

# Central and North West London NHS Foundation Trust

## Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

# Summary of findings

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

## Background to the trust

The trust provides services predominantly to the London Boroughs of Brent, Camden, Harrow, Hillingdon, Kensington & Chelsea and Westminster and, outside London, to Milton Keynes. In addition, it provides some services to City of London, the London Boroughs of Ealing, Enfield, Hammersmith and Fulham, Islington, as well as Buckinghamshire, Hampshire, Kent and Surrey. The trust also provides some national services, including the National Problem Gambling Clinic and Vincent Square Eating Disorders Service. The trust is a significant provider of offender healthcare in prisons and immigration centres.

The trust supports people from many different communities in areas of great affluence and areas of high deprivation. It employs around 7,000 staff. In 2017-18 staff provided care and treatment for 333,209 patients in the community and 4,467 in hospital. The trust has an annual income in the region of £490 million.

The trust provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICU)
- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Forensic inpatient/secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Substance misuse services
- Wards for older people with mental health problems
- Wards for people with learning disabilities of autism
- Community dental services
- Community health inpatient services
- Community health services for adults
- Community health services for children, young people and families
- Sexual health services
- End of life care

The trust and its services have been inspected 13 times since 2015:

- February 2015 – comprehensive inspection of Central and North West London NHS Foundation Trust.

# Summary of findings

- March 2016 - IRC Colnbrook joint HMI Prisons inspection.
- September 2016 – HMP Woodhill focused inspection.
- October 2016 - Unannounced inspection of Acute wards for adults of working age and psychiatric intensive care units.
- January 2017 – Unannounced inspection of wards for older people with mental health problems.
- March 2017- Announced inspection of wards for people with a learning disability or autism.
- May 2017 – Announced inspection of community-based mental health services for adults of working age.
- May 2017 – Well-led review (this was carried out as a pilot for the next phase of CQC’s inspection methodology).
- June 2017 – IRC Colnbrook focused inspection to follow up on breaches found at previous inspection.
- September 2017 - HMP Woodhill focused inspection to follow up on breaches from previous inspection.
- February 2018 - Children Looked After and Safeguarding Review (CLAS) of health providers in the London Borough of Barnet area, including CNWL substance misuse services.
- September 2018 – Unannounced inspection of Vincent Square Specialist Eating Disorders Service following a serious incident.
- December 2018 – Announced inspection of IRC Colnbrook.

In 2015, we rated the trust as requires improvement. At subsequent re-inspections, the trust rating improved to good overall, with eight of the mental health core services good. In addition, wards for people with a learning disability or autism were rated outstanding. Furthermore, four community healthcare services were rated good and sexual health services were rated outstanding.

At the previous inspection the trust was found to be in breach of the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 – Person centred care
- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding
- Regulation 15 – Premises and equipment
- Regulation 16 - Receiving and acting on complaints
- Regulation 17 – Good governance
- Regulation 18 - Staffing

As a result, we asked the trust to make improvements as follows:

- to bed management to reduce delays to admissions
- care plans and risk assessments
- physical health checks following rapid tranquillisation
- use of restraint and associated record keeping
- waiting times for psychological therapies
- care coordination, premises and equipment

# Summary of findings

- staff support and training
- incident reporting, awareness of complaints procedures

Some issues only affected specific services. During this inspection we checked to see if improvements had been made and sustained in three core mental health services and we also considered the overall leadership of the trust during a well-led review.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Good** ● → ←

## What this trust does

Central and North West London NHS Foundation Trust (CNWL) was first established as a mental health trust. Over the years the trust has broadened its remit to include community health services and offender healthcare and widened its geographical spread.

At the time of inspection CNWL was providing health and social care services to a population of around three million people living in the south-east of England, particularly in central and north-west London and Milton Keynes.

The trust delivers a wide range of community services including health visiting, school nursing, inpatient intermediate care, podiatry, community dental services, complex wound clinics, wheelchair services, inpatient rehabilitation, intermediate care including rapid response, speech and language therapy, children looked after service, palliative care and sexual health.

The mental health services provided to adults and children by the trust are predominantly located in the five London boroughs of Westminster, Kensington and Chelsea, Brent, Harrow and Hillingdon. Services are also provided in Milton Keynes. The trust also provides specialist eating disorder, perinatal and addiction services, including a national gambling clinic. Offender healthcare services are provided across the south of England.

The trust provides court and police liaison and diversion services in Hammersmith and Fulham, Kensington and Chelsea, Westminster, Brent, Harrow, Hillingdon and City of London. These services are inspected by the health and justice team and HMI Prisons.

Following the Grenfell Tower fire in June 2017, the trust developed the Grenfell Health and Wellbeing Service. This is now the largest trauma service in Europe with 50 trauma-trained therapists, child and adolescent mental health services and a school nursing team.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

# Summary of findings

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. We inspected three services as part of our ongoing checks on the safety and quality of healthcare services:

- Wards for older people with mental health problems
- Community-based mental health services for adults of working age
- Acute wards for adults of working age and psychiatric intensive care units (PICU)

These services were selected as all three had previously be found to require improvement in the area of safe care and treatment (the safe question).

## What we found

### Overall trust

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

- On this occasion, we inspected five key questions for three core services; a total of fifteen key questions. The rating improved for three key questions and worsened for one - from good to requires improvement. This meant that the overall pattern of ratings for the whole trust remained broadly the same. When these ratings were combined with the previous ratings from services not inspected this time, 15 core services are rated as good and two as outstanding.
- We rated the trust as good for well-led. The trust had a highly experienced, skilled and respected executive leadership team. They were inspiring, committed and continuously challenged themselves to improve services to meet the needs of patients.
- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to provide high quality care to their local communities and those in receipt of specialist services.
- The trust had a strong, cohesive senior leadership team which had instilled a positive 'can-do' culture within the organisation. Senior leaders expected high standards of themselves and their colleagues, but most staff regarded them as kind and supportive when teams and individuals were facing challenges. The depth of knowledge held by senior leaders about each service and the people running them was phenomenal given the size of the trust.
- The divisional structure and borough-based working for local services were fully embedded and there was evidence of strong partnership working, with good foundations to increase this much further. The trust was participating effectively in local care systems and with NHS partners to drive progress and develop new models of care, such as integrated community health services in Hillingdon.
- The board had good oversight of operational issues across all divisions. The governance processes were robust and ensured that both achievements and concerns were escalated appropriately. Problem areas had largely been identified before we brought them up and work was, for the most part, underway to resolve matters. The trust was very responsive and took steps to increase the pace of improvement and the support available following our feedback.
- The trust had a strong grip on its finances. It was on target to achieve its control target for 2018 -19. Its spending on agency staff had significantly reduced and it was working to drive it down further.

# Summary of findings

- The trust was fully committed to working in partnership with patients and, increasingly, carers. There were many excellent examples of patient and carer involvement at many levels within the organisation, including well established peer support workers.
- The trust was committed to improving the safety of staff, patients and the wider community and there were a number of initiatives and programmes in place to try to achieve this. For example, the roll out of the safer leave project for both detained and informal patients on the mental health wards. The trust was just short of its target of 95% compliance with statutory and mandatory training, averaging 93% which was high for a trust of this size.
- The trust had worked creatively to meet emerging needs. A large-scale example was their response to the Grenfell tragedy where they, alongside many partners, were seeking to try to meet mental health needs that had been triggered, or exacerbated, by the trauma. On a smaller scale, the Campbell Centre at Milton Keynes had developed a social recovery team to focus on resolving practical issues for patients which delayed discharge.
- The trust was making good progress with their quality improvement (QI) work, and despite this approach only being used in practice for about 18 months, it was becoming established across the trust. The trust had received an award from the South of England QI collaborative for building capability and capacity. During the inspection many of the staff we met spoke about their involvement in QI projects. At the time of the well-led review there were 276 active projects and 32 completed projects. The trust had a QI microsite which was accessible on the trusts website. This live site enabled staff to access resources, sign up for training events and record progress with their own project. This enabled services to identify similar projects and learn from each other. The trust was working with patients and carers and they were actively involved in 26% of the projects.
- All staff we spoke with acknowledged they were provided with good learning and development opportunities and, through the trust's recovery and wellbeing college, patients who used mental health services and their carers benefited from access to a wide range of courses. Trust mental health staff and staff working in partnership with them could also access these courses. The trust had invested in the development of leadership skills and we noted the competency and confidence of most leaders at all levels of the organisation.
- The trust was making good progress with promoting equality diversity and human rights throughout the organisation. They had stated a commitment to becoming one of the most inclusive employers in the NHS by 2020. The trust had three well-established staff networks in place to support staff and to promote equality and diversity; the Black, Asian and minority ethnic staff network, the disability equality network and the lesbian, gay, bisexual and transgender staff network. Stonewall ranked the trust equal 28th in its list of top employers for 2019 (only five healthcare employers were in the top 100).
- The trust had developed robust and innovative ways of managing its estate of 150 sites in ways that were just starting to benefit staff, patients and its finances. With the exception of one site, where there were ongoing negotiations with commissioners, the trust had plans in place to eliminate all its dormitory bedroom accommodation.
- The trust transferred most of its services to a new electronic patient record system during our inspection; possibly the biggest migration of its kind in the UK. Technically, it went well, although staff were still in the process of getting used to it and some areas needed more time and support than originally envisaged. The new system will enhance joined up work with primary care services.
- Trust staff had access to a full range of accurate and clearly displayed data relevant to their work which could be viewed at numerous levels from trust-wide to individual team or ward. Clinicians were involved in digital developments to ensure they complemented clinical work.
- The trust's communications strategy was working extremely well and staff commented favourably about the high quality of communications and the relative ease of finding information, when needed, on the trust's intranet site.

# Summary of findings

- The trust's public website had been developed with the needs of people with communication difficulties in mind with links to a growing library of easy-read information on every page. The intranet and microsites were developed to make it as easy as possible for staff to adjust the information to their needs in terms of colour and font.

However:

- Our inspection did identify wards and teams where improvements were needed. The trust was already aware of where services were facing challenges and was providing additional leadership and support.
- The inspection did find that some of the improvements recommended at the previous inspection had not taken place. This included ensuring patients on the wards for older people had access to specialist staff such as a dietician when needed, or that information was put into accessible formats for patients with dementia or other cognitive impairments.
- Recruitment and retention of staff remained challenging for the trust; and they were working creatively to address this within the context of national shortages. Despite the use of temporary staff where needed, some teams were struggling to deliver consistently high-quality care.
- Some staff were not receiving supervision at the frequency required by the trust's own policy and neither this, nor the quality, was monitored in a systematic way by managers, unless individuals had set up their own systems. This had also been identified as an area for improvement at the previous inspection. During the inspection the trust was piloting an online system to address this, but this would need to be embedded.

