CNWL

Inspection report

Trust Headquarters
350 Euston Road
London
NW1 3AX

Tel: 020 3214 5700

www.cnwl.org

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Is this organisation well-led?

Leadership

- The trust had a highly experienced, skilled and respected executive leadership team. Internal staff and external stakeholders commented positively about 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 when 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. For one of the roles, the executive director of strategy and performance, it had been decided not to replace the post-holder but to reconfigure the directors' portfolios. For the executive director of nursing the recruitment process was underway and included time for a handover period.

- The trust was divided into three divisions, each providing a wide range of services. Due to the size and complexity of the trust, each of these divisions was as large as many other trusts. Each division was led by a clinical, nursing and management lead. The divisional leadership teams were very impressive, demonstrating extensive knowledge of their areas of responsibility and a passion to deliver high quality care.

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

- The trust had a skilled board in place who had a good understanding of how to undertake their role effectively. The trust board consisted of the chair, chief executive, six non-

executive directors and five executive directors. The non-executive directors had a range of experience in senior leadership roles in the public sector, finance, marketing, academic organisations, clinical work and commissioning. Two of the non-executive directors were reaching the end of their terms. An exercise had taken place to assess the skills of the board and identify areas where new directors could enhance the board further. The selection process with the governors also focused on ensuring people had the right values. Two new appointments had been made and the new non-executive directors were starting shortly both bringing with them considerable experience. The chair was also due to reach the end of her term later in the year, but it was hoped that she would extend her stay whilst the new directors were settling into their roles.

- The trust board membership did not reflect the communities served by the trust and the staff employed by the trust. The trust chair and chief executive were very aware of this and wanted to see the diversity improve alongside ensuring people with the appropriate skills and experience joined the board. The trust was continuing to work with NHS Improvement to identify a suitable associate non-executive director for the trust.

- The non-executive directors felt well supported with their learning and development. Recently appointed non-executive directors had completed a bespoke induction process. This included receiving a pack of information, meeting key people and visits to services to gain an understanding of the work of the trust as well as completing some mandatory training. There was also access to the external training provided by NHS Improvement on how to be an effective non-executive director where needed. Learning was also promoted through board workshops and away days. The workshops, which took place in the months between board meetings, allowed opportunities to discuss topics in more detail and to think more strategically. All non-executive directors had an appraisal to support their development and had their individual development needs identified. They were also supported to access other external training if requested and there were opportunities to network and share learning with other trusts.

- All board members had lead areas including non-executive directors who chaired specific committees or were leads in areas of work. For example, one of the non-executive directors was the senior independent director and another led on promoting trust staff being able to ‘speak up’. Board members would attend each other’s committees to understand their work and ensure issues that extended across more than one committee were considered in a joined-up manner. Non-executive directors were also linked with a division so they could develop a more in-depth knowledge of these services.

- Arrangements were in place to ensure trust directors met the fit and proper persons’ criteria. We reviewed the checks made by the trust on the non-executive directors who had joined since the previous inspection. This showed the trust had carried out the necessary checks on directors. Enhanced level checks with the disclosure and barring service (DBS) had been completed.

- All members of 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 an additional understanding of the challenges of delivering services through a programme of board visits. These visits were written up and discussed in detail in part two of the board meeting so that any specific concerns could be raised and addressed. Board members also made additional visits outside the formal programme of visits. The executive team recognised that visiting services and engaging with patients and staff were a central part of their role. The chief operating officer had recently worked a shift on a ward at St Pancras to get a clearer understanding of the challenges being faced by that service. Staff

across the trust were positive about the visibility of the board and members of the senior leadership team.

- All members of the trust board demonstrated a commitment to ensuring that people who used services and their families received the best care and treatment possible. They were concerned to get it right for each individual. Staff across the trust were positive about the visibility of the board 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.

- Leadership and talent management was covered in the workforce strategy. The trust had invested in developing leadership skills and knowledge at every level of the trust and at this inspection we noted the very high calibre of most staff in posts graded 8a and above.

- The trust offered in-house and university commissioned development programmes, combining soft skills with more traditional theoretical elements. Most programmes included action learning sets to develop reflective and supervisory skills. Some offered formal qualifications. The trust's management fundamentals programme for senior clinical leaders was delivered in conjunction with Imperial College. Staff could also access the NHS Leadership Academy courses.

- In addition to the above, Black, Asian and minority ethnic (BAME) staff working at band 8A and above could participate in the developing diverse leaders programme. Those within bands 4 – 6 could access a BAME aspiring leaders programme and there was an intention to launch a BAME development programme for Band 7 staff later in 2019.

Vision and strategy

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

- The trust had further developed its quality and clinical strategy in partnership with people who used their services, carers, staff and other stakeholders. This identified some key principles in terms of future service development and how these would be tested. This included the principles of ensuring the needs of patients and carers were put first; that there would be clarity on what the trust could offer; that performance of services would be understood; innovation and efficiency promoted and staff would be supported to achieve their goals. This informed service development across physical and mental health services and sat alongside a commitment to continue rolling out quality improvement across the trust.

- The trust had a process in place to develop strategic and operational plans. The trusts current five-year plan was ending in 2020/21 and discussions were already taking place to consider how this would be updated. This was being done within the context of the wider environment in which the trust operated including the recently launched NHS long term plan. Non-executive directors described how they attended a facilitated board workshop to start working on this.

- The trust board had developed four trust objectives of quality; workforce; finance and efficiency; partnership and business development. Each year the board would consider how they needed to focus their delivery linked to these objectives and this would form the framework for planning at a trust and divisional level. The divisions would then develop their detailed plans including plans to transform services. These comprehensive plans were completed with a focus on delivering high quality care and financial sustainability.

- The trust was very aware of the diversity of the communities supported by the trust and plans reflected the specific needs of the local populations. The trust had many initiatives aimed at meeting the specific needs of people from minority ethnic groups. One example of a co-produced development was with a local church and an African congregation in Brent. The local pastor identified, in discussion with their congregation, that they were not accessing sexual health services. The trust worked with them to arrange a daytime clinic in the church. The church had promoted the service and it is was well attended.

- The trust was an active partner within a complex landscape across London and the South of England, including Milton Keynes. 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.

- Since the previous inspection the trust had demonstrated its commitment to working in partnership 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 1,900 adults were referred to CNWL services and 490 children as a result of the fire. 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.

Culture

- Leaders told us they wanted to create a culture where staff are empowered to contribute to decisions that affect them, and to make improvements in their work where feasible.

- The staff morale across the trust was largely positive with staff expressing how proud they were of the trust and their individual teams. Most staff whilst recognising the challenges of their job, felt well supported by their managers and teams. Staff were motivated to deliver high quality care and there were many examples of staff working hard to meet the individual needs of people who used the services and supporting them to be actively involved in decisions about their treatment and how services were delivered by the trust. The trust also had a good understanding of where there were pockets of unhappy staff and the reasons for this. Arrangements were in place to provide additional support to these staff where needed.

- Just prior to the inspection the results of the 2017/18 national NHS staff survey were published. The trust had an overall engagement score of 6.9 similar to their results the previous year and to other trusts. The trust had responded to the results promptly and

prepared a high-level report for the quality and performance committee. They had identified two areas of greatest concern. The first related to staff morale where they had identified services with lower morale and the potential reasons for this. Proposed actions to address this included additional engagement events with a focus on team identity. They also suggested for the services with the most significant challenges a programme of facilitation and coaching provided by external facilitators to support them to address their specific issues. The second area for improvement related to reduced levels of satisfaction with immediate line managers. The action for this was the promotion of the leadership development programme for front-line ward and team managers. This was work being directly championed by the chair and chief executive.

- Senior leaders in the trust were committed to making improvements in the Workforce Race Equality Standard (WRES) which became compulsory for all NHS trusts in April 2015. They recognised they had more to do and had an action plan to improve WRES scores. This aimed to address concerns around opportunities for career progression by including a BAME member on recruitment interviews for positions of 8a and above. They were also working to address bullying and harassment through discussions in open forums and working with the Freedom to Speak Up Guardians. Work was also ongoing to reduce the numbers of BAME staff involved in disciplinary processes for example through an increased use of mediation. The chair and CEO received 'reverse mentoring' from BAME network representatives so they had the opportunity to reflect on the impact of their actions and decisions on racial equality within the trust.

- 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. This was overseen by an equality, diversity and inclusion steering group attended by all the networks. They had four overarching equality, diversity and inclusion objectives. These included having committed high quality leadership; having inclusive teams; addressing under-representation of ethnic minority and disabled staff in senior roles and providing accessible information and communication about diversity and inclusion.

- The staff networks were developing well. The trust had relaunched all the staff networks with visible support from the board. This included BAME, LGBT+ (lesbian, gay, bisexual, transgender); carers at work; people with a disability and people with lived experience of mental health issues. Network chairs had time and support to promote the work of the networks. The LGBT+ network had supported the trust to become the highest scoring healthcare provider on the Stonewall index at joint 28th position in the employer awards 2019.

- The trust actively promoted a culture of supporting people to speak up including presentations at all the corporate staff inductions. Staff largely felt able to speak up about issues or concerns without a fear of retribution. This was done mainly through line management, although the chief executive made staff aware that they could bring concerns directly to her if needed or speak to other leaders across the trust. This was supported by staff having access to a Freedom to Speak Up Guardian (FSUG) and other processes for speaking up. A non-executive director was the trust's lead 'speak up guardian'. In addition, six staff governors were also 'speak up guardians'. They had received some training and guidance and were supported in this role by the trust secretary. They did not have dedicated hours available for this role. The role of the FSUG had been publicised throughout the trust using the intranet and posters. The trust secretary had also been to a few staff teams to talk about the FSUG and the importance of speaking up. In 2017/18 only 9 cases were addressed by the FSUG. Reports were produced for the board. The inspection found that staff had a mixed knowledge of the FSUG. Since the last inspection

there had been cases of student nurses and junior doctors raising concerns about safety and standards of care, but these were not always being raised or addressed in a timely manner. The trust recognised the challenges for students raising issues and were trying to work with the educational organisations and the students themselves to support them to share concerns.

- The arrangements for the trust to have a Guardian of Safe Working Hours, were working well. This role was carried out by a consultant psychiatrist. They supported the junior doctors' forum and encouraged junior doctors to complete exception reports and had an overview of all reports. The last quarterly report went to the board in September 2018. There were a low number of exception reports: February – April 2018 – 8 reports and 1 fine and May to July 2018 – 3 reports and 1 fine.

- The report to board was very thorough looking at the wider arrangements for junior doctor on call arrangements. They recognised that around 15% of shifts needed to be covered by bank or agency staff. There was also an issue that doctors working excessive overtime might not always be identified.

