff considered they had a good understanding of the issues facing the staff and patients on the wards.

Good governance

- Local governance processes were in place. Each month the ward managers submitted information electronically to centralised teams. This was in relation to safeguarding figures, medicine incidents and staffing returns, such as training and supervision that staff had undertaken, sickness and absences. Information about the staffing of wards was provided, along with the ward occupancy levels. We were also shown the monitoring of delayed discharges, care programme approach and physical health targets.
- Wards had key performance indicators around admission, physical health and care planning, and these were audited weekly. This ensured that care plans were up-to-date and individual areas of risk were incorporated into care plans.
- Monitoring of incidents and complaints took place, with action plans developed as learning points from these. Similarly, in accordance with the productive wards initiatives, there were incident trackers for medicines errors, absconsions and violent and aggressive incidents.
- Monitoring of adherence to the requirements of the MHA was audited on each ward, with details on the whiteboards to remind staff to speak with patients about their rights on a regular basis. The MHA compliance audit results for Crane ward was 100% for informing patients of their rights within 24 hours. However, there was a lack of monitoring at the ward or provider level of the impact of bed management pressures and the ability to facilitate patients' entitlement to take section 17 leave.
- The trust monitored infection control across all services and this was overseen by central committees. The ward managers showed us the cleanliness audits that were undertaken on the ward each month and how this was logged onto the electronic systems to inform the centralised team.
- The ward managers told us that they had sufficient time to manage the wards. Administrative staff worked on each ward to provide additional support.
- Ward managers were not aware of being able to add items to the trust risk register, and were unclear of what items specific to their area of work were recorded on the register. However, most assumed that the over-occupancy/ bed management issues featured highly on the risk register, as they felt this had the most significant impact on the acute care pathway services.

Leadership, morale and staff engagement

- The acute wards for working age adults were not well managed overall. There were bed managers in place

Are services well-led?

Requires improvement

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.

and staff were working very hard to manage daily bed pressures safely. Contingency measures had not been in place to prevent the impact on patients from the high bed occupancy. Whilst the trust had taken steps just prior to the inspection to access beds outside the trust, this response had been planned after the problems had developed and patients' safety and dignity had been compromised.

- The individual wards were well-led. Ward managers and modern matrons were visible on the wards during the day, were accessible to patients and provided support and guidance to staff. The culture on the wards was open and encouraged staff to bring forward ideas for improving care and developing the service.
- Ward staff we spoke with were committed to their work and to ensuring patients were appropriately cared for. Some staff spoke of the bed management issues as bringing staff together more in ensuring that the service still operated effectively, despite the extra pressures placed upon them.
- Staff were aware of whistle-blowing processes and felt able to report concerns and improvements needed to managers. They were confident they would be listened to by their line manager.
- The staff were kept up to date about developments in the trust through regular emails and bulletins. Staff were positive about the recent changes to the directorate and line management structures, to the service lines for the delivery of care, and felt this was a good move for the trust to enable more joined-up work in the care and treatment that patients received as inpatients and in the community.
- At the time of our inspection we were not made aware of any grievance procedures being pursued within the wards, and there were no allegations of bullying or harassment.
- The ward managers told us about the leadership training and development opportunities they had been provided with by the trust. Some managers were undertaking the Mary Seacole leadership programme, which they found beneficial to enhancing their work and skills as a manager.
- The staff were generally enthusiastic and positive about working for the trust. They felt well managed and there was good team-work. Staff said there were opportunities for career development in CNWL, through leadership training and gaining professional qualifications. They felt supported by the managers to attend these.
- We asked staff and patients about any specific ways the trust sought to gather their views and suggestions about areas for improvement. There was a lack of awareness of any such processes, and we did not see any advertising of ways to do this.

Commitment to quality improvement and innovation

- The OT team at Hillingdon Hospital MHS told us about ongoing research they were involved in with a local university. This was a four year project and involved former and current patients in research around their experience of using OT and how this had an impact on their lives.
- At The Gordon Hospital the staff described that CNWL was at the start of the second year of a three-year homelessness prevention initiative (HPI) that supported patients admitted to a Westminster acute mental health bed who were homeless or at risk of homelessness. This project assessed and supported people to help facilitate discharge planning and reduce readmission with the aid of peer support workers. The HPI social worker attended daily MDT meetings at The Gordon Hospital to identify patients in need of the service.

Psychiatric intensive care unit (PICU)

Vision and values

- Staff knew the trust's vision and values.
- Staff knew the names of senior staff in the organisation and said there were regular visits from senior staff and other board members to the units.

Good governance

- The units were all well managed and led. Staff and managers were informed about the non-completion of mandatory training.
- The main information held by ward managers was about staff training. There was also information about performance on the electronic records system.

Are services well-led?

Requires improvement

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.

- The ward managers all felt they had the autonomy to run their wards including the ability to manage their own budget.

Leadership, morale and staff engagement

- Staff knew there was a whistle-blowing process and said if this was needed they would look up who to contact.
- Staff were very comfortable about their ability to raise concerns within the trust and felt they would be listened to and there would be a response.
- The staff were very positive about working in the PICU. They felt well managed and able to raise issues. Opportunities for training and career development and team working were good.
- Staff said there were opportunities for leadership training and to gain professional qualifications. They talked positively about the recovery college within the trust.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although numerous ligature risks had been identified on the acute and PICU wards staff were not able to articulate the measures being taken to manage these risks for the patients using the service. There were a number of blind spots in the wards that did not have a clear line of sight. Measures were not always in place to reduce risks to patients and staff. Significant numbers of detained patients were absconding whilst receiving inpatient care. This needed to be reviewed so that measures could be put into place to reduce the risk to patients. This is a breach of Regulation 10 (1)(b)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Patients were not being protected against the risks of unsuitable control or restraint.

This section is primarily information for the provider

Requirement notices

The training of staff in current best practice in terms of prone restraint had not been completed across whole staff teams to ensure that staff had the necessary skills to restrain people safely where this intervention was needed.

This is a breach of Regulation 11(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services 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. This is a breach of Regulation 9(1)(a)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Patients were not being protected against the risks of unsafe or unsuitable care. The records relating to the seclusion of patients did not provide a clear record of medical and nursing reviews, to demonstrate that these were carried out in accordance with the code of practice: Mental Health Act 1983.

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 20(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The trust did not take appropriate steps to ensure there were sufficient numbers of staff. The failure to increase staffing numbers in response to increased numbers of patients on the wards put patients at risk of not having their needs met appropriately. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The trust had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The wards were over-occupied. On admission to the ward, patients did not have a designated bed and often slept on other wards. Patients returning from leave did not have a bed on their return to the ward. Some people in the acute wards experienced several moves between wards for non-clinical reasons during one admission. Of these, some people were transferred during the night or went to wards where they did not know, or were not known by, the multidisciplinary team.

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 9,10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The trust did not have an effective system to inform people of how to make a complaint. There was a lack of information in the PICU's 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 is a breach of Regulation 19(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The trust did not have suitable arrangements to ensure the dignity and privacy of people. Patients were not able to make telephone calls in private. At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity. This is a breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The trust did not have suitable arrangements in place to protect patients against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems to reflect information that it is reasonable to expect the trust to be aware and make changes to the care provided. The trust management had not anticipated increases in the demand for acute inpatient beds and put contingency plans in place that preserved the safety and dignity of patients. This was a breach of regulation 10(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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.