## Are services safe?

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

- At this inspection we rated safe as good in two of the services and requires improvement in one. When these ratings were combined with the other existing ratings from previous inspections, 15 of the trust services were rated good and two rated requires improvement.
- The trust was working creatively to improve staff recruitment and retention. Offender care and learning disabilities services were particularly challenged by vacancies and there was targeted work to recruit to these posts. The trust was working with ten universities to support clinical training, including placements within the trust, in an effort to attract newly qualified staff. Schemes, such as Capital Nurse and preceptorships were in place. Retention and engagement events were held for existing staff and an internal transfer system had been established to make it easier for staff to move between different roles in the trust. In February 2019, the trust vacancy rate average for the calendar year was 13.91% against a target of 12%. Turnover rate average for the calendar year was 16.2% against a target of 15%.
- The trust was committed to improving its premises to enhance patient safety. This involved eliminating dormitories and creating ensuite bathrooms. To facilitate this programme, the trust had already commenced a reduction of beds to improve safety.
- The trust had well established workstreams set up to improve the sexual safety of patients and staff on mental health inpatient wards and had participated in CQC's review of this topic. They were revising how sexual safety incidents were reported including the grading of harm; developing a training package; using a sexual safety leaflet commended nationally; continuing to work to improve the safety of the environment; ensuring sexual safety incidents affecting staff are reported to HR.
- The trust was committed to reducing restrictive interventions. It had adopted a 'zero tolerance' approach to prone restraint in January 2018 and by September 2018 it had achieved a 50% reduction. When prone restraint was used,

# Summary of findings

94% of incidents lasted less than four minutes. Previously the trust was an outlier for the use of prone restraint, but recent data showed it was now within the middle 50%. All restraints were monitored by the trust's restrictive interventions group and trends were recorded and benchmarked within the trust and against national data. Data analysis showed that the trust's use of restraint for adult acute wards, psychiatric intensive care units and older adults' wards was approaching the best 25% nationally. Restraint and de-escalation training was co-produced and co-delivered. Two full-time peer support workers were working within the team that provided training in the therapeutic management of violence and aggression.

- The use of seclusion was also monitored. Between 39-63 episodes of seclusion per month had been recorded within the trust over the period April 2018 to January 2019. Child and adolescent mental health inpatient services do not contain seclusion rooms, but the external door could be locked to maintain safety. When this happened, it was recorded as seclusion and in January 2019 six seclusions took place in this service.
- The trust learnt from serious incidents. Following an increase in deaths on the rail line in Milton Keynes, the trust worked as part of a multiagency 'gold group' lead by the British Transport Police and Network Rail. This included work to train all platform staff in suicide prevention. Improved information sharing about 'near misses' has benefitted patient care and there have been fewer incidents at the station.
- The trust incident reporting system was designed to automatically feedback progress to incident reporters. This complemented local arrangements to support and de-brief staff when an incident occurred. Staff were well-informed about incidents within their own services and significant incidents elsewhere in the trust. However, there was still scope to improve the sharing of good practice and learning from incidents between similar teams across different geographical areas.
- The trust had made good progress in ensuring staff received statutory and mandatory training, averaging a 93% completion rate.
- Medicines optimisation within the trust was good, and effectively integrated into trust governance arrangements. The chief pharmacist post was filled on an interim basis with a plan to fill the substantive post by August 2019. The pharmacy team provided leadership for medicine optimisation and included a medicine safety officer (MSO) post who reviewed all medicine related incidents. However, electronic prescribing and medicines administration (EPMA) was only available within offender care and addictions services. Planned changes to the trust's digital infrastructure made it more feasible to implement it more widely. A business case had been developed for extending EPMA to inpatient settings and the trust intended to submit its bid before November 2019 for funding in 2020/21.

However:

- While most wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose, a few were not. Bedrooms on two wards at the Gordon Hospital were too small for safe use by patients in distress. Also at the Gordon Hospital, rooms designed to offer flexible accommodation for male or female patients were breaching guidance to eliminate mixed gender accommodation. Pond Ward at Park Royal was not clean. By the end of the inspection the trust had addressed all these matters and where needed taken rooms out of use.
- Whilst the trust was working to recruit and retain staff and most wards had safe staffing levels, a few wards were struggling to maintain safe staffing. Some wards did not have enough medical cover and some nursing staff told us they felt unsafe at night, especially when they had to attend to patient admissions as well as those already on the ward. We also heard from staff who said that patient leave was sometimes cancelled or that they could not leave the ward to attend training.
- With the exception of the Campbell Centre where there were call bells, patients did not have access to a means of calling for urgent assistance from staff.



# Summary of findings

- Whilst systems were in place to support staff to be safe while working on their own, some staff in community teams were not yet using these systems.

## Are services effective?

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

- At this inspection we rated effective as good in two of the services and requires improvement in one service. When these ratings were combined with the other existing ratings from previous inspections, two of the trust services were rated outstanding, 14 were rated good and one requires improvement.
- In the core services inspected, assessment and monitoring of patients' physical health, including after rapid tranquillisation, had improved and robust processes were in place to make sure patients' mental and physical health needs were met. The new electronic patient record system matched the one used by GPs in some boroughs so this would make blood test results and similar more accessible to relevant trust staff. In addition, the new system included a physical health tab that, if used correctly by staff, will make the trust better able to produce reports on this topic and monitor performance. Patients were supported to make healthy lifestyle choices.
- The trust offered patients care and treatment in line with national guidance and best practice. Managers and senior clinicians were fully aware of the guidance applicable to their area and senior leaders were often involved in developing it at national level so were exceptionally well informed. Staff told us they could rely on getting up-to-date information from the trust to guide their practice.
- The trust enabled staff to develop their skills and experience to undertake their roles. Staff could access continuing professional development and all staff focus groups commented positively on this. Staff could apply for courses and training linked to their personal development plan. The trust monitored the percentage of staff with an in-date appraisal and this had averaged at 91% across the year. This information was available for teams.
- We found examples of effective multidisciplinary teams in many of the services we visited. There was a strong focus on discharge planning in conjunction with community colleagues; the Campbell Centre at Milton Keynes was particularly strong in both regards.
- Relevant staff had easy access to patient records and this was set to improve with the new electronic patient records system, as, in some boroughs, GPs used the same system. This meant, for example, it was easy to check patients' prescribed medicines on admission.
- Staff met their legal responsibilities in relation to the Mental Health Act 1983 and Mental Capacity Act 2005. However, some areas for improvement were identified in a few services.

However:

- The trust had not been monitoring whether staff received regular supervision. The inspection found that whilst most staff were satisfied with the quality of the supervision they received, there were teams where regular supervision was not delivered. The trust addressed this immediately and purchased a system to pilot supervisions being completed recorded on-line.
- Not all wards for older people with mental health needs had timely access to specialists. For example, on Kershaw and Redwood wards staff had not had access to a dietician since November 2018. Arrangements were put into place by the trust immediately after the inspection. Some wards experienced delays of several weeks when referring patient for input from a physiotherapist or speech and language therapist.
- On the wards for older people with mental health problems not all staff had received training in dementia. Many of the patients had dementia or a cognitive impairment. Following our inspection, the trust arranged for relevant staff to complete dementia care e-learning by 29 March 2019.

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- The trust had some good practice in falls prevention such as non-slip socks, access to falls mats and adjustable bed heights. On the wards for older people with mental health problems there had only been one serious incident reported in a year attributable to a fall. However, a few patients across a number of wards did not have a completed falls risk assessment on admission, which was not in line with the trust's policy for prevention and management of falls. For one patient, staff only filled out a falls risk assessment following a fall on the ward.

## Are services caring?

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

- At this inspection we rated caring as good in all three of the services. When these ratings were combined with the other existing ratings from previous inspections, three of the trust services were rated outstanding and 14 were rated good.
- In quarter three of the financial year, 92% of people completing the Friends and Family Test said that they would be likely or extremely likely to recommend CNWL services. This was the same proportion as in quarters one and two. The overall satisfaction rate across year to date was 95% for community services and 88% for mental health. This is broadly in line with the national average for similar trusts.
- The trust had an active patient involvement forum and carers' council. Both groups were involved in developing the trust-wide patient and carer involvement strategy and action plan. There were many opportunities for patients and carers to make their views known at every level of the service. The trust and divisional boards discussed all formal feedback received, as well as any informal feedback from patients and carers gleaned during board visits to services.
- The trust's wellbeing and recovery college offered a wide range of courses and workshops which are co-designed and co-delivered by peer recovery trainers (people with lived experience of mental health issues) and mental health practitioners. Patients of mental health services and their carers, as well as staff, had access to these sessions, which covered topics such as understanding self-harm, a good night's sleep and exploring what works for me.
- The trust could provide many examples of working in an inclusive way with patients. For example, offender care had recruited thirteen patient experience leads to enhance patient involvement with a group that could be hard to engage. Patients, carers and staff had worked together to co-produce more dementia-friendly environments on wards for older people. Carers had been involved in putting on a carers conference together with the trust.
- We saw many examples of kindness, compassion and respect in action during the inspection. The desire of the trust and divisional boards to do their best for patients was evident at every meeting we attended. When talking about any aspect of the work of the trust senior leaders, as well as the majority of staff, never lost sight of the individual patient experience; it was what motivated them.

However:

- The annual national community mental health survey saw a slight decrease in the performance of the trust and this was the case for many trusts. The trust had put together an action plan in response with a focus on overall experience of care, patient contact time, dignity and respect, more help with physical health, financial and employment needs.
- Sometimes, at ward level, staff were too slow to feedback to patients about what was being done in respect of any concerns they raised at community meetings.

## Are services responsive?

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

- At this inspection we rated responsive as good in all three of the services. When these ratings were combined with the other existing ratings from previous inspections, two of the trust services were rated outstanding, 13 good and two were rated requires improvement.

# Summary of findings

- Whilst the trust still experienced spikes in activity and pressure on beds, patient flow reported improvement with acute mental health beds for adults at 95% occupancy. Out of area placements increased slightly in month 10, but was still below the set target.
- The trust had established a 24/7 single point of access to most of its mental health services and was achieving set access targets in many areas; including early intervention in psychosis and, in community healthcare, district nursing. Urgent access targets for mental health were also consistently achieved, but meeting access times for routine mental health services was more challenging, with only 77% achieving the threshold in month 10, against a target of 95%. We saw that the trust examined performance against the targets each month during its quality and performance committee and challenged managers to explain any breaches.
- On acute mental health wards, where there was particular pressure on beds, the trust had adopted the 'red to green' system which endeavoured to make every day of a hospital admission productive and a step towards recovery and discharge. The trust was committed to helping patients to find and sustain employment and had established an employment service to this end.
- The trust worked with people from diverse communities, with over 100 languages spoken in the areas it covers. Most staff were well-informed and sensitive to the needs of people from different communities. The trust supported its staff to do this by providing them with relevant policies and training. For example, it had recently revised its compassionate care after death policy to provide staff with guidance about the customs of different faiths.
- The trust had an equality, diversity and inclusion strategy (EDI). Since our last inspection the trust had developed an EDI steering group to oversee the EDI aspects of workforce and service delivery matters. The steering group met quarterly and reported to the trust board through the Quality and Performance committee. The trust was particularly strong in supporting both staff and patients who were lesbian, gay, bisexual or transgender (LGBT+). The trust was supplying healthcare to a transgender unit within a prison and some of the wards had also developed expertise in this area of work.
- Concerns and complaints were treated seriously, investigated and lessons learned from the results. Complaint responses were detailed, personalised and described the actions that the trust were taking. The trust offered contact details of staff in the event that the complainant wished to discuss the findings or required further support. The trust responded to 98 - 100% of complaints within the timescales laid out in their complaints policy in the first half of 2018-19. They had identified that concerns, complaints and negative comments tended to be about long waiting times for accessing services, lack of communication and information from staff or lack of support and communication from care coordinators.