- When we spoke with doctors in training we got a mixed response, some were having an entirely positive experience with the trust, others had a number of concerns. It seemed to be site specific. Doctors at Park Royal and St Charles said they were listened to, but nothing seemed to change as a result. There was a general complaint about payroll performance.

- The senior leadership team recognised that the staff recruitment and retention challenges were their greatest risk in delivering high quality care. This was included on the board assurance framework. A report was presented at each board meeting updating the trust position against key workforce indicators and actions being taken to promote improvement where needed.

- The trust was maintaining its focus on recruitment and retention of staff. Staff vacancies in the 10 months between April 2018 and January 2019 had been between 10.6% and 14%. They were 13.9% in January 2019. For the same period turnover had been between 16.2% and 17%. It stood at 16.2% in January 2019. Sickness had remained around 3.2% for the year. The trust had a good knowledge of areas which were outliers and needed more support. Agency spend had reduced to an average of £1.2m a month in the current financial year, a significant improvement on previous year when it averaged £2.5m a month. Spending on bank staff averaged £2.1m a month for the current financial year. The lead in time for staff rosters was on average 6 weeks in advance.

- The trust was working creatively to improve staff recruitment and retention. The trust board monitored any 'hot spots' and action being taken. 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 being held for existing staff and a new internal transfer system had been established to make it easier for staff to move between different roles in the trust. There was now a clear internal pathway for staff seeking a new challenge, with bureaucracy kept to a minimum. The trust had seconded a staff member from each division to work with HR to improve recruitment and retention.

- The trust was working to support the development of new roles. This included associate nurses; nursing apprenticeships and a range of other apprenticeship schemes. They were

considering how the principles of the Capital Nurse programme could be used for other hard-to-recruit professions.

- The trust was making good progress with the completion of mandatory training. Average compliance throughout the year had been 93%, just below the trust target. All the courses had a completion rate over 85%. The trust workforce paper was updated to show compliance for each course and the divisions were addressing non-compliance where needed.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✗	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	**Number of eligible staff**	**Number of staff trained**	**YTD Compliance (%)**	**Trust Target Met**	**Compliance change when compared to previous year**
Basic Life Support	2	2	100%	✓	→
Health and Safety (Slips, Trips and Falls)	4477	4379	98%	✓	↑
Manual Handling - Object	3496	3404	97%	✓	↓
Prevent Awareness - Level 1	512	493	96%	✓	↑
Safeguarding Children (Level 1)	521	500	96%	✓	↑
Equality and Diversity	4478	4290	96%	✓	↑
Infection Prevention (Level 1)	507	485	96%	✓	↑
Safeguarding Adults (Level 1)	540	515	95%	✓	↓
Safeguarding Children (Level 3)	3948	3751	95%	✓	↑
Information Governance	4478	4239	95%	✓	↑
Safeguarding Adults (Level 2)	3937	3701	94%	✗	↓
Personal Safety - MVA	74	69	93%	✗	↑
Non-Inpatient Fire Safety	3512	3257	93%	✗	↑
Infection Prevention (Level 2)	3963	3659	92%	✗	↑
Adult Basic Life Support	498	458	92%	✗	↑
Conflict Resolution	1785	1626	91%	✗	↑
Emergency Life Support	3551	3230	91%	✗	↑
Personal Safety Breakaway - Level 1	1732	1557	90%	✗	↑
Manual Handling - People	972	853	88%	✗	↑
Prevent WRAP	3954	3434	87%	✗	↑

Physical Intervention	762	661	87%	✖	↓
Immediate Life Support	410	355	87%	✖	↑
Inpatient Fire Safety	996	845	85%	✖	↑
Breakaway	2	1	50%	✖	→
Total	**49107**	**45764**	**93%**		↑

- 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. The overall satisfaction with the quality of appraisals in the latest staff survey was slightly below average at 5.5 compared to 5.7. All this data was available by team so that targeted work could take place to improve the number and quality of appraisals.

- 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 were introducing an online system as a pilot to monitor completion.

- The trust recognised the importance of promoting staff wellbeing and had won an excellence award from the London Healthy Workplace Charter backed by the Mayor of London. 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 ukelele. The trust had also focused on the mental wellbeing of staff with their staying well at work service (SW@W). This supported staff with severe and enduring mental health issues; those on long-term 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's policy on openness and transparency fully complied with national guidance on the duty of candour. It outlined the trust's expectations, starting with an initial verbal apology and action, followed by written notification and an investigation. It concluded with a sharing of the investigation and the action being taken. Staff recorded the duty of candour on the trust's incident reporting system. Each division was responsible for monitoring to check all parts of the process were completed within the appropriate timeframe.

- We have always found the trust to be open, honest and prompt in their dealings with CQC. The quality of their internal investigation reports when things go wrong is high. After the inspection of three core services in January and February 2019 we gave high level feedback on both the positives and negatives to the trust. They acted immediately to develop an action plan to address the issues raised. We returned unannounced to Park Royal on 19 March 2019 to check progress and found significant changes had been made to address all our concerns. We also returned unannounced to the Gordon Hospital on 25 March 2019 and found improvements, with new leaders in post or just about to start.

- With the launch of its new electronic patient record system during the inspection, the trust was now in a stronger position to record and report on the requirement for and use of accessible information with patients with an assessed need for this. We saw that some patients' records were already flagged. Staff had access to accessible information to share with patients. For example, information about specific sections of the Mental Health Act. We did not see extensive use of this in the services we visited, such as wards for older people with mental health problems, so the trust could do more to promote its use. The trust website carried links on every page to a growing library of accessible information and the trust intranet site had been configured to allow staff with specific needs, such as dyslexia or poor vision, to easily configure the screen to match their preference.

Governance

- The trust had structures, systems and processes in place to provide assurance and deliver the trust's key programmes.

- The board operated effectively. The board met six times a year and was well attended. The meeting was well chaired and board members provided constructive challenge although a couple of newer non-executive directors were notably quieter. The chair helpfully summarised key points and any actions at the end of each agenda topic. The agenda was structured similarly for each meeting with standing agenda items such as the performance report and finance report. There was a rolling programme to ensure that where reports needed to come to the board that this would take place when needed. The board papers were clear and at the front had the name of the lead director and a summary, purpose and recommendation. The papers did not indicate which board sub-committee they aligned with or how they linked back to the trust strategic priorities and, where relevant, the board assurance framework. These details could be usefully added to show how the specific topic aligned with the trust wide governance processes. Immediately after the well-led review that trust produced a revised board paper front sheet to use going forward.

- There were some items discussed in part two of the board meeting which for most trusts would appear 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 2 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.

- There were four core sub-committees of the board – quality and performance; audit; business and finance; informatics. There were also three specialist committees – investment; nominations and remuneration. Non-executive directors were clear about their responsibilities in terms of chairing and attending the sub-committees. They worked hard to ensure there was an appropriate level of communication between the sub-committees. The committees produced a summary for the board and the non-executive chairs understood the issues that needed to be escalated.

- 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 included arrangements for monitoring incidents, serious incidents, safeguarding children and vulnerable adults, infection prevention and control, the management of medicines, the management of risk and health and safety. The accountability framework oversaw the clinical effectiveness of services. The framework included arrangements for monitoring performance indicators, progress with

meeting CQUIN targets, compliance with mandatory training and appraisal, clinical and national audit findings and complying with NICE guidelines.

- There were three divisions in the trust each with a divisional director and medical and nursing director. The three divisions each had responsibility for a number of boroughs and other specialist services. This helped to facilitate joint working with clinical commissioning groups and local authorities. Since the previous inspection divisions had become more self-reliant and self-governing entities whilst retaining trust wide oversight, accountability and control. At a directorate level assurance took place through a quarterly executive review meeting led by members of the senior executive team. These meetings considered all aspects of the directorate's operational performance and discussed plans for the directorate going forward. A representative from each division also attended the quality and performance committee which was a sub-committee of the board.

- If a service was not performing there were three levels of actions which could take place. These comprised management action that was monitored by the divisional board; an accelerated improvement programme monitored by the executive board and quality and performance committee; special measures monitored by the board. The second two actions were used infrequently.

- The trust had measures to share information and learning across the divisions. The measures included information on the intranet in a range of accessible formats such as 'clinical message of the week'; regular meetings of divisional leads; a nurse forum and other clinical networks; peer reviews of services across divisions and some networks of services. It was recognised that sharing information across a wide geographical area and a range of services was challenging.

- The trust board was mindful of the need to achieve a focus on both mental health and community healthcare services and, within them, both the large and the small services. For example, the quality and performance committee was now giving community services more focus, including specialist services like sexual health.

- The trust had improved its physical healthcare offer to people in receipt of mental health services. In some settings, such as St Charles, we found the trust was exceeding NICE guidance. The implementation of the new electronic patient record system, with a physical healthcare tab, was about to make it easier for the trust to monitor and report on this area. In some of the boroughs covered by the trust, GPs were on the same system, which would make communication about physical health much easier, particularly in regard to the reconciliation of medicines and test results. In terms of performance, divisions already monitored compliance with a variety of metrics to improve effectiveness. For example, cardio-metabolic screening and interventions in mental health services, the offering and uptake of HIV tests in sexual health, successful completions of the opiate and alcohol pathways in addictions, the uptake of blood borne vaccinations (BBV) in offender care services.

- In the last 12 months the trust had revised the deteriorating patient policy to include sepsis. The trust now used the NEWS2 system to identify deterioration in patients' physical health and an adapted version in the community. In the core services inspected, NEWS needed further work, notably escalation processes. The incorporation of NEWS2 into the new electronic patient record system should make its correct use easier to monitor.

- Medicines optimisation within the trust was good, and effectively integrated into the trust governance. The medicines optimisation group met quarterly and led on the analysis and dissemination of learning. Medicines management standards were monitored by divisional

medicines optimisation groups. The medicines competency framework was mandatory for all registered nurses (every 3 years) supported the delivery of safe and effective practice.

- The chief pharmacist post was occupied on an interim basis with the plan to fill the substantive post by August 2019. The pharmacy team provided leadership for medicine optimisation, and a medicines safety officer (MSO) post had been established.

- Forthcoming improvements to the IT infrastructure within the trust provided opportunities for improvements to medicines optimisation. Electronic prescribing and medicines administration (EPMA) was only available within offender care and addiction services. Planned changes to the trust's digital infrastructure made it more feasible to implement more widely. A business case had been developed to extend EPMA to inpatient settings and the trust intended to submit a bid by November 2019 for funding in 2020/2.