However:

- Although urgent referrals were flagged and given priority, some teams were not meeting the trust targets to assess people, whose referral was less urgent, in a timely manner. The target times set by the trust were 28 days for the referral to assessment for the community mental health teams and 14 days for the early intervention services. The median waiting times for the 6 months up to December 2018 were 42 days for the Hillingdon East and West community team and 38 days for the Milton Keynes assertive outreach team. Other teams met or nearly met the target. The teams kept in contact with patients while they were waiting to be assessed.
- At the last inspection on the wards for older people with mental health problems, information which was provided was not routinely available in an accessible format for patients with dementia or cognitive impairment. For example, information on notice boards, leaflets, activity schedules and menus. At this inspection, some progress had been made, but there was still room for improvement.

## Are services well-led?

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

# Summary of findings

- The trust had a highly experienced, skilled and respected executive leadership team. They were inspiring, committed and continuously challenged themselves to improve services to meet the needs of patients. Internal staff and external stakeholders commented positively on the leadership of the trust. Most of the executive leadership team had been in their posts for ten years or more which had provided considerable stability during a period where the trust had grown and managed considerable change. At the time of the inspection two of the executive directors had announced their retirement. Their succession had been carefully planned.
- Leaders promoted a culture within the trust which was open, honest and responsive. This was reflected in how the trust managed the many challenging situations they faced. At all levels of the organisation they spoke openly about where improvements were needed and how they would be addressed. An example of this was in relation to safeguarding concerns at one of the inpatient sites where action was taken to ensure patients were safe and additional leadership input was provided to support the necessary improvements.
- The trust board demonstrated a commitment to ensuring that people who use services and their families received the best care and treatment possible. The trust board gained insight into the challenges of delivering services through being linked to a division of the trust and board visits. Some clinically trained executive directors occasionally worked alongside staff within services to get a grass-roots perspective or to help during periods of intense pressure. Staff across the trust were positive about the visibility of the non-executive directors and members of the senior leadership team. Given the size of the trust, senior leaders' knowledge of each service and the people working within them was exceptional.
- The trust had a clear vision and values. These had been developed in partnership with patients, carers, staff and a wide range of stakeholders. The vision and values of the trust were understood by staff throughout the trust and they could articulate how these related to their work within the organisation and the care delivered to patients. Staff spoke passionately about how they would go the extra mile to meet people's individual needs.
- The trust continuously strove to meet the needs of local communities. Since the previous inspection, the trust demonstrated this through its exceptional response to the Grenfell fire. The trust had been a partner in the response to address the immediate needs and longer-term trauma of this experience both directly and through co-ordination with other providers. In 2017/18 1900 adults were referred to CNWL services and 490 children. In such an unprecedented situation the trust had to work with the local community to identify bespoke solutions to meet the needs of the local population. The trust was now delivering long term services in the area.
- The trust embraced partnership working and was willing to take either a lead or supporting role dependant on what was appropriate in that geographical area. The trust leadership team actively participated in the work of three sustainability and transformation partnerships. It worked with a wide range of local and specialised commissioners through its divisions and boroughs. The trust was part of two accountable care partnerships (ACP) in Hillingdon and Milton Keynes. ACPs are new models of care which seek to provide local people with comprehensive coordinated services in a partnership arrangement between the NHS, local authority and, sometimes, third sector providers.
- The trust recognised the importance of promoting staff well-being and had won an excellence award from the London Healthy Workplace Charter backed by the Mayor of London. The trust had to meet a set of standards to meet the mental and physical healthcare needs of staff. One of the reasons for this award was that the trust had set up a fund to arrange a variety of classes including Zumba, yoga, mindfulness and playing the ukelele. The trust had also focused on the mental well-being of staff with their staying well at work service (SW@W). This supported staff on medication; without permanent homes; or needing help with redeployment. They also recognised the importance of providing financial support to staff and had won an award for a scheme called Money Wizard which was an online tool helping staff feel more in control of their finances.
- The trust engaged effectively with staff and had a remarkably effective communications strategy which made full use of social media. The trust intranet was easy to navigate and information was provided through a range of mediums

# Summary of findings

including 'three-minute reads', the clinical message of the week, the chief executive's blog and three key messages after each board meeting. The trust also used on-line forums for staff to discuss topics and share good practice. Clinicians told us they could rely on receiving excellent updates on legislation and guidance through internal communications. The trust was creative in how they shared key messages with staff. For example, a professionally produced and performed video of staff singing and dancing to promote the staff having a flu vaccination had been well received and contributed to a 76% immunisation rate.

- People who used services and had lived experience were involved in the work of the trust. Examples of this were the recovery college for people using mental health services and the user involvement work in sexual health services for people with HIV. There was also increased user and carer involvement in staff interview panels. Examples of this involvement were shared in the quarterly report on patient feedback and involvement. The trust employed a range of peer support workers with different skills and experience. They carried out a wide range of roles supporting patients and contributing to service improvements. For example, restraint and de-escalation training was co-produced and co-delivered with two full-time peer support workers working as trainers within the team that provided training in the therapeutic management of violence and aggression.
- The trust was making good progress with their quality improvement (QI) work, and despite this approach only being in place for about a year and a half it was becoming established across the trust. The trust had received an award from the South of England QI collaborative for building capability and capacity. During the inspection many of the staff we met spoke about their involvement in QI projects. At the time of the well-led review there were 276 active projects and 32 completed projects. The trust had an excellent QI microsite which was accessible on the trusts website. This live site enabled staff to access resources, sign up for training events and record progress with their own project. This enabled services to identify similar projects and learn from each other. The trust was working with patients and carers and they were actively involved in 26% of the projects.
- Staff at all levels of the organisation had access to a wide range of information to support them with performing their roles. Since the last inspection the trust had implemented a business intelligence tool. This provided live information at all levels of the organisation to support the clinical delivery of the service. For example, teams could know on an individual named basis which patients needed to have their care programme approach meeting or to be followed up within seven days of being discharged.
- The trust provided its estates and facilities function through a wholly owned subsidiary which was very dynamic in its approach, looking for creative solutions to estate challenges. The subsidiary provided an estates and facilities service. It ensured that money raised by property disposals remained within the NHS and the model was attracting a lot of interest from other trusts.
- The governance processes worked well at different levels of the trust through an overarching accountability framework. The accountability framework identified what must be shared at different levels of the organisation and oversaw the clinical effectiveness of services. Since the previous inspection divisions had become more self-reliant and self-governing entities whilst retaining trust wide oversight, accountability and control. The trust board had a good understanding of where services were experiencing challenges and how this was being addressed.

However:

- There were some items discussed in part two of the board meeting which could be in part one. This included feedback from board visits and the trust risk register. The reason given by the trust for this, was that putting the papers in part two enabled an open discussion where specific services might be discussed in more detail. The trust recognised there was a balance to be struck between being open with the public and not sharing information which should be confidential and said they would review this.

# Summary of findings

- The trust actively promoted a culture of supporting people to speak up and had a number of ways in which they could raise concerns. This was supported by staff having access to a Freedom to Speak Up Guardian (FSUG). However, the inspection found that staff had a mixed knowledge of the FSUG.

The inspection did find that some of the improvements recommended at the previous inspection had not taken place. This included ensuring patients on the wards for older people had access to specialist staff such as a dietician when needed, or that information was put into accessible formats for patients with dementia or other cognitive impairments.

## Ratings tables

The ratings tables show the ratings for each key question and service type, as well as the overall ratings for community healthcare services and mental health services and the trust as a whole. They include the current ratings for parts of the trust not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took account of factors including the relative size of services and we used our professional judgement to reach fair and balanced judgements.

## Outstanding practice

We found examples of outstanding practice in a number of the trust's services, but especially in the area of leadership and governance. For more information, see the outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 12 Safe care and treatment; Regulation 17 Good governance and Regulation 18 Staffing.

There were five things the trust must put right in relation to breaches of these three regulations.

For more information see the areas for improvement section of this report.

## Action we have taken

We issued requirement notices in respect of the three regulations that had been breached in three services.

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

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

We found examples of outstanding practice in the following services.

Trust-wide

# Summary of findings

- The trust demonstrated an exceptional response to the Grenfell fire. They had been a partner in the response to address the immediate needs and longer-term trauma of this experience both directly and through co-ordination with other providers. In 2017/18 1900 adults were referred to CNWL services and 490 children. In such an unprecedented situation the trust had to work with the local community to identify bespoke solutions to meet the needs of the local population. The trust was now delivering long term services in the area. They were advising other countries on how to provide support following major incidents.
- The trust was very innovative in how it promoted staff well-being and had won an excellence award from the London Healthy Workplace Charter backed by the Mayor of London. The trust had to meet a set of standards to meet the mental and physical healthcare needs of staff. One of the reasons for this award was that the trust had set up a fund to arrange a variety of classes including Zumba, yoga, mindfulness and playing the ukelele. The trust had also focused on the mental well-being of staff with their staying well at work service (SW@W). This supported staff on medication; without permanent homes; or needing help with redeployment. They also recognised the importance of providing financial support to staff and had won an award for a scheme called Money Wizard which was an online tool helping staff feel more in control of their finances.
- The trust engaged effectively with staff and had a remarkably effective communications strategy which made full use of social media. The trust intranet was easy to navigate and information was provided through a range of mediums including ‘three-minute reads’, the clinical message of the week, the chief executive’s blog and three key messages after each board meeting. For example, a professionally produced and performed video of staff singing and dancing to promote the staff having a flu vaccination had been well received and contributed to a 76% immunisation rate.
- The trust was the highest ranked NHS organisation in the Stonewall awards at equal 28th in its list of top employers for 2019 (only five healthcare employers were in the top 100).