- The trust had clear structures and procedures for keeping scrutiny of the Mental Health Act (MHA) and Mental Capacity Act (MCA) at the forefront of practice. Policies were subject to review, and there was board level buy in to the sub-groups that monitored the day-to-day functioning of MHA activity. Despite the size of the trust, the mental health law team had a presence on each inpatient site and also spent time in community settings. The director of nursing was the executive lead for mental health law and oversaw the work of the mental health law team. The trust head of mental health law was responsible for the strategic role out of any new or revised policy and the dissemination of information about new legislation.

- The mental health law office team, which comprised the mental health law officers on each site and the centrally based mental health law managers, met every month to review concerns and also to try and collate evidence of good practice. The mental health law office was overseen by the associate director of quality, safeguarding, safety and security who reported to the director of nursing. There were six designated localities which covered all of the sites of the trust and each locality had its own mental health law locality manager and mental health law officers. Mental health law team meetings informed the mental health law group, which reported to the trust board. The structure of the administration of deprivation of liberty safeguards (DoLS) under the MCA was different. This function was manged by the safeguarding and MCA leads, who reported to the head of social care.

- A yearly mental health law performance report and quarterly mental health law compliance reports were presented to the board by the mental health law group. These included analyses of trends over the past year, but also recorded incidents of unlawful detentions, unlawful treatment, and problems with MHA assessments. The rate of these incidents was compared to the national average and the evidence consistently showed that the trust was below the national average for incidents that breached the Act or the Code of Practice. The majority of breaches were first identified by the local mental health law office. All were discussed in team meetings and by the mental health law group and, where necessary, meetings were arranged with the relevant staff. Lessons learned were written up and disseminated across the trust.

- The mental health law office conducted a number of audits each year, particularly focussed on matters brought to its attention by CQC MHA review reports. Data was collected from the electronic records system by way of a business intelligence application.

- Through inspection and MHA reviews CQC had noted a possible over reliance on the use of section 62 while waiting for a second opinion appointed doctor (SOAD) to attend. The trust had developed a tracker for SOAD requests and at present there were 30 cases outstanding. Requests had been lodged with CQC for 28 of these cases. CTO patients had to wait the longest time, with one patient waiting 147 days for a SOAD to be identified.

Management of risk issues and performance

- The trust had systems in place to report risks and ensure these were being addressed. The trust had risk registers at team level that fed into divisional registers. These were brought together in the corporate risk register. Staff told us that the risk registers were an effective way of escalating concerns and that managers were responsive when issues were raised. The corporate risk register was reviewed in part two of the board meeting and changes in levels of risk were discussed and agreed. All members of the board could articulate the areas of high level risk. Future potential risks and how these might be mitigated were considered at board away days.

- The top corporate risks were on the board assurance framework (BAF). The BAF clearly identified the corporate risks, the risk level and the actions being taken to mitigate the risk. It did not show how long the risk had been on the BAF or which sub-committee of the board had responsibility for the oversight of the risk and mitigations. The BAF was reviewed at each audit committee meeting.

- The trust had a procedure for managing serious incidents. This included how to report the incident, escalation procedures and how the incident should be investigated.

- We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

- Between 19 October 2017 and 19 October 2018, the trust reported 126 serious incidents. The most common type of incident was apparent/actual/suspected self-inflicted harm with 66. Thirty-three of these incidents occurred in community-based mental health services for adults of working age.

- We reviewed the serious incidents reported by the trust to STEIS over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 131 reported. Three incidents were added to STEIS but later de-escalated, two incidents were duplicates and one related to a prison incident.

Core Service	Apparent/actual/suspected self-inflicted harm	Sub-optimal care of the deteriorating patient	Pressure ulcer	Slips/trips/falls	Disruptive/ aggressive/ violent behaviour	Apparent/actual/suspected homicide	Abuse/alleged abuse of adult patient by third party	Surgical/invasive procedure incident	Medication incident	Abuse/alleged abuse of child patient by third party	Failure to obtain appropriate bed for child who needed it	Accident e.g. collision/scald (not slip/trip/fall)	Other	Pending review (a category must be selected before incident is closed)	Abuse/alleged abuse of child patient by staff	Confidential information leak/information governance breach	Total
MH - Community-based mental health services for adults of working age	33	8	1	0	2	1	0	0	1	0	0	1	0	0	0	0	**47**
CHS - Adults Community	3	1	11	0	0	0	0	0	1	0	0	0	0	0	0	1	**17**
Other - PMS service	11	2	0	0	0	1	0	0	0	0	0	0	0	1	0	0	**15**
MH - Acute wards for adults of working age and psychiatric intensive care units	6	3	0	1	1	1	2	0	0	0	0	0	0	0	0	0	**14**
MH - Other Specialist Services	6	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	**9**
CHS - Community Inpatients	1	3	1	2	0	0	0	0	0	0	0	0	0	0	1	0	**8**
MH - Community-based mental health services for older people	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**5**
CHS - Sexual Health	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	**3**
MH - Long stay/rehabilitation mental health wards for working age adults	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**3**
MH - Specialist community mental health services for	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	**2**

Core Service	Apparent/actual/suspected self-inflicted harm	Sub-optimal care of the deteriorating patient	Pressure ulcer	Slips/trips/falls	Disruptive/ aggressive/ violent behaviour	Apparent/actual/suspected homicide	Abuse/alleged abuse of adult patient by third party	Surgical/invasive procedure incident	Medication incident	Abuse/alleged abuse of child patient by third party	Failure to obtain appropriate bed for child who needed it	Accident e.g. collision/scald (not slip/trip/fall)	Other	Pending review (a category must be selected before incident is closed)	Abuse/alleged abuse of child patient by staff	Confidential information leak/information governance breach	Total
children and young people																	
MH - Wards for older people with mental health problems	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
CHS - Community Dental	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	**1**
MH - substance misuse	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Total	**66**	**18**	**14**	**5**	**4**	**4**	**3**	**3**	**2**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**126**

- Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. The average time taken for the trust to report incidents to NRLS was 44 days. Based on the number of reported incidents there was no evidence of under reporting.

- The highest reporting categories of incidents reported to the NRLS for this trust for the period 19 October 2017 to 18 October 2018 were ‘disruptive, aggressive behaviour (includes patient-to-patient)’, ‘access, admission, transfer, discharge (including missing patient)’ and ‘patient accident’. These three categories accounted for none of the 78 deaths reported. Self-harming behaviour accounted for 39 of them, the remaining 39 were categorised as ‘other’.

- Ninety-seven percent of the total incidents reported were classed as no harm (86%) or low harm (11%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Disruptive, aggressive behaviour (includes patient-to-patient)	2800	223	28			3051
Access, admission, transfer, discharge (including missing patient)	2124	38	5			2167
Patient accident	970	254	30	2		1256

Self-harming behaviour	854	235	26	5	39	1159
Medication	1081	19	2			1102
Implementation of care and ongoing monitoring / review	448	394	222			1064
Infrastructure (including staffing, facilities, environment)	836	18	2			856
Other	528	136	15	1	39	719
Documentation (including electronic & paper records, identification and drug charts)	511	7	2			520
Clinical assessment (including diagnosis, scans, tests, assessments)	418	9	1			428
Patient abuse (by staff / third party)	283	38	22	1		344
Medical device / equipment	232	4				236
Consent, communication, confidentiality	133	1	1			135
Treatment, procedure	70	15	4			89
Infection Control Incident	26	8				34
Total	**11314**	**1399**	**360**	**9**	**78**	**13160**

- Organisations that report more incidents usually have a better and more effective safety culture than those that report fewer incidents. A trust performing well will report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death). This trust reported more incidents from 19 October 2017 to 18 October 2018 compared with the previous 12 months. In the most recent year there were more incidents in the 'No harm', 'Moderate' and 'Death' categories.

Level of harm	**19 October 2016 – 18 October 2017**	**19 October 2017 – 18 October 2018**
No harm	9538	11314
Low	1400	1399
Moderate	295	360
Severe	23	9
Death	62	78
Total incidents	**11318**	**13160**

- After our site visit to the Gordon Hospital a serious incident took place involving an attack on a staff member by a patient who had recently returned from unescorted leave. The trust

voluntarily closed the Gordon Hospital to new admissions and was reviewing its procedures whilst an investigation took place.

- The trust had had been subject to three external reviews in the last 12 months (1 November 2017 to 1 November 2018). These covered individual patient care and/or broader issues in health visiting; district nursing and tissue viability; learning disabilities community healthcare teams. The trust informed us that, together with the relevant clinical commissioning groups (CCGs), they were reviewing the findings and recommendations. Subsequent action plans will be managed through governance structures in NHS England, CCGs and the sub-committees of the trust board. Final reports will be published.

- The chief coroner's office publishes the local coroners' reports to prevent future deaths. These contain a summary of recommendations, which have been made by local coroners with the intention of learning lessons from individuals' deaths. In the last two years, three prevention of future death reports were sent to the trust relating to people cared for in prison. During the inspection period itself, the trust was copied into three coroners' letters sent to commissioners of their services about various commissioning failings in relation to the trust's services.

- The trust had arrangements in place to monitor and address safety priorities. The executive director of nursing and quality, in partnership with the medical director and chief operating officer met weekly to review all new serious incidents, ensure that any immediate learning was being acted on and identify areas of focus for the serious incident investigation which followed.

- The quality and performance committee received a monthly report on key safety issues within the trust, which included an overview of serious incidents and other incidents, such as the use of restraint across the organisation. A quarterly incident, serious incident and learning from deaths report went to the board. At a divisional level the accountability framework included arrangements for monitoring incidents, serious incidents, safeguarding children and adults, infection prevention and control, the management of medicines, the management of risk and health and safety.

- Examples of improvements included 'safety huddles' (a quality improvement initiative) which were in place across a range of services, a model which had been shared at the south of England patient safety collaborative and adopted by other trusts across this region. Safety huddles provided a framework for teams to come together to discuss specific incidents and learning and to decide if escalation or other action was required. There was an automated system where reporters of incidents could receive feedback on incidents they reported. This complemented face to face discussion and reflection. Clinical message of the week shared important safety and quality information trust wide. Since its launch in May 2017 the trust had shared over 75 clinical messages. Topics covered included resuscitation, the deteriorating patient, effective communication, medicines management including safe prescribing and administration, suicide awareness and risk factors. The trust also used internal clinical risk alerts. Following the declaration of a 'never event' in sexual health services where the incorrect inter-uterine device (IUD) was inserted into a patient; improvements were made to improve safety of IUD insertion through the implementation of World Health Organisation (WHO) style checklist.