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

- At Northwick Park, mental health staff were paired up with their general acute colleagues in a three-month development programme. The programme included opportunities to shadow shifts and was initiated to encourage knowledge-sharing and learning between mental health and acute wards.
- Interagency work was exceptionally well developed at the Campbell Centre, aided by the social recovery team. This dynamic team predominantly comprised peer support workers with a range of lived experience. They had consolidated and enhanced links with statutory and third sector organisations working in Milton Keynes in order to benefit patients in the acute wards. There were particularly strong links with the police and fourteen local police officers had recently attended a course on psychosis facilitated by the service. Opportunities for reciprocal training were seized by members of the staff team who raised awareness of mental health within local agencies in exchange for briefings on issues, such as housing.
- Staff on Pine Ward had implemented a number of strategies to reduce the number of restrictive interventions. They included more effective team working, focussing on patients at times of higher risk (for instance, in the first 48 hours of admission) and encouraging more patient and carer involvement. Following this initiative, there were 67 restraints between May 2017 and May 2018, compared to 112 between May 2016 and May 2017. Similarly, during this period the number of prone (chest down) restraints fell from 64 to 13 and the number of times seclusion was used fell from 76 to 40.

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

- Each London team had an employment specialist advisor who worked with the employment service within the trust to establish individual placement and support (IPS) networks for patients. This meant that people who used the services were supported to find and retain jobs. This programme had been recognised as a national centre of excellence.

# Summary of findings

- In Brent early intervention team, there had been considerable work with a local football club to develop a project to engage patients and provide additional focus for the team to work with patients while also promoting inclusion within the local community.

## Areas for improvement

We found areas for improvement including breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 12 Safe care and treatment; Regulation 17 Good governance and Regulation 18 Staffing.

There were five things the trust must put right in relation to breaches of these three regulations. There were an additional five requirements outstanding from earlier inspections in three services that we did not inspect in early 2019.

In addition, we found 31 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. There were an additional 56 actions outstanding from inspections prior to the current inspection which related to 14 services that we did not inspect during early 2019.

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **MUST** take to improve

Acute wards for adults of working age and psychiatric intensive care units (PICU) (June 2019)

- The trust must ensure it continues to comply with guidance on mixed-sex accommodation for Gerrard and Vincent Wards (Gordon Hospital). They must also continue not to use bedrooms which are too small to safely support patients.
- The trust must review how patients can alert staff to any need for help when they are in their bedrooms.

Wards for older people with mental health problems (June 2019)

- The trust must ensure that inpatients have timely access to the full range of specialists to meet their needs, in particular, dietetics, speech and language therapists and physiotherapists.
- The trust must ensure that staff are appropriately trained in dementia care so they are equipped with the skills to support this patient group.

Community-based mental health services for adults of working age (June 2019)

- The trust must ensure that assessments and reviews are carried out in a timely manner, particularly in the Milton Keynes urgent access team.

Eating Disorders Service (November 2018)

- The provider must review their ward ligature risk assessment to ensure all ligature risks are correctly identified and that sufficient detail is available to staff about what actions they should take to mitigate the identified risks.

Crisis services and health based places of safety (June 2015)

- The trust must ensure that when a person is assessed as requiring an inpatient bed that they are able to access a bed promptly.



# Summary of findings

- The trust must ensure that the access to the trust's places of safety promotes the patients' dignity and privacy by the provision of a separate entrance.
- The trust must ensure people's private conversations cannot be overheard in adjoining interview rooms at St Charles hospital.

## Long stay/rehabilitation mental health wards for working age adults (June 2015)

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

## Action the trust **SHOULD** take to improve

### Trust wide (June 2019)

- The trust should review the arrangements for the Freedom to Speak up Guardian to ensure staff know how to make contact if needed and find the support easy to access.
- The trust should embed the system for ensuring staff have regular access to high quality supervision.
- The trust should review if topics discussed in part two of the board could be transferred to part one.

### Acute wards for adults of working age and psychiatric intensive care units (PICU) (June 2019)

- The trust should ensure it embeds the system to monitor whether staff are receiving regular supervision and that this is of a good quality.
- The trust should ensure that the frequency and content of team meetings are sufficient for the effective functioning of the wards.
- The trust should ensure any actions identified through their fire risk management processes are followed up robustly, regularly reviewed and clearly recorded at the Campbell Centre.
- The trust should review the use of the quiet room on Ganges Ward as a bedroom, due to the poor access to bathroom facilities.
- The trust should ensure that patients' privacy and dignity is maintained at the Gordon Hospital (clear windows overlooking private dwelling).
- The trust should consider the installation of observation windows that provide better privacy for patients whenever they replace any bedroom doors.
- The trust should review staffing levels on wards when staff report they feel unsafe and inform staff of the outcome.
- The trust should continue their recruitment processes to ensure adequate medical cover at the Gordon Hospital.
- The trust should ensure that 'as required' (PRN) medicines are reviewed regularly.
- The trust should make sure all relevant staff know how and when to assess patients' capacity and that they record the discussion and subsequent decision. Regulation 18(2)(a)
- The trust should continue its efforts to ensure that care plans across all wards are recovery orientated, personalised and regularly reviewed.
- The trust should continue its efforts to ensure that risk assessments are reviewed regularly and after any incidents.
- The trust should continue its efforts to improve patient access to weekend and evening activities.

# Summary of findings

- The trust should ensure that findings from audits are always shared with the relevant ward manager so they can be followed up.

## Community-based mental health services for adults of working age (June 2019)

- The trust should continue its work to recruit and retain permanent staff across the community teams, although the many initiatives already in place were recognised.
- The trust should ensure all staff understand and follow the lone working policies put in place by the trust.
- The trust should continue to improve the recorded risk information available within the records of all patients seen by the service and ensure there are robust risk management plans in place where risks have been identified.
- The trust should ensure that there are systems in place to check that staff explain patients' rights to people subject to compulsory treatment orders (CTOs), in accordance with the Mental Health Act Code of Practice.
- The trust should continue the work to improve the telephone systems, to enable staff to do their work effectively and make it easier for patients and others to contact the service.
- The trust should ensure that opportunities for patient engagement are offered across the different teams so that patients in all local areas have opportunities for involvement.
- The trust should ensure staff throughout the service have access to information about the role and contact details of the trust freedom to speak up guardian.
- The trust should continue to explore opportunities for sharing best practice and learning across teams in different geographical areas.

## Wards for older people with mental health problems (June 2019)

- The trust should ensure work is further progressed so that patients with dementia and cognitive impairment across all the wards for older people with mental health needs receive information in formats that they can read and understand.
- The trust should ensure that staff at Beatrice Place give patients every possible assistance to make a specific decision for themselves before they assume that the patient lacks the mental capacity to do this.
- The trust should follow their own policy in prevention and management of falls, and ensure that staff complete a falls risk assessment for all patients on admission. Staff must review the relevant falls risk assessment following a patient fall.
- The trust should ensure that staff on Kershaw and Redwood wards have access to hand held alarms that summon staff assistance, if required, in a timely manner.
- The trust should ensure that the system for recording and monitoring supervision is embedded across the service.
- The trust should ensure that informal complaints are logged to monitor for themes and to ensure learning and improvement.

In addition, two recommendations from the 2017 inspection have been carried forward as they relate to a part of the service we did not inspect this time:

- The trust should ensure that the ligature risk assessment on TOPAS ward includes details of the ligature points in the garden and the steps taken to mitigate these risks.
- The trust should ensure on TOPAS ward that there is a sign on the door stating that informal patients can leave the ward.

# Summary of findings

## Eating disorders service (November 2018)

- The trust should consider how to improve the local staff induction process to help ensure that temporary staff working on the ward know about environmental risks and risks that are specific to this patient group including the signs and symptoms of re-feeding syndrome. Inclusion of the trust's values should also be considered to improve patient experience when interacting with temporary staff.
- The trust should consider how they can encourage more feedback from patients.
- The trust should ensure that lessons learned from incidents on the ward and in the wider organisation are shared with staff so that necessary changes can be implemented promptly.

## Wards for people with learning disabilities of autism (June 2017)

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

## Child and adolescent mental health wards (June 2015)

- The trust should consider the broader implications of the personal search policy in the service. There was a risk that children could bring in dangerous items that could go undetected.
- The trust should ensure that all families understand when restraint may be used on their child and why.

## Community dental services (June 2015)

- The trust should continue to work closely with commissioners to ensure that patients in Hillingdon PDS can access care and treatment needed within a reasonable timescale.

## Community health inpatient services (June 2015)

- The trust should provide facilities for patients to store their medication where they are able to self-administer.
- The staff at the Windsor unit in Milton Keynes should receive regular supervision.
- The trust should ensure that patient records at the Windsor unit in Milton Keynes are well organised.
- The trust should ensure the manager post at the Windsor unit in Milton Keynes is filled.
- The trust should ensure good practice is shared across the community inpatient services.

## Community health services for adults (June 2015)

- The district nursing staff in Hillingdon should all have with them the essential equipment needed to do their job.
- Where teams are using electronic and paper patient notes the recording should be more consistent.
- Assessments and the review of assessments should be completed in line with the agreed procedures for the team.
- The district nursing teams in Hillingdon should all maintain high standards of infection control practice.

## Community mental health services for people with learning disabilities or autism (June 2015)

- Accurate records should be available of the training staff have completed to ensure staff complete the necessary training.
- Vacant occupational therapy and speech and language therapy posts should be filled as soon as possible to ensure people who use the service have access to that professional input where needed.

# Summary of findings

## Community-based mental health services for older people (June 2015)

- The care plans should include a full physical healthcare management plan where physical health issues noted on initial assessments.
- The teams should explore if care plans can be provided in a more accessible format.
- The services should ensure all staff have access to regular formal supervision
- The services should collate informal verbal complaints so that lessons can be learnt from these.

## Forensic inpatient/secure wards (June 2015)

- The trust should consider how learning from incidents across different divisions is embedded in practice especially where there are wards with similarities either in geography or function such as other wards on the Park Royal site and other rehabilitation wards in the trust.
- The trust should consider if a seclusion room can be provided on the same floor as the wards.
- The trust should ensure areas for work identified in infection control audits are carried through.
- The trust should provide ongoing training and support to ensure all staff had a good understanding of the Mental Capacity Act and how this would be used in practice with the patients using these services.
- The trust should ensure that repairs to equipment in the wards are reported and fixed in a timely manner.

## Long stay/rehabilitation mental health wards for working age adults (June 2015)

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

## Mental health crisis services and health-based places of safety (June 2015)

- The trust should ensure the building work to make the Gordon Hospital places of safety is completed.
- The trust should ensure people's risk assessments are updated on the trust's electronic records system to accurately reflect their changing risk.

# Summary of findings

- Arrangements for lone working should be reviewed to ensure that all teams have robust systems in place.
- Where appropriate, staff should record when they have assessed a person's capacity to make a decision within the written records.
- The teams should consider ways to ensure they collect regular feedback from people who have used their services.

## Specialist community mental health services for children and young people (June 2015)

- The trust should ensure that the lone working policy and use of panic alarms are embedded across the service. There was a difference in how the panic alarm system and lone working system was operating across the teams. This meant that if there was an incident other staff in the team would not be alerted to this, and be able to offer effective support or take steps to ensure staff safety in a timely manner.
- The trust should ensure that all staff know how to report incidents and understand the duty of candour regulation. The duty of candour was introduced for providers to ensure they are open and honest with people when something goes wrong with their care and treatment.
- The trust should ensure that staff are appropriately supported about changes that affect them during the ongoing reconfiguration of the CAMHS community services.
- The trust should ensure young people and their families are clear on who to contact in a crisis out of hours.

## Substance misuse services (June 2015)

- The trust should ensure that each person receiving treatment has potential risks associated with the treatment assessed, and that where potential risks are identified an appropriate plan to manage or mitigate these risks is put in place. This work had been identified by the trust and needs to be completed.
- The trust should ensure that a robust system to monitor and dispose of medical equipment that has passed its expiry date is in place at each site.
- The trust should ensure that every patient with identified health risks, such as at QT prolongation, are referred at regular intervals for electrocardiograms (heart tracing), in line with trust policy and procedure.
- The trust should ensure that staff record information relating to physical health checks in a standardised format to ensure that this information is readily accessible to all staff who may need to access it.
- The trust should ensure that recovery care plans across all sites are holistic and contain all information relating to care and treatment including the views of the patient.
- The trust should ensure that a clear policy and procedure is available at all sites that provides guidance on the frequency with which patients prescribed controlled medicines should be reviewed by the prescribing doctor.
- The trust should ensure that premises promote the dignity of people needing to access facilities at each geographical site.

All 'musts' and 'shoulds' outstanding from inspections in 2015 - 2018 will be followed up at the next inspection of the relevant core services.

For more information see the areas for improvement section of this report.

# Summary of findings

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

- The trust had a highly experienced, skilled and respected executive leadership team. They were inspiring, committed and continuously challenged themselves to improve services to meet the needs of patients. Internal staff and external stakeholders commented positively on the leadership of the trust. Most of the executive leadership team had been in their posts for ten years or more which had provided considerable stability during a period where the trust had grown and managed considerable change. At the time of the inspection two of the executive directors had announced their retirement. Their succession had been carefully planned.
- Leaders promoted a culture within the trust which was open, honest and responsive. This was reflected in how the trust managed the many challenging situations they faced. At all levels of the organisation they spoke openly about where improvements were needed and how they would be addressed. An example of this was in relation to safeguarding concerns at one of the inpatient sites where action was taken to ensure patients were safe and additional leadership input was provided to support the necessary improvements.
- The trust board demonstrated a commitment to ensuring that people who use services and their families received the best care and treatment possible. The trust board gained insight into the challenges of delivering services through being linked to a division of the trust and board visits. Some clinically trained executive directors occasionally worked alongside staff within services to get a grass-roots perspective or to help during periods of intense pressure. Staff across the trust were positive about the visibility of the non-executive directors and members of the senior leadership team. Given the size of the trust, senior leaders' knowledge of each service and the people working within them was exceptional.
- The trust had a clear vision and values. These had been developed in partnership with patients, carers, staff and a wide range of stakeholders. The vision and values of the trust were understood by staff throughout the trust and they could articulate how these related to their work within the organisation and the care delivered to patients. Staff spoke passionately about how they would go the extra mile to meet people's individual needs.
- The trust continuously strove to meet the needs of local communities. Since the previous inspection, the trust demonstrated this through its exceptional response to the Grenfell fire. The trust had been a partner in the response to address the immediate needs and longer-term trauma of this experience both directly and through co-ordination with other providers. In 2017/18 1900 adults were referred to CNWL services and 490 children. In such an unprecedented situation the trust had to work with the local community to identify bespoke solutions to meet the needs of the local population. The trust was now delivering long term services in the area.
- The trust embraced partnership working and was willing to take either a lead or supporting role dependant on what was appropriate in that geographical area. The trust leadership team actively participated in the work of three sustainability and transformation partnerships. It worked with a wide range of local and specialised commissioners through its divisions and boroughs. The trust was part of two accountable care partnerships (ACP) in Hillingdon and Milton Keynes. ACPs are new models of care which seek to provide local people with comprehensive coordinated services in a partnership arrangement between the NHS, local authority and, sometimes, third sector providers.
- The trust recognised the importance of promoting staff well-being and had won an excellence award from the London Healthy Workplace Charter backed by the Mayor of London. The trust had to meet a set of standards to meet the

# Summary of findings

mental and physical healthcare needs of staff. One of the reasons for this award was that the trust had set up a fund to arrange a variety of classes including Zumba, yoga, mindfulness and playing the ukelele. The trust had also focused on the mental well-being of staff with their staying well at work service (SW@W). This supported staff on medication; without permanent homes; or needing help with redeployment. They also recognised the importance of providing financial support to staff and had won an award for a scheme called Money Wizard which was an online tool helping staff feel more in control of their finances.

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- People who used services and had lived experience were involved in the work of the trust. Examples of this were the recovery college for people using mental health services and the user involvement work in sexual health services for people with HIV. There was also increased user and carer involvement in staff interview panels. Examples of this involvement were shared in the quarterly report on patient feedback and involvement. The trust employed a range of peer support workers with different skills and experience. They carried out a wide range of roles supporting patients and contributing to service improvements. For example, restraint and de-escalation training was co-produced and co-delivered with two full-time peer support workers working as trainers within the team that provided training in the therapeutic management of violence and aggression.
- The trust was making good progress with their quality improvement (QI) work, and despite this approach only being in place for about a year and a half it was becoming established across the trust. The trust had received an award from the South of England QI collaborative for building capability and capacity. During the inspection many of the staff we met spoke about their involvement in QI projects. At the time of the well-led review there were 276 active projects and 32 completed projects. The trust had an excellent QI microsite which was accessible on the trusts website. This live site enabled staff to access resources, sign up for training events and record progress with their own project. This enabled services to identify similar projects and learn from each other. The trust was working with patients and carers and they were actively involved in 26% of the projects.
- Staff at all levels of the organisation had access to a wide range of information to support them with performing their roles. Since the last inspection the trust had implemented a business intelligence tool. This provided live information at all levels of the organisation to support the clinical delivery of the service. For example, teams could know on an individual named basis which patients needed to have their care programme approach meeting or to be followed up within seven days of being discharged.
- The trust provided its estates and facilities function through a wholly owned subsidiary which was very dynamic in its approach, looking for creative solutions to estate challenges. The subsidiary provided an estates and facilities service. It ensured that money raised by property disposals remained within the NHS and the model was attracting a lot of interest from other trusts.
- The governance processes worked well at different levels of the trust through an overarching accountability framework. The accountability framework identified what must be shared at different levels of the organisation and oversaw the clinical effectiveness of services. Since the previous inspection divisions had become more self-reliant and self-governing entities whilst retaining trust wide oversight, accountability and control. The trust board had a good understanding of where services were experiencing challenges and how this was being addressed.

# Summary of findings

However:

- There were some items discussed in part two of the board meeting which could be in part one. This included feedback from board visits and the trust risk register. The reason given by the trust for this, was that putting the papers in part two enabled an open discussion where specific services might be discussed in more detail. The trust recognised there was a balance to be struck between being open with the public and not sharing information which should be confidential and said they would review this.
- The trust actively promoted a culture of supporting people to speak up and had a number of ways in which they could raise concerns. This was supported by staff having access to a Freedom to Speak Up Guardian (FSUG). However, the inspection found that staff had a mixed knowledge of the FSUG.
- The inspection did find that some of the improvements recommended at the previous inspection had not taken place. This included ensuring patients on the wards for older people had access to specialist staff such as a dietician when needed, or that information was put into accessible formats for patients with dementia or other cognitive impairments.



## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Jun 2019	Good ↔ Jun 2019	Outstanding ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

### Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good ↔ Jun 2015	Good ↔ Jun 2015	Outstanding ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015
Mental health	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015
Community health services for children and young people	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015
Community health inpatient services	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015
Community end of life care	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015
Community dental services	Good →← Jun 2015	Good →← Jun 2015	Outstanding →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015
Sexual health services	Good →← Jun 2015	Outstanding →← Jun 2015	Outstanding →← Jun 2015	Outstanding →← Jun 2015	Good →← Jun 2015	Outstanding →← Jun 2015
<b>Overall*</b>	Good →← Jun 2015	Good →← Jun 2015	Outstanding →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Requires improvement ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015
Forensic inpatient or secure wards	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015
Child and adolescent mental health wards	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015
Wards for older people with mental health problems	Good ↑ Jun 2019	Requires improvement ↓ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019
Wards for people with a learning disability or autism	Good ↔ Jun 2017	Outstanding ↔ Jun 2017	Outstanding ↔ Jun 2017	Outstanding ↔ Jun 2017	Outstanding ↔ Jun 2017	Outstanding ↔ Jun 2017
Community-based mental health services for adults of working age	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019
Mental health crisis services and health-based places of safety	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Requires improvement ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015
Specialist community mental health services for children and young people	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015
Community-based mental health services for older people	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015	Good ↔ Jun 2015
Specialist mental health eating disorder services	Requires improvement ↔ Nov 2018	Good ↔ Nov 2018	Good ↔ Nov 2018	Good ↔ Nov 2018	Good ↔ Nov 2018	Good ↔ Nov 2018
<b>Overall</b>	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

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

Good  

## Key facts and figures

Central and North West London NHS Foundation Trust (CNWL) provides community-based mental health services for adults of working age across four London boroughs, Westminster, Kensington and Chelsea, Harrow, Hillingdon and Brent and in Milton Keynes.

During this inspection, we visited the following services

### Brent

- Harness (Harlesden and Neasden) Community Mental Health Team (CMHT)
- Kilburn CMHT
- Kingsbury and Willesden CMHT
- Brent Early Intervention in Psychosis service

### Hillingdon

- Hillingdon North CMHT
- Hillingdon East CMHT
- Hillingdon West CMHT

### Harrow

- Harrow East CMHT
- Harrow West CMHT

### Milton Keynes

- Milton Keynes Urgent Access Team (UAT)
- Milton Keynes Recovery and Rehabilitation Team
- Milton Keynes Assertive Outreach Team (AOT)
- Milton Keynes Specialist Therapies Team
- Milton Keynes Early Intervention in Psychosis service

We also visited the cross-borough Harrow and Hillingdon Early Intervention in Psychosis service.

Community-based mental health services for adults of working age were last inspected in May 2017 when the overall rating was requires improvement, with a rating of requires improvement in safe, requires improvement in effective, good in caring, good in responsive and good in well-led.

Our most recent inspection of the community mental health teams for adults of working age took place between 28 January and 7 February 2019. It was a short-notice announced inspection where the service was told two days before our inspection. This was in line with CQC guidance.

This inspection was part of a larger inspection of mental health services within the trust.