- Whilst the trust had systems to share learning from incidents across the divisions this did not always work effectively. An example of where shared learning could improve was following the deaths of several patients attending the early intervention service (EIS) in Brent. The trust conducted a thematic review and identified matters requiring attention within the service. As a result, the service was operating in line with NICE guidance and

patients were receiving an improved service. However, the lessons learned had not been embedded in some other EIS, notably Milton Keynes.

- We looked at six randomly selected serious incident investigation reports and found these were completed to a high standard. They contained sufficient detail to understand the judgements and recommendations in the report. The rationale for deciding if the incident was predictable or preventable was clearly laid out. The recommendations made in the reports were specific and detailed, and focused on practical steps which could be taken to improve safety and care. We also saw that when a patient had died, the trust immediately communicated with the patient's family members or partner. If they wished to, family members or a partner were supported to be involved in the serious incident investigation. This included contributing to the terms of reference for the investigation.

- The trust had a suicide prevention group. The trust was finalising its suicide prevention strategy, which will be presented at the mortality review group. This drew upon a range of key policy guidance, current research and NICE guidelines.

- The trust was working on reducing the risk and harm from violence and aggression and reducing restrictive practices. The trust's restrictive interventions group oversaw the work to improve patient experience and reduce the use of restrictive practices. The use of restraint was closely monitored and the use of prone restraint showed signs of improvement. The trust had approved a violence reduction strategy, developed in collaboration with service users and carers. A range of evidenced-based practice had been identified. This included a pilot project of simulation-based de-escalation training with plans to roll this out if successful. Restraint and de-escalation training was co-produced and co-delivered with two full-time peer support workers working as trainers. These improvements were seen during the inspection, especially on one acute mental health ward where they had taken part in a pilot study.

- The trust was working to further reduce falls although there was more to do. A trust falls prevention group had produced and launched a revised falls prevention policy in 2018, setting out new processes for use across the organisation. A falls board reviews trust wide data and makes recommendations to improve practice. They also use external best practice information, particularly results from the new national audit of inpatient falls, to benchmark and improve practices. The inspection found that staff within the wards for older people with mental health problems were not consistently aware of the trust's policy of carrying out a falls assessment to screen all older people admitted to the service.

- The trust monitored numbers of pressure ulcers and carried out incident investigations. A recent change in how numbers of pressure ulcers were calculated, with the inclusion of moisture lesions, meant there was an increase in the numbers reported to the board just prior to the inspection. Pressure ulcers were largely identified by district nurses in the community. The trust's tissue viability team had completed a quality improvement project to reduce pressure ulcers and improve patient outcomes for older people on an inpatient ward. A leaflet had been produced to provide guidance to other teams. Staff implemented the 'stop the pressure' campaign and in last year's quality account the trust reported significant reductions in avoidable pressure ulcers in local care homes and inpatient units.

- The trust had set up a group looking at how they could improve the sexual safety on mental health inpatient wards. They had set up a task and finish oversight group and reported to the quality and performance committee. They had made several recommendations that were being put into action. This included revising how sexual safety incidents were reported including the grading of harm; developing a training package; producing 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 recognised the importance of having a strong programme of quality assurance. The trust had a comprehensive programme of audits. In 2017-18 the trust took part in 14 national clinical audits and three confidential enquiries (100% participation). The trust also undertook a wide range of local audits. We saw examples of how this promoted learning and improvements.

- Systems were in place to ensure guidance used by the trust reflected NICE clinical guidance. All NICE quality standards and guidelines were graded for relevance to trust services. Compliance with NICE guidance was embedded at a divisional level and reported through quarterly divisional governance reports. Clinical policy development incorporated NICE guidance. The annual clinical audit list included audits that checked compliance with NICE guidance either as a trust-wide priority or in specific services. Clinicians said they felt well informed by the trust on latest guidance through internal communications. Developments have been made to provide timely access to psychological therapies across mental health services. For example, in the recovery and rehabilitation services in Milton Keynes new psychology appointments had been made with a view to developing the psychology provision. This included offerings of cognitive behaviour therapy (CBT), family interventions and one-to-one sessions.

- Appropriate staff recruitment checks were in place. The trust had implemented a system to ensure staff did not start working until all the necessary checks had been completed. We looked at recruitment files for ten randomly selected members of staff and the systems were thorough and working effectively.

- Systems were in place to ensure medical revalidation was taking place. For 2017/18 revalidations were completed as planned unless the doctor was on prolonged leave or a new starter. The trust had just completed a peer review visit which had highlighted some useful areas for improvement. This included the need to ensure appraisals also incorporated a review of clinical work doctors were undertaking outside the trust. For nurse revalidation the trust maintained revalidation and re-registration dates on the electronic staff records system. This was automatically updated through the Nursing and Midwifery Council website to ensure all nurse registration was current. Automatic reminders were sent to staff in advance of their revalidation date.

- The trust had appropriate measures for safeguarding in place. There was a trust-wide quarterly safeguarding meeting which reported through an annual report to the board. Quarterly safeguarding meetings also took place at a divisional level. The executive director of nursing and quality was the executive lead for safeguarding, while the associate director of quality, safeguarding and safety was the lead officer for safeguarding. There were safeguarding adult leads in each division and 6.5 whole time named professionals for safeguarding children across the trust. Safeguarding leads contributed to the work of safeguarding boards in each of the boroughs and supported staff training within the trust.

- Processes were in place to maintain standards of infection prevention and control (IPC). The trust had an infection prevention service. A comprehensive annual infection control report went to the board. This included updates on IPC surveillance, audits, root cause analysis undertaken and outbreak management. It also included lessons learnt on IPC practices across the trust. The trust took infection prevention and control (IPC) seriously, the most recent report in January 2019 was generally positive. Two cases of Clostridium Difficile had been identified, but a root cause analysis had concluded this was not due to any lapse of care within the trust. Cleaning scores were exceeding the target set. The IPC

nursing team for Diggory division recently won an award for excellence in innovation for delivering the IPC agenda. The trust had identified that the levels of sharps injuries was not decreasing and there was a need to improve sharps management across the trust. Options were being reviewed by the IPC team, occupational health and procurement with advice from the medical devices safety officer, with a view to commencing a quality improvement project.

- 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 trust had an estates strategy in place which was complex as there were several sites where significant capital developments were needed. For example, the trust had three wards on the St Pancras site which was being redeveloped and these wards had to be relocated. They had plans in place to eliminate dormitories in all their sites except for Milton Keynes where further work was needed on the future configuration of services. Governance arrangements were in place for the wholly owned subsidiary with any investment above £500,000 needing approval from the trust. The subsidiary board was chaired by a non-executive director.

- The trust had systems in place to maintain fire safety although the inspection identified areas where these needed to be strengthened. They conducted annual fire safety risk assessments and servicing of fire safety equipment. There were areas of work that were the responsibility of the wards or teams, such as arranging evacuation drills. The inspection found one site where fire drills had not been done and where fire extinguishers had been moved to an office to avoid them being used as a weapon but no signs were available to ensure staff knew where they were. The trust was very responsive and addressed the concerns immediately. They had also approved the funding for a fire officer to carry out ongoing checks.

- The trust was prepared for emergencies and had business continuity plans in place to address foreseeable unexpected situations such as loss of utilities. An external review for NHSE in 2018 showed a compliance rating of ‘substantial’ for their emergency planning resilience and response. An internal review identified some areas for further development including the need to increase training to test for a major incident. The trust also had plans to increase e-learning; do more workplace risk assessments; provide more business continuity workshops.

- The trust had strong financial leadership. At the time of inspection the trust was in segment 1 of NHS Improvement’s (NHSI) single oversight framework. This meant it had maximum autonomy, no potential support needs identified and received the lowest level of oversight from NHSI. The trust was forecasting it would meet its control total for 2018/19, assuming the remaining £1.5m pay award pressure was funded centrally. It had been another challenging year financially, including a include one-off impairment for new clinical systems, estimated at £5m. The trust had done well in reducing its agency spend. It was averaging £1.2m a month, below its target of £1.4m; a significant improvement on its average of £2.5m a month in the previous year. Turnover was set to increase in 2019/20 with the successful bid for Ealing community healthcare services. The trust had been asked to make significant cost improvements and this process always included an impact assessment so that clinicians could ensure patient care was not adversely affected.

- The trust had introduced a finance savings group. This was a monthly forum where divisions and corporate services were held to account for the delivery of their budgets and savings plans. Particular areas of concern could be escalated to find solutions.

Information Management

- 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 identify which patients were due for their care programme approach meeting or were scheduled for follow up within seven days of being discharged.

- A comprehensive quality and performance report was completed monthly providing assurance against the trust's key performance indicators. The trust was making use of run charts to display trends over time and providing a concise explanation of what the data showed, any outliers and actions being taken. This was reviewed at the quality and performance committee and the board.

- Non-executive directors were generally very positive about data quality, although they recognised this always had to be kept under review. The trust had comprehensive systems to monitor data quality and this was largely carried out at a divisional level with the involvement of clinical staff where appropriate. The trust also made use of benchmarking data and this sometimes helped to identify data quality issues.

- The trust switched most of its services to a new electronic patient record system during the inspection. This was a major undertaking involving approximately seventy million data transfers. At the Goodall divisional board meeting it was reported that the electronic patient records system transition had gone well across the trust in terms of the technology with no data losses and staff were finding it more user-friendly than the previous system. The main issues now were getting staff familiar with the system, which took time, and ensuring consistency in recording and storage of information.

- The trust was in the process of switching IT suppliers and, as part of that, it was moving to a cloud-based system of storage.

- Staff authorised to access clinical records were trained in the functional use of the corresponding clinical system. This had been a big undertaking prior to the introduction of the new system. In the lead up to the transfer the trust had cleansed its records and was confident they were in much better shape. Staff completed annual data security and information governance training to ensure they understood their confidentiality responsibilities. Clinical systems were subject to the highest security standards, including smartcard access control. Following a focus group with doctors in training at one of the trust's sites, Health Education England was alerted to an issue with doctors' access to patient records which had not been picked up by the trust. Junior doctors were using their predecessors' login details to access patient records. This issue had since been resolved.

- An IT programme board reported to the informatics sub-committee of the board. In December 2018 they reported to NHS England that they had completed work relating to cyber security, including the isolation or removal of unsupported systems; and that they had tested the business continuity plans which were in place.

- With the rollout of the new electronic patient record system having been achieved, the priority was to strengthen the governance arrangements for digital development within the trust, alongside a revised strategy to reflect the next phase of digital work.

- Clinicians were directly involved in any digital developments. The trust had a clinical systems expert reference group to prioritise, scope and prescribe clinical processes, and to ensure clinician best practice requirements are embedded in any new system design. The new electronic patient record system's mobile working capabilities will allow for more timely access to clinical data 'on the move'. A number of pilots were taking place using digital technology. For example, in Hillingdon, staff were trialling an app which suggested healthier alternatives when a food item's bar code was scanned.