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

Before the inspection visit, we reviewed information we held about the community mental health services for adults of working age and following the inspection visit, we requested further information from the trust.

During the inspection visit, the inspection team:

- visited 15 teams providing community mental health services for adults of working age and looked at the quality of the environment in which patients were seen
- observed staff interactions with patients in the waiting room areas
- spoke with 94 members of staff, including team managers, service managers, doctors, nurses, social workers, occupational therapists, support workers, admin workers, employment specialist workers, clinical psychologists, assistant psychologists and peer support workers
- spoke with 24 patients and six carers
- looked at 58 patient care and treatment records
- checked 25 prescription charts
- carried out a specific check on the management of medicines in Brent and Harrow
- attended and observed eight 'zoning' meetings
- attended and observed (with patient consent) four home visits carried out by staff
- attended and observed three clozapine clinics
- attended and observed two seniors' meetings in Brent and Hillingdon and one pathway meeting in Brent
- checked six staff supervision records
- attended and observed one clinical review meeting and one allocation meeting
- reviewed policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly.
- Patient risk was well-managed by most services and staff were aware of the key risks before visiting patients. Teams across the trust held regular meetings where clinical risk was explicitly discussed. However, some recorded risk assessments did not clearly state how the risk should be addressed, which could potentially mean that staff, especially if they were new to the team, might not know what steps to take.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.

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

- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well led and the governance processes ensured that that procedures relating to the work of the service ran smoothly.

However:

- For some teams, assessments that were agreed to be less urgent did not take place in a timely manner.
- Whilst systems were in place to protect staff who were lone working, some staff were not familiar with lone working procedures, particularly in Harrow and Brent. This could put staff at risk when working alone.
- Some staff did not have a good understanding of the role of the freedom to speak up guardian so were unaware they could raise concerns through the guardian.

## Is the service safe?

Good  

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

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The number of patients on the caseload of the teams, and of individual members of staff, was closely monitored and not too high to prevent staff from giving each patient the time they needed. Staff had completed mandatory training. However, some teams were struggling to recruit and retain staff, although, where needed, they used long-term agency staff to improve the consistency of care.
- Staff assessed and managed risks to patients with regular clinical meetings and use of duty staff. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. However, some risk assessment records did not include a clear description of what action should be taken in response to specific risks which could potentially lead to an incident, especially in teams where there were higher levels of temporary staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, systems were not in place to monitor the number of, and progress with, child safeguarding referrals.
- The service used systems and processes to safely prescribe, administer, record, transport and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The teams had an improving track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned

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

with the whole team and the wider service. There was good sharing of learning between teams in the same geographical area but scope to improve communication and learning between teams delivering similar services across different geographical areas. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Whilst systems were in place to support staff to be safe while working on their own, some staff were not yet using these systems.

## Is the service effective?

**Good** ● ↑

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

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs of patients, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included, or had access to, the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, the frequency of supervision varied across the team and the trust was implementing a system so this could be monitored.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the trust's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Managers had not ensured there were processes in place to ensure that patients who were subject to community treatment orders had their rights explained to them and that this was monitored consistently.

## Is the service caring?

**Good** ● → ←

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

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

However:

- There were more opportunities for patient involvement in some boroughs. For example, in some teams, patients were actively participating in staff recruitment processes but in others this was not the case.

## Is the service responsive?

Good ● → ←

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

- The referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Staff followed up patients who missed appointments.
- Although urgent referrals were flagged and given priority, some teams were not meeting the ambitious trust targets to assess people, whose referral was less urgent, within the timescales set. The teams kept in contact with patients while they were waiting to be assessed.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The phone systems in Hillingdon and Harrow were problematic, but work was underway to resolve this.

## Is the service well-led?

Good ● → ←

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.



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

- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. Where we found there were areas for improvement, leaders were aware of these issues and had plans in place to address them.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

However:

- Some staff within the service did not have a good understanding of the role of the freedom to speak up guardian within the trust and did not know how to make contact with them to report concerns if necessary.

## Outstanding practice

- Each London team had an employment specialist advisor who worked with the employment service within the trust to establish individual placement and support (IPS) networks for patients. This meant that people who used the services were supported to find and retain jobs. This programme had been recognised as a national centre of excellence.
- In Brent early intervention team, there had been considerable work with a local football club to develop a project to engage patients and provide additional focus for the team to work with patients while also promoting inclusion within the local community.

## Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that assessments and reviews are carried out in a timely manner, particularly in the Milton Keynes urgent access team. Regulation 18(1)

Action the provider **SHOULD** take to improve

- The trust should continue its work to recruit and retain permanent staff across the community teams, although the many initiatives already in place were recognised. Regulation 18(1)
- The trust should ensure all staff understand and follow the lone working policies put in place by the trust. Regulation 17(1)(2)(b)
- The trust should continue to improve the recorded risk information available within the records of all patients seen by the service and ensure there are robust risk management plans in place where risks have been identified. Regulation 12(1)(2)(a)(b)
- The trust should ensure that there are systems in place to check that staff explain patients' rights to people subject to compulsory treatment orders (CTOs), in accordance with the Mental Health Act Code of Practice. Regulation 17(1)(2)(a)
- The trust should continue the work to improve the telephone systems, to enable staff to do their work effectively and make it easier for patients and others to contact the service. Regulation 15(1)(c)
- The trust should ensure that opportunities for patient engagement are offered across the different teams so that patients in all local areas have opportunities for involvement. Regulation 10(2)(b)

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

- The trust should ensure staff throughout the service have access to information about the role and contact details of the trust freedom to speak up guardian. Regulation 16(2)
- The trust should continue to explore opportunities for sharing best practice and learning across teams in different geographical areas. Regulation 18(2)

# Wards for older people with mental health problems

Good   

## Key facts and figures

Central and North West London NHS Foundation Trust (CNWL) provides inpatient wards for people over the age of 65 with both functional and organic mental health disorders. Organic mental illness is usually caused by diseases affecting the brain, such as Alzheimer's. Functional mental illness may include conditions such as depression, schizophrenia, mood disorders or anxiety.

CNWL has the following wards for people with mental health problems.

- Kershaw Ward and Redwood Ward are based at St Charles Mental Health Centre. Redwood Ward is a 17-bedded ward and Kershaw is a 14-bedded ward. Both are mixed gender wards for older adults with functional and organic mental health problems.
- Oaktree Ward is based at Hillingdon Mental Health Centre and is a 17-bedded assessment service. It accommodates both men and women and provides care to older adults with functional and organic mental health problems.
- Ellington Ward is based at Northwick Park Mental Health Centre and is a 24-bedded ward. It accommodates both men and women and provides care to older adults with functional and organic mental health problems.
- Beatrice Place is based in Kensington and Chelsea and is a 24-bedded continuing care service. The service accommodates both men and women and provides care to older adults with functional and organic mental health problems.
- The older persons assessment service (TOPAS) is a 20-bedded assessment and treatment service for male and female older adults who have complex or acute mental health problems both functional and organic. The service is based at the Waterhall Care Centre in Milton Keynes.

We inspected all wards for older people with mental health problems, apart from TOPAS.

We last inspected the wards for older people with mental health problems in January 2017, when we rated the service as good overall; with a rating of good in effective, caring, responsive and well-led, and a rating of requires improvement in safe.

Our inspection of wards for older people with mental health problems took place between 4 and 7 February 2019 and was announced (staff knew we were coming) two days before the inspection. This was in line with CQC guidance.

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

During this inspection visit, the inspection team:

- visited each of the wards (apart from TOPAS), looked at the quality of the physical environment, and observed how staff communicated with patients
- spoke with 13 patients and 10 carers
- spoke with the ward managers and modern matrons
- spoke with the Kensington and Chelsea borough director and deputy borough director
- spoke with the Hillingdon deputy borough director

# Wards for older people with mental health problems

- spoke with 28 other members of staff, including registered nurses, healthcare assistants, occupational therapists, consultant psychiatrists, an administrator, a clinical psychologist and the trust patient and carer engagement lead
- looked at 24 patient care and treatment records
- attended and observed one handover meeting
- attended and observed three ward rounds
- attended and observed two lunches
- carried out a specific check of medicines management on all the wards
- looked at policies, procedures and other documents relating to the running of the services.

## Summary of this service

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

- Patients were looked after in a safe and clean environment by sufficient numbers of staff who were committed to meeting their needs. The service protected patients from the risk of abuse and avoidable harm. There were clear, open and transparent processes for reporting incidents.
- The care and treatment for most patients was assessed, planned, delivered and reviewed regularly. Staff completed physical health checks and on-going healthcare investigations and healthcare monitoring. Staff participated in a wide range of clinical audits to monitor the effectiveness of the service, and they monitored the outcomes of patients' care and treatment.
- Patients and carers spoke positively about the care, support and treatment they received. They said staff treated patients with kindness, respect and compassion. Staff recognised and respected the totality of patients' needs and they involved and supported patients, and those close to them, in decisions about their care and treatment.
- Staff worked in collaboration with community teams within the trust and local social services to facilitate patient discharges.
- The choice of food took account of special dietary requirements and religious or cultural needs.
- Staff had a good understanding of the trust's vision and values for the service and felt supported and valued by their managers. They described a positive culture and felt comfortable raising any issues to their managers. Staff were involved in quality improvement initiatives.
- At the last inspection, not all staff received supervision, and the system for recording supervision was not robust. At this inspection, most staff had received supervision and the trust was implementing a system to check supervision took place regularly.
- Most wards were in the process of applying for national accreditation (a quality assurance scheme) and Ellington Ward had achieved it.

However:

- Whilst there had been a number of improvements since our last inspection and there was a good standard of care across the service as a whole, there were inconsistencies that impacted on patients and staff on specific wards, which the trust needed to attend to.

# Wards for older people with mental health problems

- Not all wards had timely access to specialists to meet the needs of older adults. For example, Kershaw and Redwood wards had not had regular access to a dietician since November 2018. Arrangements were put into place by the trust immediately after the inspection. Whilst access to psychological therapies had improved since our last inspection, patients at Beatrice Place were still experiencing delays.
- Not all staff had received training in dementia despite the fact that a large majority of the patients had dementia or a cognitive impairment. This was not in line with National Institute for Health and Care Excellence (NICE) guidance, which states that people with dementia should receive care from staff appropriately trained in dementia care. Following our site visit, the trust arranged for relevant staff to complete dementia care training by 29 March 2019 and put arrangements in place to monitor attendance going forward.
- The quality of staff supervision records was poor on Redwood Ward.
- At the last inspection, information which was provided was not routinely available in an accessible format for patients with dementia or cognitive impairments; for example, information on notice boards, leaflets, activity schedules and menus. At this inspection, some progress had been made, but there was still further room for improvement.
- The trust had some good practice in falls prevention such as non-slip socks, access to falls mats and adjustable bed heights. There had only been one serious incident reported in a year attributable to a fall. However, a few patients did not have a completed falls risk assessment on admission, which was not in line with the trust's policy for prevention and management of falls.
- The large size and layout of Kershaw Ward and Redwood Ward did not allow staff to observe all parts of the ward. Although staff had put mitigations in place, we observed during our inspection that staff were not always present in areas of the wards due to its large size, which left patients unattended. On Redwood Ward, the environmental risk assessment had not identified all of the potential blind spots on the wards. These blind spots made patient observation difficult. However, following our inspection, the trust installed mirrors for these blind spots.
- At the last inspection, there was no tracking of informal complaints. At this inspection, most wards had made improvements but Kershaw Ward and Redwood wards did not keep a log of their informal complaints to identify any themes or learning.
- At the last inspection, there was a lack of systems in place to learn from incidents across the divisional structure of the trust. At this inspection, although this had improved, we still found there were no formal arrangements in place for staff across the older adult wards to share learning and good practice. Some staff were unaware of incidents on other older adult wards, but knew about serious incidents that had occurred elsewhere.

## Is the service safe?

Good  

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff followed best practice in anticipating, de-escalating and managing behaviour which challenged. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.

# Wards for older people with mental health problems

- At the last inspection, staff were not clear about the requirements for reporting incidents of restraint when used to deliver personal care. At this inspection, they were clear about the trust's expectations and improvements had been made. Staff completed specific forms when restraint for personal care was used, and developed care plans for patients who required restraint for personal care. Managers monitored use of restraint for personal care and fed this back to the trust's restrictive interventions reduction programme for assurance.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with their team.
- At the last inspection, staffing levels on Ellington Ward did not always give staff enough time to take breaks from their work. During this inspection, this was no longer the case.

However:

- The trust had some good practice in falls prevention such as non-slip socks, access to falls mats and adjustable bed heights. There had only been one serious incident reported in a year attributable to a fall. However, a few patients across a number of wards did not have a completed falls risk assessment on admission, which was not in line with the trust's policy for prevention and management of falls. For one patient, staff only filled out a falls risk assessment following a fall on the ward.
- On Kershaw Ward, a member of staff was observed signing medication administration charts before administering each patient's medicines. The trust addressed this immediately.
- Patients had alarms in their bedrooms to summon assistance, but staff on Kershaw Ward and Redwood Ward did not have access to personal alarms, and instead relied on wall alarms in the event of an emergency. Staff reported they would like personal alarms in the event that they could not reach a wall alarm in a timely manner.
- The large size and layout of Kershaw Ward and Redwood Ward did not allow staff to observe all parts of the ward. Although staff had put mitigations in place, we observed during our inspection that staff were not always present in areas of the wards due to its large size, which left patients unattended. On Redwood Ward, the environmental risk assessment had not identified all of the potential blind spots on the wards. These blind spots made patient observation difficult. However, following our inspection, the trust had installed mirrors for these blind spots.
- At the last inspection, there were no arrangements in place to share learning across the wards for older people with mental health problems across different geographical areas and this remained a challenge for the trust.. At this inspection, although this had improved, we still found there were no formal arrangements in place for staff across the older adult wards to share learning and good practice. Some staff were unaware of incidents on other older adult wards, but knew about serious incidents that had occurred elsewhere
- The trust migrated to a new electronic patient record system during our inspection; this meant that some information was hard for staff to locate.

## Is the service effective?

**Requires improvement** ● ↓

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

# Wards for older people with mental health problems

- Not all wards had timely access to specialists to meet the needs of older adults. On Kershaw and Redwood wards patients had not had regular access to a dietician since November 2018. Arrangements were put into place by the trust immediately after the inspection. Some wards experienced delays of several weeks when referring patients for input from a physiotherapist or speech and language therapist.
- At the last inspection, Beatrice Place and Redwood Ward did not have a dedicated clinical psychologist. At this inspection, Beatrice Place experienced delays when requesting input from a clinical psychologist. Redwood Ward now had a dedicated clinical psychologist.
- Not all staff had received training in dementia. A large majority of the patients had dementia or a cognitive impairment. This was not in line with National Institute for Health and Care Excellence (NICE) guidance, which states that people with dementia should receive care from staff appropriately trained in dementia care. Following our site visit, the trust arranged for relevant staff to complete dementia care training by 29 March 2019 and put arrangements in place to monitor attendance going forward.
- The trust had been successful in recruiting a permanent consultant for Kershaw Ward, but they were on maternity leave at the time of inspection. Interim cover was available.
- At the last inspection, not all staff received supervision, and the system for recording supervision was not robust. At this inspection, most staff had received supervision and the trust was implementing a system to ensure supervision took place regularly. However, the quality of supervision records viewed on Redwood Ward was poor.
- At the last inspection, mental capacity assessments at Beatrice Place contained very brief information, lacked detail and failed to mention if any discussion had taken place. At this inspection, there was still room for improvement. Staff at Beatrice Place were not recording assessments of patients' capacity to consent to care interventions appropriately. Staff did not give patients every possible assistance to make a specific decision for themselves before they assumed lack of mental capacity. We found family and interpreters were not always involved when they should have been, and staff sometimes assumed patients lacked capacity for all decision-making due to their cognitive impairment.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. At Beatrice Place, we saw excellent life story information in patients' care plans.
- Staff used recognised rating scales, such as the health of the nation outcome scales, to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Members of the multidisciplinary team provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment.
- At the last inspection, care plan audits on Oaktree Ward did not have action plans or timescales to address audit findings. During this inspection, this was no longer an issue, and all wards completed care plan audits with action plans and timescales.

# Wards for older people with mental health problems

## Is the service caring?

Good ● → ←

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

- Patients and carers spoke positively about the care, support and treatment they received.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. Although, at Beatrice Place, staff needed to ensure they involved families and carers, when appropriate, to aid completion of patient mental capacity assessments.

## Is the service responsive?

Good ● → ←

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

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- Patients were cared for in an environment that promoted their comfort, dignity and privacy.
- Patients could make hot drinks and snacks at any time and received support to do so if required.
- Patients had access to a programme of therapeutic activities. At Beatrice Place, staff had implemented the namaste care programme for people with advanced dementia. It involved sensory stimulation activities, such as hand massages and aromatherapy oils.
- The service treated formal complaints seriously, investigated them, learned lessons from the results, and shared these with the whole team.
- Staff actively supported the diverse needs and religious beliefs of patients.
- At the last inspection, we found that some ward environments did not support patients with dementia or cognitive impairment. At this inspection, we found improvements had been made to make them more dementia-friendly.

However:

- At the last inspection, information which was provided was not routinely available in an accessible format for patients with dementia or cognitive impairment. For example, information on notice boards, leaflets, activity schedules and menus. At this inspection, some progress had been made, but there was still room for improvement.
- At the last inspection, there was no tracking of informal complaints. At this inspection, some wards had made progress, and others had not. Kershaw Ward and Redwood Ward did not keep a log of their informal complaints. This meant that there was a risk that themes which emerged through informal complaints were not resulting in learning and improvement.



# Wards for older people with mental health problems

## Is the service well-led?

Good   

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they applied to the work of their team.
- Governance and performance arrangements were in place within the service that supported the delivery of the service, identified most risks and monitored most aspects of the quality and safety of the services provided.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day to day work and provided opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local and national quality improvement activities.

However:

- There were two recommendations where we found improvements had not been fully implemented from the previous CQC inspection. However, following this inspection, the trust acted in a responsive manner and sent CQC an action plan detailing progress made with the recommendations since the last inspection, and how they planned to address new concerns found on Redwood and Kershaw wards.

## Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that inpatients have timely access to the full range of specialists to meet their needs, in particular, dietetics, speech and language therapists and physiotherapists. Regulation 18(1)
- The trust must ensure that staff are appropriately trained in dementia care so they are equipped with the skills to support this patient group. Regulation 18(1)(2)(a)

Action the provider **SHOULD** take to improve

- The trust should ensure work is further progressed so that patients with dementia and cognitive impairment across all the wards for older people with mental health needs receive information in formats that they can read and understand. Regulation 10(1)(2)(b)
- The trust should ensure that staff at Beatrice Place give patients every possible assistance to make a specific decision for themselves before they assume that the patient lacks the mental capacity to do this. Regulation 11(1)(2) (3)(4)
- The trust should follow their own policy in prevention and management of falls, and ensure that staff complete a falls risk assessment for all patients on admission. Staff must review the relevant falls risk assessment following a patient fall. Regulation 12(1)(2)(a)(b).
- The trust should ensure that staff on Kershaw and Redwood wards have access to hand held alarms that summon staff assistance, if required, in a timely manner. Regulation 17(1)(2)(b)

# Wards for older people with mental health problems

- The trust should ensure that the system for recording and monitoring supervision is embedded across the service. The trust should ensure supervision is thorough on all wards and includes clinical discussions about patient care and treatment. Regulation 17(1)(2)(a)
- The trust should ensure that informal complaints are logged to monitor for themes and to ensure learning and improvement. (17(1)(2)(a))
- The trust should ensure that arrangements are in place to share learning and good practice across the wards for older people with mental health problems. (17(1)(2)(a))

In addition, there were two recommendations from the 2017 inspection, which related to a part of the service we did not inspect this time. They will be carried forward:

- The trust should ensure that the ligature risk assessment on TOPAS ward includes details of the ligature points in the garden and the steps taken to mitigate these risks.
- The trust should ensure on TOPAS ward that there is a sign on the door stating that informal patients can leave the ward.

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

Good   

## Key facts and figures

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 located in six hospitals:

### **The Campbell Centre in Milton Keynes:**

- Willow Ward – 19 beds, for women
- Hazel ward – 19 beds, for men

### **Park Royal Mental Health Centre in Brent:**

- Pine Ward – 24 beds, for men
- Pond Ward – 24 beds, for women
- Shore Ward – 18 beds, for both men and women
- Caspian Ward – 13 beds, a PICU for men

### **St Charles Mental Health Unit in Kensington:**

- Amazon Ward – 17 beds, for both men and women
- Danube Ward – 16 beds, for both men and women
- Thames Ward – 17 beds, for both men and women
- Ganges Ward – 17 beds, for both men and women
- Shannon Ward – 12 beds, a PICU for women
- Nile Ward – 14 beds, a PICU for men

### **The Gordon Hospital in Westminster:**

- Vincent Ward – 20 beds, for both men and women
- Ebury Ward, 19 beds, for both men and women
- Gerrard Ward – 18 beds, for both men and women

(Each ward had reduced in size to 16 beds by the end of the inspection.)