Engagement

- The trust was working in partnership with patients and carers. There was an active patient involvement forum and carers' council. Patients with lived experience were increasingly working as paid employees or volunteers in different roles throughout the trust and 25% of all QI projects involved a patient or carer. A patient and carer involvement strategy had been developed. It recognised the good work that already existed, but wanted to see involvement increase and be more consistent. Our findings confirmed that there was plenty of good practice in patient and carer involvement and engagement and all teams were demonstrating it to some extent. However, the emphasis varied significantly from team to team within the same service. The expectations could have been better defined for each type of service.

- Good practice examples included participation in a monthly community steering group looking at future models for community mental health services; there were over 40 applicants. A weekly 'speak up' group took place, supported by an independent advocate, across the inpatient learning disability services to give patients an opportunity to discuss any concerns. On a monthly basis, a representative from the 'speak up' group fed the concerns raised into the learning disability service's care quality management meeting concerns. The dementia care pathway utilised established service user expert reference groups across the trust in older adult services to support further pathway development and provide people with the opportunity to feedback on their care. The trust board meetings routinely heard from a patient or carer about their experience and board members met people who used services during visits and in other areas of work.

- Patients and carers had other opportunities to provide feedback to the trust, including speaking informally to staff, completing the friends and family test and contacting the patient feedback and complaints service. Interpreters and accessible formats could be supplied to enable patients and carers to give feedback. However, we found that there was significant variation in the way patients' community meetings on the acute mental health wards were structured and recorded. Issues raised were not always followed up by appropriate people and, if they were, this was not clearly recorded or communicated. On some wards, due to the location of the meetings, it could be difficult for patients to hear, especially if they had sensory issues.

- In line with other organisations the friends and family response rates were low at 3.1% in quarter three. The trust actively encouraged people to give feedback either online or by using a printed copy of the form. Forms were available in different languages and accessible formats. In mental health 88% of patients would recommend the service compared to a national average of 89%. In community services 95% of patients would recommend the service compared to a national average of 96%.

- Complaints were managed well by the trust. The chief executive had overall responsibility for complaints and had delegated responsibility for signing off complaints to the trust's three

divisional directors. Each divisional director was responsible for ensuring their services responded to and investigated complaints in line with trust policy. The trust had a patient feedback and complaints service (FP&C), formerly known as the patient support service. The PF&C was a single point of access for people wishing to give feedback or to make a complaint. The trust's complaints manager was responsible for managing the PF&C, overseeing the training of staff in the use of the trust's complaints policy, providing support to investigators and staff named in complaints and supporting managers undertaking the investigation of high risk, complex or sensitive complaints.

- The biggest volume of complaints related to care delivery / clinical treatment. Complaints were tracked weekly, both centrally and at a divisional / borough level, to ensure timely response. Complaint themes were reviewed on a quarterly basis to better understand any emerging concerns across the services. Monitoring of patient feedback, complaints, compliments and concerns (informal complaints) occurred monthly via divisional quality dashboards and quarterly trends were highlighted and shared with divisional boards and the quality and performance committee.

- The trust was asked to comment on their targets for responding to complaints and their performance against these targets over the last 12 months. They were meeting their target of completing complaints investigations within 25 days or the date agreed with the complainant in 97% of cases. We reviewed ten recent complaints records and found them to be in line with the trust's policy. Not all the concluding letters to complainants followed the trust's template, but they did contain information about the next stage of the complaints process if the complainant was not happy with the outcome.

- Between 1 November 2017 – 31 October 2018, the trust had resolved 1,145 complaints without a formal process. This had been achieved through meetings and/or mediation. Only one complaint had been referred to the ombudsman during this period. In the same period, the trust recorded 2,900 compliments. Community health services for adults had the highest number of compliments with 28%, followed by sexual health services with 25% and community-based mental health services for adults of working age with 10%.

- People who used services and had lived experience were involved in the work of the trust. Examples of this were the wellbeing and 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 CNWL wellbeing and recovery college offered courses and workshops for mental health patients and carers, co-designed and co-delivered by peer recovery trainers (people with lived experience of mental health issues) and mental health practitioners. Topics included understanding self-harm, a good night's sleep and exploring what works for me. Carers events were held locally to support carers' needs across many sites. A recent meditation event was hosted for carers in the learning disability service which was well attended and well received.

- The trust had many examples of how they worked to meet the protected characteristics of people who use their services. For example, there was a chaplaincy and faith service and

when patients expressed an interest they offered multi-faith visitors who could attend the ward; access to religious texts; visits to local places of worship; access to multi-faith rooms; appropriate meals to meet peoples religious or cultural needs and mealtimes to accommodate peoples' needs, for example on religious days/periods such as Ramadan.

- The trust's central London action on sexual health (CLASH) team and the health promotion outreach team had collaborated with a mental health charity to provide an LGBT+ and women-only drop-in sessions to provide counselling and support to Islington residents who experience mental health problems. An organisation which provides condoms to NHS trusts and GPs across the UK was working with the trust to deliver London-wide HIV prevention services for men who have sex with men (MSM), This was commissioned by a London borough on behalf of all London boroughs. The trust had consulted with patients, carers and staff about a revised transgender policy which incorporated a transitioning guide. A staff member who had transitioned had also appeared in a short film for the trust's website. The trust had received funding for a project to improve mental health support for young people from African and middle eastern backgrounds who are affected by gang culture. The trust had also run a workshop on the over-representation of black males in mental health services, resulting in initiatives around closer working with GPs to refer cases earlier, and drug and alcohol services raising awareness of the risk of psychosis when using skunk or other illicit substances.

- New contracts were awarded for interpretation and translation services in November 2017. Since then, 93% of bookings had been fulfilled, and 2168 bookings made. For British sign language (BSL), 82% of bookings had been fulfilled, and 386 bookings made since the beginning of the contract.

- Governors felt very engaged in the work of the trust and well supported. There were around 30 governors and elections were taking place at the time of the inspection. Governors were offered a training session to support them to understand their role and then ongoing opportunities for learning throughout the year. They had quarterly council of governors meetings which were attended by the chair and several of the non-executive directors. The governors did not attend the sub-committees of the board, apart from the nominations committee which they chaired, but there was a separate governor planning committee. Governors were supported to take part in visits to services. They also participated in a range of advisory panels. Before the council of governors meeting they met informally with the chair.

- The trust had over 15,000 members. They received a newsletter. There were a couple of member events a year where a topic of interest would be discussed.

- The trust engaged effectively with staff and had a remarkably effective communications strategy which made full use of social media. Information was provided through a range of mediums including 'three minute reads', the clinical message of the week, medicines safety bulletin, newsletters, magazine, the chief executive's blog and three key messages after each board meeting. The trust also used online 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.

- Content scored high for accessibility, readability, creativity and flair. Most importantly, the trust's intranet site was easy to navigate and staff told us it was not difficult to find what they were looking for. Innovative communication methods were used, for example, the professionally produced and performed video of staff singing and dancing to promote staff flu vaccination uptake (which contributed to a 76% success rate). A trust-wide team brief on key issues had recently been developed for discussion in team meetings. Teams were

encouraged to pass on feedback about how the issues listed affected them and their service. The only negative comments about staff engagement and communication that we heard were from doctors in training who felt that some of their information needs were overlooked.

- Each division had responsibility for sharing key information with staff through divisional and team meetings. This included learning from incidents and complaints. Each division also had their own communication strategy and local leaders used a range of methods to communicate with staff, including emails, social media and direct contact. However, some of the wards we visited did not hold team or similar meetings at regular intervals, nor were the agendas well-structured or the actions and outcomes clearly recorded. It was particularly an issue on wards carrying a high number of vacancies or without a permanent ward manager, yet these were the teams which would benefit most from these meetings.

- The trust held an annual Gem award event for staff across the trust who went 'the extra mile' and who demonstrated the trust's core values of compassion, respect, empowerment and partnership. Hidden Gem awards were monthly awards which promoted best practice within the trust and rewarded staff for their extraordinary efforts. The board promoted the use of formal 'thank yous' to acknowledge good practice. Each division also had its own methods of celebrating success.

- Senior leaders were very visible and gave staff the opportunity to raise issues. Structured programmes of visits took place during the day and night. Executive directors who were registered clinicians occasionally worked shifts to better understand the issues experienced by front-line staff. The chief operating officer had recently worked a shift at St Pancras Hospital. Meetings took place at a range of venues to allow leaders to see different parts of the organisation. Listening events were regularly held and we attended a question and answer session between the BAME network and the chair and chief executive. A listening event for doctors in training had led to some improvements in the rooms they used when on-call.

- Trade union and staffside representatives said there were good relations with the trust. Representatives could usually get time to attend meetings if they gave a week's notice. The size of the trust meant they had to spend a lot of time travelling, but they were optimistic about digital developments reducing this. Many of their concerns were similar to those of leaders within the trust and they were working together to look at issues such as the over-representation of BAME staff in disciplinary hearings. An additional concern related to the lack of knowledge among middle managers about work related legislation and guidance and trust policy. They confirmed our finding that staff supervision was of variable quality and quantity. The board monitored numbers of employee relations cases (disciplinary; grievance; appeals; dignity at work) and how long they were taking to resolve.

Learning, continuous improvement and innovation

- The news section of the trust website celebrated lots of innovation large and small across the trust, too numerous to mention in this report. Probably the most significant innovation had been the work associated with Grenfell Tower and the development of trauma-informed services in partnership with the local community. The establishment of a social recovery team at the Campbell Centre at Milton Keynes had significantly contributed to good bed management by dealing with the non-clinical issues that can cause discharges to be delayed, such as the absence of ID or welfare benefits. The majority of this team comprised peer support workers. The trust is an innovator in the field of addictions with its National Problem Gambling Clinic and Club Drug Clinic.

- The trust had a well-developed individual placement and support service (IPS) which provided bespoke support for people with mental health difficulties and/or substance misuse to gain and retain employment. CNWL was recognised as a national centre of excellence within the UK in the delivery of IPS. Employment specialists were integrated into clinical teams in community services including peer employment specialists who had experience of using trust services.

- 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.

- The trust had utilised the Institute for Healthcare Improvement's model for improvement framework. They had a corporate QI team (one head, a part-time clinical lead, three part-time leads for each division, one programme manager and further support roles) to support the directorates in their QI initiatives. The work was overseen by a quality improvement programme board which reported to the trust board through the quality and performance committee.