### **Northwick Park Mental Health Unit in Harrow:**

- Eastlake Ward – 23 beds, for both men and women
- Ferneley Ward – 22 beds, for both men and women

### **Riverside Mental Health Unit in Hillingdon:**

- Crane Ward – 18 beds, for women
- Frays Ward – 23 beds, for men

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

- Colne Ward – 8 beds, a PICU for men

We previously inspected this service in October 2016 and found the service was good overall with some poor practice following the administration of rapid tranquillisation and a high level of restraint on the wards which was not always well-recorded. On this inspection we found these issues had been addressed. Our inspection of acute and PICU wards took place between 16 January and 25 March 2019 and staff had short notice of our visit in line with CQC guidance. We made unannounced return visits to the Park Royal and Gordon Hospital sites to check that promised improvements had taken place and found that changes had been implemented.

During this inspection visit, the inspection team:

- Visited all six sites and checked the quality of the ward environment for all twenty wards.
- Observed how staff were caring for patients, interacting with them during activities and at mealtimes.
- Spoke with 92 patients who were using the service.
- Spoke with the matrons, managers and/or deputy managers for each of the wards.
- Spoke with the clinical directors, safeguarding leads and Mental Health Act administrators for each borough.
- Spoke with 137 other staff members; including doctors, nurses, psychologists, peer support workers, healthcare assistants, art therapists, gym instructors, activity co-ordinators, occupational therapists, service managers, matrons, deputy service directors, administrators, domestics, housekeepers.
- Met with six carers.
- Reviewed 93 care and treatment records of patients across acute and PICU wards.
- Reviewed 133 medicines records across all the wards.
- Reviewed 20 records of rapid tranquillisation administration and monitoring.
- Attended a safety huddle.
- Attended eight handovers, eleven multidisciplinary meetings and ward rounds,
- Observed four service user and carer meetings.
- Looked at a range of policies, procedures and other documents relating to the operation of the services.

## Summary of this service

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

- Throughout the inspection we saw good practice, particularly at the Campbell Centre, Northwick Park, some individual wards on other sites and in the psychiatric intensive care units. The site where there were the most concerns was at the Gordon Hospital where there had been a serious safeguarding incident. The trust was aware that this service needed additional leadership support and had put this into place.
- Wards had made progress in minimising the use of restrictive practices and followed good practice with respect to safeguarding.

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

- Medicines were mostly managed safely, although at St Charles, the Campbell Centre and Northwick Park, 'as required' medicines were not reviewed regularly or when not used by the patients for whom they were prescribed for over 14 days.
- The service provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided, although there were some inconsistencies in both areas.
- Ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards, although patients on the wards at St Charles had limited access to psychological therapies.
- Managers ensured that ward staff received training and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was usually available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly. However, whilst most wards had regular team meetings using a standard agenda to ensure all the necessary topics were covered, a few did not take place regularly or the record of the meeting read like a 'to do list'.

However:

- While most wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose, a few were not. Bedrooms on two wards at the Gordon Hospital were too small for safe use by patients in distress. At the Gordon Hospital, rooms designed to offer flexible accommodation for male or female patients were breaching guidance to eliminate mixed gender accommodation. Pond Ward at Park Royal was not clean in some areas. By the end of the inspection the trust had addressed all these matters and, where needed, taken rooms out of use.
- Whilst the trust was working to recruit and retain staff, and most wards had safe staffing levels, a few wards were struggling to maintain safe staffing. Some wards did not have enough medical cover and some nursing staff told us they felt unsafe at night, especially when they had to attend to patient admissions as well as those already on the ward. We also heard from staff who said that patient leave was sometimes cancelled or that they could not leave the ward to attend training
- Staff on most wards developed holistic, recovery-oriented care plans informed by a comprehensive assessment, but there was room for improvement on other wards.
- Whilst staff generally understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff did not always request an opinion from a second opinion appointed doctor (SOAD) in good time. There were discrepancies in the completion of patients' capacity assessments.
- Most staff told us that they received regular supervision and they were happy with the content, but records were patchy on some wards. The trust was introducing an online system to monitor supervision, but this was at an early stage.

## Is the service safe?

**Requires improvement** ● → ←

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

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

- While most wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose, a few were not. Bedrooms on two wards at the Gordon Hospital were too small for safe use by patients in distress. At the Gordon Hospital, rooms designed to offer flexible accommodation for male or female patients were breaching guidance to eliminate mixed gender accommodation. Pond Ward at Park Royal was not clean. By the end of the inspection the trust had addressed all these matters and where needed taken rooms out of use.
- Whilst the trust was working to recruit and retain staff and most wards had safe staffing levels, a few wards were struggling to maintain safe staffing. Some wards did not have enough medical cover and some nursing staff told us they felt unsafe at night, especially when they had to attend to patient admissions as well as those already on the ward. We also heard from staff who said that patient leave was sometimes cancelled or that they could not leave the ward to attend training
- Although staff usually assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour, there were inconsistencies at the Gordon Hospital where risk assessments and risk management plans were not up to date.
- Medicines were mostly managed safely. The exceptions were at St Charles, the Campbell Centre and Northwick Park. Here, staff did not review 'as required' medicines regularly or when not used by the patient for whom they were prescribed for over 14 days.
- With the exception of the Campbell Centre where there were call bells, patients did not have access to a means of calling for urgent assistance from staff.
- While fire safety was generally of a good standard, at the Campbell Centre actions from the fire safety risk assessment had not been followed through and regular fire drills had not taken place. The trust was about to appoint a fire officer to monitor internal compliance with fire safety across the trust.

However:

- Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse; and they knew how to apply it.
- Staff access to clinical information was improving and there was a new system in place to enable them to maintain high quality electronic clinical records.
- Staff regularly reviewed the effects of medications on each patient's physical health.
- The service usually managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

Good   

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.

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

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.
- Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

However:

- Staff on most wards developed holistic, recovery-oriented care plans informed by a comprehensive assessment, but on a few wards there remained room for improvement.
- Whilst staff generally understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, they did not always request an opinion from a second opinion appointed doctor (SOAD) in good time. There were discrepancies in the completion of patients' capacity assessments on some wards.
- Most staff told us that they received regular supervision and they were happy with the content, but records were patchy on some wards. The trust was piloting an online system to monitor supervision, but this was at an early stage.

## Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff usually involved patients in care planning and risk assessment when they were well enough to participate and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

Good   

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

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

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. The main cause of discharge delays was the lack of suitable housing which was not within the scope of the trust's responsibilities.
- The food was of a good quality and patients could make hot drinks and snacks at any time, unless temporary safety restrictions were in place.
- Patients had access to a range of therapeutic activities and work was taking place to ensure these were available in the evening and weekend.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service usually treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Staff did not respond promptly on all wards to concerns raised by patients at community meetings. This meant that patients had to ask repeatedly.

## Is the service well-led?

Good   

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

- Where there were gaps in leadership, the trust was managing to recruit high quality people or move them across from stable teams, so we were confident the weakest wards would improve.
- Elsewhere, leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Most staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had improved access to the information they needed to provide safe and effective care.
- Staff engaged actively in local and national quality improvement activities, but on a few occasions ward managers had not received feedback from audits which could inform improvements.

However:

- At the Gordon Hospital, staff morale was quite low and a few other wards needed to make improvements. The trust knew where services needed additional leadership support and had put this into place.

## Outstanding practice

- At Northwick Park, mental health staff were paired up with colleagues from the general hospital next door in a three-month development programme. The programme included opportunities to shadow shifts and was initiated to encourage knowledge-sharing and learning between mental health and acute wards.



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

- Interagency work was exceptionally well developed at the Campbell Centre, aided by the social recovery team. This dynamic team predominantly comprised peer support workers with a range of lived experience. They had consolidated and enhanced links with statutory and third sector organisations working in Milton Keynes in order to benefit patients in the acute wards. There were particularly strong links with the police and fourteen local police officers had recently attended a course on psychosis facilitated by the service. Opportunities for reciprocal training were seized by members of the staff team who raised awareness of mental health within local agencies in exchange for briefings on issues such as housing.
- Staff on Pine Ward had implemented a number of strategies to reduce the number of restrictive interventions. They included more effective team working, focussing on patients at times of higher risk (for instance, in the first 48 hours of admission) and encouraging more patient and carer involvement. Following this initiative, there were 67 restraints between May 2017 and May 2018, compared to 112 between May 2016 and May 2017. Similarly, during this period the number of prone (chest down) restraints fell from 64 to 13 and the number of times seclusion was used fell from 76 to 40.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure it continues to comply with guidance on mixed-sex accommodation for Gerrard and Vincent Wards (Gordon Hospital). They must also continue not to use bedrooms which are too small to safely support patients. Regulation 17(1)(2)(a)(b)
- The trust must review how patients can alert staff to any need for help when they are in their bedrooms. Regulation 12(2)(a)(b)

### Action the provider SHOULD take to improve

- The trust should ensure it embeds the system to monitor whether staff are receiving regular supervision and that this is of a good quality. Regulation 17(1)(2)(a)
- The trust should ensure that the frequency and content of team meetings are sufficient for the effective functioning of the wards. Regulation 17(1)(2)(a)
- The trust should ensure any actions identified through their fire risk management processes are followed up robustly, regularly reviewed and clearly recorded at the Campbell Centre. Regulation 12(2)(d)
- The trust should review the use of the quiet room on Ganges Ward as a bedroom, due to the poor access to bathroom facilities. Regulation 10(1)(2)(a)
- The trust should ensure that patients' privacy and dignity is maintained at the Gordon Hospital (clear windows overlooking private dwelling). Regulation 10(2)(a)
- The trust should consider the installation of observation windows that provide better privacy for patients whenever they replace any bedroom doors. Regulation 10(1)(2)(a)
- The trust should review staffing levels on wards when staff report they feel unsafe and inform staff of the outcome. Regulation 18(1)
- The trust should continue their recruitment processes to ensure adequate medical cover at the Gordon Hospital. Regulation 18(1)
- The trust should ensure that 'as required' (PRN) medicines are reviewed regularly. Regulation 12 (1)(2)(g)

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

- The trust should make sure all relevant staff know how and when to assess patients' capacity and that they record the discussion and subsequent decision. Regulation 18(2)(a)
- The trust should continue its efforts to ensure that care plans across all wards are recovery orientated, personalised and regularly reviewed. Regulation 9(1)(3)(a)(b)
- The trust should continue its efforts to ensure that risk assessments are reviewed regularly and after any incidents. Regulation 12(1)(2)(a)(b)
- The trust should continue its efforts to improve patient access to weekend and evening activities. Regulation 9(1)(a)(b)(c)
- The trust should ensure that findings from audits are always shared with the relevant ward manager so they can be followed up. Regulation 17(1)(2)(a)(b)

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

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

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

# Our inspection team

Jane Ray, Head of Hospital Inspections, Mental Health, London led this inspection. An executive reviewer, Jane Tomkinson, Chief Executive Officer, at Liverpool Heart and Chest Hospital, supported our inspection of well-led for the trust overall.

The team included five inspection managers, 18 inspectors, four pharmacist inspectors, five Mental Health Act reviewers, two assistant inspectors, 1 inspection planner, 16 specialist advisers, and two experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.