- Staff had access to a range of training with two cohorts of 30 staff trained as coaches, two cohorts of 90 staff completing a three-day improvement science in action, senior clinicians learning about QI as part of their management fundamentals training, regular half day bite-size training available and three learning events each attended by 30 people. In total 1,082 staff had received training.

- 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 trust's 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 25% of the projects.

- The programme had five priorities for the future, workforce improvement; clinical effectiveness; improving access to services; improving patient and carer experience and improving patient safety. There were lots of ideas for how QI could be taken forward, one of which was to encourage its use for staff working in corporate roles.

- NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.
- The table below shows services across the trust awarded or working towards an accreditation at the end of March 2019.

Core Service	Ward / team	Accreditation type	Status
Wards for older adults	Oaktree ward	AIMS	In progress

Wards for working age adults	Frays ward	AIMS	Initial stages
Wards for working age adults	Crane ward	AIMS	Accredited
Specialist MH Rehab	Colham Green	AIMS	Accredited
Specialist MH Rehab	Ascot	AIMS	Accredited
Specialist MH Rehab	Roxbourne	AIMS	Accredited
Specialist MH Rehab	Kenton	AIMS	In progress
Specialist MH Rehab	Birch Villa	AIMS	In progress
Specialist MH Rehab	Bluebell	AIMS	Initial stages
Specialist MH Rehab	Rosedale	AIMS	Initial stages
MH - specialist service	Vincent Square	QED	In progress
CAMHS	Collingham	QNIC	Accredited
Wards for older adults	Ellington, NWP	AIMS	Accredited
Wards for older adults	Redwood, St Charles	AIMS	In progress
Wards for older adults	Kershaw, St Charles	AIMS	In progress
Wards for older adults	1 Beatrice Place	AIMS	In progress
Wards for working age adults	Ganges, St Charles	AIMS	In progress
Wards for working age adults	Thames, St Charles	AIMS	In progress

Wards for working age adults	Shore, Park Royal	AIMS	In progress
Wards for working age adults	Gerard, Gordon	AIMS	In progress
Wards for working age adults	Caspian PICU - Park Royal	AIMS	Accredited
Wards for adults with LD or autism	Carlton House	Quality Network for Inpatient Learning	Accredited
Wards for adults with LD or autism	Preston House	Quality Network for Inpatient Learning	Accredited
MH crisis service (psych liaison)	St Mary's Psych Liaison	Psychiatric Liaison Accreditation Network (PLAN)	Accredited
MH crisis service (psych liaison)	Chelsea & Westminster Psych Liaison	Psychiatric Liaison Accreditation Network (PLAN)	Accredited
MH crisis service (psych liaison)	Central Middlesex Psych Liaison	Psychiatric Liaison Accreditation Network (PLAN)	Accredited
Working Age Wards	Harrow ECT	Electroconvulsive Therapy Accreditation Service (ECTAS)	Accredited
Working Age Wards	K&C ECT	Electroconvulsive Therapy Accreditation Service (ECTAS)	Accredited
Community based MH services for older adults	KCW Memory Service	Memory Service National Accreditation Programme	Accredited
MH - other specialist service	Perinatal - Coombe Wood Mother & Baby Unit	Quality Network for Perinatal Mental Health Services	Accredited
Wards for working age adults	Campbell Centre, Milton Keynes- Willow Ward & Hazel Wared	AIMS	Accredited
Wards for older adults	TOPAS (The Older Persons Assessment Service), Milton Keynes	AIMS	Accredited
MH crisis service (psych liaison)	Hospital Liason Team, Milton Keynes	Psychiatric Liaison Accreditation Network (PLAN)	Accredited
Community based MH services for older adults	Memory Assessment Service, Milton Keynes	Memory Service National Accreditation Programme	Accredited

- The trust was actively working towards all their acute and older people inpatient wards being accredited and members of the relevant quality networks through the Royal College of Psychiatrists' Centre for Quality Improvement.

- The trust had a research and development strategy and was working towards building a research culture in the trust as part of promoting clinical excellence. The trust had links with academic institutions such as University College London (UCL) and Imperial College London which enabled them to bring together experienced researchers and clinical staff. Links with other academic organisations were being promoted. The trust had around 30 honorary academic staff.

- There were several examples of high impact research which had taken place including: sexual health services which researched the use of antiviral therapy to prevent HIV infection; research that contributed to evidence-based end of life care; the use of therapy for women experiencing pre-natal anxiety.

- Clinicians said that the trust was supportive of individuals who wished to participate in research. The trust had 51 (36 mental health and 15 sexual safety) funded studies involving 1,819 patients. This included four research studies which had received National Institute for Health Research (NIHR) for patient benefit project grants and one which had received an NIHR programme grant for advanced research.

- The trust research lead was an academic from UCL who worked at the trust part-time reporting to the medical director. Within a few services there were research champions liaising with clinical staff. The trust promoted research through a starter grant scheme where staff from all professional backgrounds could apply for funds to initiate research. About nine projects had been funded. In addition, the trust offered funding for staff to attend courses linked to research and eight had succeeded in having their application approved. While research was predominantly led by medics, physiotherapists and occupational therapists were also research focused. A research conference was arranged with 250 people attending to share the learning from research.

- The trust recognised the importance of involving people who use services in all aspects of research including identifying priorities, designing the study and carrying out the research. The trust had a research partnership group for service users and carers promoting input into adult mental health studies. Other clinical areas such as sexual health had access to their own network of service users. There were examples of research being planned with input from people who use services and carers.

- The trust had a well-established system for learning from deaths. The trust had a well-attended central mortality review group which met monthly and was chaired by the medical director. It included clinical membership from all divisions and patient and carer representatives. The group looked at all relevant deaths of patients with a diagnosis of learning disability, autism or mental illness and used a sampling approach for other deaths that had been reported. All deaths of patients with learning disabilities were reported to the national learning disabilities mortality review (LeDeR) programme. We attended a mortality review group meeting and saw that it was comprehensive and thorough. As well as

reviewing individual death investigation reports it considered wider issues, such as the report of the independent panel into deaths at Gosport War Memorial Hospital. The mortality review group reported regularly to the board.

- Improvements had taken place in response to the learning from mortality reviews. For example, in Milton Keynes following an increase in people harming themselves on the train line, the trust worked as part of a multi-agency ‘gold group’ led by British Transport Police and Network Rail. This included training staff who worked in the station. As a result of this work the number of incidents had reduced.

Areas for improvement - ‘shoulds’

- 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.
- The trust should embed their plans to appoint a fire officer to ensure fire safety arrangements were maintained on each ward.

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Campbell Centre	Hazel Ward	19	Male
Campbell Centre	Willow Ward	19	Female
Hillingdon Hospital Mental Health Mental Health Centre (Riverside)	Colne Ward	8	Male
Hillingdon Hospital Mental Health Centre (Riverside)	Crane Ward	18	Female
Hillingdon Hospital Mental Health Centre (Riverside)	Frays Ward	23	Male
Northwick Park	Eastlake Ward	23	Mixed
Northwick Park	Ferneley Ward	22	Mixed
Park Royal Centre for Mental Health	Caspian Ward	13	Male
Park Royal Centre for Mental Health	Pine Ward	24	Female
Park Royal Centre for Mental Health	Pond Ward	24	Male
Park Royal Centre for Mental Health	Shore Ward	18	Mixed
St Charles	Amazon Ward	17	Mixed
St Charles	Danube Ward	16	Mixed
St Charles	Ganges Ward	17	Mixed
St Charles	Nile Ward	14	Male
St Charles	Shannon Ward	12	Female
St Charles	Thames Ward	17	Mixed
The Gordon Hospital	Ebury Ward	19 (reduced to 16 during the inspection)	Mixed
The Gordon Hospital	Gerrard Ward	19 (reduced to 16 during the inspection)	Mixed

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
The Gordon Hospital	Vincent Ward	19 (reduced to 16 during the inspection)	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Acute wards for adults of working age

Safe and clean care environments

Safety of the ward layout

- Staff did regular risk assessments of the care environment. Staff completed daily environmental checklists on all the acute wards. The checklist covered safety, security, cleanliness and infection control. These checks included ensuring that all fire safety equipment was intact, in the right place and that fire escape routes were clear.
- On each ward there was an up to date ligature risk assessment which explained the location of potential ligature anchor points and what actions were in place to mitigate the risks to patients. At our previous inspection in October 2016, we recommended that the ligature risk assessment for the Campbell Centre should include the garden area. At this inspection we found that the courtyard garden areas for each ward were included in the ligature risk assessments. Staff told us ligature risks were highlighted to them when they came to work on the ward.
- Some parts of the wards were not easy for staff to observe. The trust had mitigated risks through installing convex mirrors and closed-circuit television in the corridors which helped staff monitor blind spots and check the safety of patients.
- However, at the Gordon Hospital we found that some activities designed to keep the ward safe were not being actively carried out. Staff told us that a member of staff should always be present at the T-junction at the male end of Vincent and Gerrard wards so that they could observe the male bedrooms and main corridor. Although there was a chair placed at the T-junctions, on at least two occasions, we found that there was no staff member monitoring the ward from this area.
- On Gerrard and Vincent wards, an extra bedroom, known as an ‘escalation’ room was available, if required, to accommodate a twentieth patient who could not be found a bed elsewhere. There was a policy in place around the use of the rooms, which were far smaller than the other rooms on the ward, and they could only be used with senior management approval. However, discussion with staff indicated that this policy was not followed.
- The Vincent and Gerrard escalation room policy had been emailed to staff on Monday 28 January 2019. The policy was dated 16 October 2017 and it had been reviewed twice in 2018. The policy stated that the bedroom should not be used for more than 24 hours and then the patient should be moved to a regular bed. If the patient was in the room for more than 24 hours then an incident report should be raised. The escalation room on Gerrard Ward, was used on 45 nights over the three month period from 1 November 2018 to 31 January 2019. This included an individual stay by a patient of 22 nights, and five night stays for three other patients. On Vincent Ward the escalation room was used for 32 nights over the same time period, with a longest stay of 11 nights for one patient and stays of six nights and five nights by two other patients. The trust policy said that only settled patients should use the

escalation rooms. However, staff told us that this was not possible to implement, as no settled patient would willingly move to such a small room to make way for a newly admitted patient.

- We raised this issue with the trust and when we returned for an unannounced visit on 25 March 2019 we found the escalation rooms were no longer in use as bedrooms and beds had been removed.
- The service did not fully comply with guidance on eliminating mixed sex accommodation. All three wards at the Gordon Hospital were mixed gender, each with male and female areas. However, on Gerrard and Vincent wards, there were three flexible bedrooms positioned on the main corridor between the male and female bedroom areas. These bedrooms did not have ensuite bathroom or toilet facilities. There was a shower/toilet nearby, directly off the main lounge/communal area. The shower/toilet was used by both men and women. Staff on both wards confirmed that they sometimes used the bedroom nearest to the male bedroom area for female patients but did not consider this was a mixed-sex accommodation breach. However, any female patient would have to walk out onto the main corridor in full view of the main lounge to reach the bathroom. To use the bathroom in the female area they would need to walk the length of the ward. This was a mixed sex accommodation breach.
- We raised this issue with the trust and when we returned for an unannounced visit on 25 March 2019 we found use of the flexible bedrooms had been discontinued with no reduction in staffing. Rooms were being cleared of beds.
- Staff on all wards had easy access to alarms but patients did not always have easy access to nurse call systems. Staff collected a personal alarm at the start of each shift. Alarms were tested each day. When a member of staff activated an alarm, indicator panels around the wards showed their location. On each ward, the shift co-ordinator allocated a member of staff as the incident responder for the shift. This person provided additional support when incidents occurred on neighbouring wards. However, with the exception of wards at the Campbell Centre, we found that call buttons were not installed in patients' bedrooms. This meant that patients might find it difficult to call for assistance, especially in the isolated areas of the wards.
- Wards had fire risk assessments in place. Wards had fire blankets and fire extinguishers, which were serviced regularly, in case of a fire. There were regular fire drills and appropriate personal evacuation plans in place for patients with mobility difficulties.
- The fire risk assessment for the Campbell Centre had been updated in September 2018. However, we noted that actions identified in the previous risk assessment in September 2017 had not been completed within the timescales set. For example, the fire procedure had not been updated and a fire drill had not been carried out since September 2017. We were informed that a table top fire drill exercise was planned for February 2019. In addition, a fire marshal check had been carried out on each ward in January 2019 and this detailed areas which required improvement such as missing fire door strips. From the information viewed it was not clear who was responsible for the follow up action and by when. We raised these issues with managers and the trust responded promptly to rectify matters.
- Overall, the service had plans for emergencies and staff understood their roles if one should happen, including sending staff at short notice to support other wards when required.

Maintenance, cleanliness and infection control

- For the most recent patient-led assessments of the care environment (PLACE) in 2018, the locations scored higher than similar trusts for cleanliness and generally scored higher than similar trusts for condition, appearance and maintenance. However, Gordon Hospital and Campbell Centre scored slightly below the average.

Site name	Cleanliness	Condition appearance and maintenance
Hillingdon Hospital MHU	99.8%	95.9%
Park Royal Centre for Mental Health	99.6%	96.0%
St Charles MHU	100.0%	97.4%
Gordon Hospital	99.5%	94.8%
Northwick Park	99.8%	97.8%
Campbell Centre	99.6%	94.3%
Trust overall	**99.8%**	**96.4%**
England average (Mental health and learning disabilities)	**98.4%**	**95.4%**

- Most patients were cared for in clean wards and domestic staff completed records which showed that all parts of the wards were cleaned according to a schedule. Most wards were well maintained, bright and had appropriate furnishings.
- However, we found some areas where cleanliness and maintenance did not meet the required standards. For example, at Park Royal, patients on Pond Ward had complained in community meetings that the ward was not clean. During our interviews with patients on Pond Ward, three patients raised this with us and, in particular, mentioned that the toilets and bathrooms were not clean. Staff and patients informed us that there were areas where maintenance works had not taken place in a timely manner. For example, an environmental audit of Pond Ward on 15 January 2019 identified graffiti on the wall, damage to a dormitory wall, flooring coming away from the wall in a communal area, a blocked sink and other issues. None of these issues had been addressed by the end of the site visit on 31 January 2019. Concerns about rodents were also raised in an interview with a patient during our inspection. The service was aware of these concerns through audits and notes from community meetings. However, plans to remedy these problems did not include dates for completion.
- We raised these issues with the trust and they told us they would act immediately to improve the Pond Ward environment. We made an unannounced return visit on 19 March 2019 and found minor repairs had been made. The ward had also been repainted, new lighting and curtains had been installed and new flooring was on order. Staff and patients commented favourably on these improvements as the ward was now cleaner and brighter.
- Similarly, the wards at the Gordon Hospital were not well maintained. There were recurrent items, identified on the environmental check forms, that were missing or broken, including a shower, radiator, shower curtains and furniture.

- Hand sanitiser and signs regarding handwashing were in place on the wards. Infection control audits were undertaken every three months, such as hand hygiene audits.

Seclusion room

- The seclusion rooms at Northwick Park, Campbell Centre and Park Royal allowed clear observations and two-way communication and had toilet facilities and a clock. However, the seclusion room at Park Royal was not fully compliant with the guidance. For example, the intercom was not working. This made it difficult for staff to communicate with a patient in the seclusion room. There were sharp edges on angled surfaces in the toilet area which could result in harm to the patient. A window covered by a metal grille was dirty. The mattress on the floor at Park Royal was thin and could be uncomfortable for patients. Also, if a person were to stand on the toilet or the basin, there was a possibility that they could release a metal grid covering the light fitting in the toilet. The service had plans to refurbish this seclusion room by the end of March 2019.

Clinic room and equipment

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Equipment on each ward included a defibrillator, oxygen masks and ligature cutters. Most wards recorded checks of emergency equipment three times each day, as per the trust policy. There were gaps in records at Thames Ward and at the Gordon Hospital.
- On most wards, staff checked the clinic room and medicine refrigerator temperatures on a daily basis. If the medicines refrigerator temperature was outside of the recommended range, staff contacted the pharmacist and the maintenance team. However, on Thames Ward, we found 20 gaps in the clinic room temperature checks, and 23 gaps in the refrigerator checks for the previous five months. On one day the room temperature was above 25 degrees with no record that staff took action. This meant that medicines may not have been stored at the correct temperature, therefore, they may not have been fully effective.
- Staff disposed of sharps and clinical waste appropriately.
- Staff maintained equipment well and kept it clean. However, staff did not always have instant access to information about when it was calibrated or cleaned. For example, the use of stickers to record when equipment had last been cleaned was sporadic across all wards. At the Gordon Hospital, the records of calibration for the clinical equipment were not immediately to hand which made extra work for staff who required this assurance as they had to seek it out.

Safe staffing

Nursing staff

- The trust assessed the minimum number of nursing staff that should work each shift on the wards. Ward managers reviewed the skill mix on a daily basis to ensure patients received safe care and treatment. Both patients and staff confirmed that the staffing on the wards was normally in accordance with the safe staffing levels calculated by the trust or higher. When

there were occasional gaps this was due to the non-availability of staff members to cover the shift at short notice.

- Each ward displayed a safe staffing notice which detailed the number of registered and non-registered staff for each shift. If more than one person required continuous observation, additional bank staff were booked. Whenever ward rounds took place, an additional registered nurse was rostered to provide cover. Where possible, wards tried to utilise regular bank staff.
- However, on some wards staff and patients raised concerns about the staffing levels. For example, on Frays Ward, a 23-bedded male acute ward, there were normally three members of staff on duty at night. Crane Ward had the same level of staffing at night and up to 18 female patients. Staff on both wards told us they felt vulnerable at night, and sometimes unsafe, depending on the level of acuity on the wards. It was particularly difficult to facilitate staff breaks at night time, as that only left two staff members across the whole ward. A significant number of admissions also took place at night, putting further pressure on staff availability for patients on the ward. Patients corroborated this, commenting that there were often delays in support from staff at night as they were needed elsewhere. Ward managers informed us that this had been raised within the trust, but there was no immediate solution.
- During 2018, the number of staff on day shifts at Park Royal had increased from two registered nurses and two healthcare assistants to three registered nurses and two healthcare assistants. At night the number of staff had increased from one registered nurse and two healthcare assistants to two registered nurses and two healthcare assistants. However, nurses and healthcare assistants on Pond Ward said the ward was still understaffed for the level of acuity.
- Since September 2018, the wards at Park Royal had recruited eight new nurses. These were either newly qualified nurses on a preceptorship programme or nurses on the Capital Nurse programme. This programme involved participants rotating to wards with different specialisms every six months. Whilst supportive of the programme, staff felt it needed to take better account of the need for stability within staff teams. They told us the nursing team was subject to frequent changes due to rotations and there could be a lack of experienced nurses on shift. When we returned to Park Royal on an unannounced visit on 19 March 2019 we found that experienced Band 6 nurses were now deployed on each shift. Staff told us they found this reassuring. Managers told us that they had retained some of the nurses on the Capital Nurse programme on a permanent basis so there should be more stability within the nursing teams in future.
- Only four of 11 nurses on Vincent Ward were permanent staff. There were specific reasons for this. However, it had impacted on primary nursing and staff ability to invest time with individual patients. Gaps in the rota were filled by bank staff with many substantive staff working long days to cover. Despite this, staff told us that they continued to struggle to fill shifts, particularly as they were not able to use agency staff. They gave examples of how this had impacted on patient appointments with a GP and a housing service. Furthermore, they said it had led to the cancellation of escorted leave, although no record was kept of this. Staff on the other wards at the Gordon Hospital confirmed they had cancelled escorted leave due to staff shortages too. Vincent Ward staff also described missing immediate life support training for the same reason.

- On other wards, staff told us that staff shortages rarely resulted in the cancellation of escorted leave or ward activities, although they might be delayed. During each shift, the nurse in charge allocated different roles to staff and recorded this on the allocations sheet. The allocations sheet showed that a member of staff was available to facilitate escorted leave for up to five hours each day.
- This service reported a vacancy rate for all staff of 22% as of 30 September 2018. It reported an overall vacancy rate of 29% for registered nurses and 10% for healthcare assistants on the same date.

Nursing establishment and vacancy rate

- This service reported a vacancy rate for all staff as of 30 September 2018. It reported an overall vacancy rate for registered nurses of 29% and 10% for healthcare assistants.

		Registered nurses			Healthcare assistants			Overall staff figures		
Location	**Ward**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Hillingdon Hospital Mental Health Site	Crane Ward	4.1	12.1	34%	5.5	10.0	55%	9.6	22.1	43%
	Colne Ward	4.7	12.7	37%	1.2	9.2	13%	5.9	21.9	27%
	Frays Ward	5.8	16.2	36%	-8.5	9.1	-94%	-2.8	25.3	-11%
Northwick Park	Eastlake Ward	9.0	16.0	56%	1.9	11.9	16%	11.9	28.9	41%
	Ferneley Ward	3.0	16.0	19%	3.1	12.9	24%	6.1	28.9	21%
Park Royal Centre for Mental Health	Pine Ward	2.8	16.2	17%	1.2	8.6	14%	4.1	24.9	16%
	Caspian Ward	6.6	16.2	41%	0.9	11.9	7%	7.5	28.1	27%
	Pond Ward	7.7	15.7	49%	-2.0	8.6	-23%	6.7	25.3	27%
	Shore Ward	7.5	18.5	40%	-0.1	11.2	-1%	8.0	30.7	26%
Campbell Centre	Hazel Ward	5.5	15.5	35%	3.0	16.0	19%	8.5	33.5	25%
	Willow Ward	6.5	16.5	39%	0.7	16.0	4%	7.2	34.5	21%
The Gordon Hospital	Gerrard Ward	2.4	17.0	14%	4.5	16.0	28%	8.1	35.0	23%
	Vincent Ward	4.5	17.5	26%	3.5	15.5	23%	8.0	33.0	24%
	Ebury Ward	1.0	17.0	6%	3.6	16.0	22%	3.6	34.0	11%

		Registered nurses			Healthcare assistants			Overall staff figures		
Location	**Ward**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
St Charles	Ganges Ward	2.1	13.1	16%	3.7	9.9	37%	5.8	24.0	24%
	Nile Ward	7.3	19.9	37%	-0.2	10.8	-2%	7.1	31.7	22%
	Thames Ward	5.1	13.1	39%	-3.9	7.9	-49%	5.2	25.0	21%
	Shannon Ward	2.9	19.9	15%	3.2	11.0	29%	6.1	31.9	19%
	Danube Ward	3.9	16.5	24%	1.1	9.1	12%	5.0	26.6	19%
	Amazon Ward	1.1	13.1	8%	-0.1	8.9	-1%	1.0	22.0	5%
Core service total		**93.4**	**318.6**	**29%**	**22.3**	**230.6**	**10%**	**122.6**	**567.3**	**22%**
Trust total		**523.3**	**2546.2**	**21%**	**283.0**	**1846.8**	**15%**	**1165.8**	**7256.6**	**16%**

NB: All figures displayed are whole-time equivalents

Bank and agency nurse usage

- Between 1 November 2017 and 31 October 2018, there were 655,220 total working hours available for registered nurses. 145,206 were covered by bank staff to cover sickness, absence or vacancies. In the same period agency staff covered 8,345 hours for registered nurses. 13,481 hours could not be filled on a like-for-like basis, but the trust told us contingencies were used, such as managers stepping down to cover or extra healthcare assistants coming in to free nurses up for essential nursing tasks.

Wards	**Total registered nurse hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Campbell Centre Hazel Ward	30303	4809	-	935	-	0	-
Campbell Centre Willow Ward	32258	6021	-	1856	-	0	-
Crane Ward	23695	11264	-	1036	-	0	-
Frays Ward	31287	9075	-	2200	-	0	-
Colne PICU Ward	24770	8192	-	481	-	351	-
Pond Ward	30871	9565	-	334	-	271	-
Shore Ward	31322	8140	-	198	-	175	-

Wards	Total registered nurse hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Caspian Ward	30956	3446	-	87	-	1384	-
Pine Ward	30956	5050	-	10	-	0	-
Eastlake Ward	31280	9675	-	302	-	3132	-
Ferneley Ward	31280	6483	-	245	-	0	-
Thames Ward	25591	6850	-	8	-	0	-
Danube Ward	32258	5778	-	66	-	0	-
Ganges Ward	25591	5435	-	10	-	0	-
Amazon Ward	25591	5008	-	194	-	0	-
Shannon Ward	38944	9982	-	379	-	0	-
Nile Ward	38944	8476	-	0	-	1177	-
Ebury Ward	33626	4842	-	0	-	0	-
Gerrard Ward	33626	7207	-	0	-	0	-
Vincent Ward	33626	6637	-	7	-	0	-

- Between 1 November 2017 and 31 October 2018, there were 452,486 total working hours available for healthcare assistants. 223,301 were filled by bank staff to cover sickness, absence or vacancies and a further 6,873 by agency staff.

Wards	Total HCA hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Campbell Centre – In Patients	6517	2370	-	0	-	0	-
Campbell Centre Hazel Ward	29162	25068	-	1384	-	0	-
Campbell Centre Willow Ward	29162	27700	-	2335	-	0	-
Crane Ward	17595	12176	-	70	-	0	-
Frays Ward	16096	6824	-	403	-	0	-
Colne PICU Ward	16031	7774	-	62	-	0	-
Pond Ward	22092	5522	-	45	-	0	-
Shore Ward	21911	4966	-	19	-	0	-
Caspian Ward	22181	11936	-	108	-	0	-
Pine Ward	21819	12049	-	8	-	0	-
Eastlake Ward	22385	11233	-	746	-	0	-
Ferneley Ward	22385	7743	-	679	-	0	-
Thames Ward	22150	8169	-	13	-	0	-

Wards	Total HCA hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Danube Ward	17810	8589	-	0	-	0	-
Ganges Ward	20195	8025	-	0	-	0	-
Amazon Ward	18566	9273	-	45	-	0	-
Shannon Ward	22267	14475	-	957	-	0	-
Nile Ward	22267	20577	-	0	-	0	-
Ebury Ward	27135	5635	-	0	-	0	-
Gerrard Ward	27135	7048	-	0	-	0	-
Vincent Ward	27135	6152	-	0	-	0	-

- On Vincent Ward, there was a shortage of staff on the day of our inspection visit, with nurse positions unfilled in the afternoon. We observed that morning staff stayed later to support colleagues on the ward. They told us that this was a common occurrence.
- On Thames Ward, the previous ward manager and several registered nurses left in quick succession several months before the inspection and there were five vacant posts; a band six registered nurse, three band five registered nurses, and one non-registered post. In the previous three months, the ward had been short of nursing staff on 61 shifts (23%). For 18 shifts (7%), two staff were on duty instead of four, and for one shift only one staff member was rostered on duty. The staffing situation on the ward had been deteriorating before the inspection. In addition to the regular nursing staff, up to 49 bank staff worked on the ward in a month. This affected the consistency of care provided to patients.
- The local leadership team had a clear action plan to address the staffing issues on Thames Ward. This included the transfer of two experienced clinical team leaders to the ward immediately after the inspection. The ward manager post was also due to be advertised. In addition, the ward was being prioritised for nursing recruitment and some bank staff were being block booked to cover vacant posts to improve consistency of care.

Turnover

- This service had 72.5 (16%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff leavers over the last 12 months	Average % staff leavers over the last 12 months
St Charles	Thames Ward	19.8	7.0	40%
	Nile Ward	24.6	8.0	36%
	Shannon Ward	25.8	6.7	27%
	Amazon Ward	21.0	3.4	16%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff leavers over the last 12 months	Average % staff leavers over the last 12 months
	Danube Ward	21.6	3.0	14%
	Ganges Ward	18.2	1.2	6%
Park Royal Centre for Mental Health	Pond Ward	17.6	6.0	32%
	Shore Ward	21.7	3.2	14%
	Pine Ward	19.8	2.0	10%
	Caspian Ward	22.6	1.0	5%
Hillingdon Hospital Mental Health Site	Crane Ward	16.5	5.0	27%
	Frays Ward	20.4	2.0	10%
	Colne Ward	16.0	1.0	7%
The Gordon Hospital	Vincent Ward	25.0	5.0	18%
	Ebury Ward	30.4	2.0	7%
	Gerrard Ward	26.9	1.0	4%
Northwick Park	Ferneley Ward	22.8	4.0	17%
	Eastlake Ward	17.0	3.0	17%
Campbell Centre	Hazel Ward	24.0	4.0	16%
	Willow Ward	27.3	4.0	15%
Core service total		**439.1**	**72.5**	**16%**
Trust Total		**6116.8**	**1269.6**	**21%**

Sickness

- The sickness rate for this service was 5.8% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 6.6%. This was above the trust average of 3.4%.

Location	Ward	Total % staff sickness (at latest month)	Average % permanent staff sickness (over the past year)
Hillingdon Hospital (Riverside)	Frays Ward	11.7%	10.9%
	Colne Ward	12.1%	10.6%
	Crane Ward	14.2%	7.2%
	Vincent Ward	5.1%	8.9%

Location	Ward	Total % staff sickness (at latest month)	Average % permanent staff sickness (over the past year)
The Gordon Hospital	Gerrard Ward	17.9%	7.4%
	Ebury Ward	2.4%	3.8%
St Charles	Amazon Ward	12.8%	10.1%
St Charles	Shannon Ward	14.7%	9.1%
	Thames Ward	6.5%	3.7%
	Ganges Ward	7.1%	4.8%
	Danube Ward	6.2%	3.4%
	Nile Ward	1.9%	2.0%
Park Royal Centre for Mental Health	Caspian Ward	0.2%	6.8%
	Pine Ward	9.5%	5.6%
	Pond Ward	1.2%	5.5%
	Shore Ward	6.2%	2.4%
Campbell Centre	Hazel Ward	1.3%	3.3%
Campbell Centre	Willow Ward	0.7%	6.4%
Northwick Park	Eastlake Ward	0.6%	2.6%
	Ferneley Ward	0.6%	1.9%
Core service total		**6.6%**	**5.8%**
Trust Total		**3.0%**	**3.4%**

Medical staff

- At Riverside, St Charles and Northwick Park, there was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency. The wards had access to consultant psychiatrists, middle grade doctors and junior doctors.
- However, at Park Royal, 17% of medical staff cover was left unfilled in the period from 1 November 2017 to 31 October 2018. In addition, 13% of medical staff hours were filled by agency staff. We were informed that there had been no permanent medical staff on Shore Ward since the summer of 2017. The consultant and junior doctor posts had been filled by

locum staff. The service had tried but failed to recruit permanent staff and had, therefore, appointed locum staff on six month contracts. The absence of permanent medical staff created the risk of a lack of continuity for patients and a lack of clinical leadership on the wards.

- Similarly, at the Gordon Hospital, there was a lack of medical cover for Vincent Ward. At the time of the inspection, a consultant psychiatrist was covering Vincent Ward for only two days each week. Staff told us that there was little senior medical cover based at the hospital at weekends. Weekend cover consisted of one junior doctor on call and a Band 6 nurse. The doctor on duty also covered the wards at St Charles.

Mandatory training

- The service provided mandatory training in key skills and knowledge to all staff and put steps in place to ensure everyone completed it. The trust provided 21 training courses that were mandatory for at least some of the staff. The compliance rate for mandatory and statutory training courses at 31 October 2018 was 92% against the trust target of 95% for completion of most courses. Ward managers held data on staff completion of mandatory training.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Adult Basic Life Support	13	13	100%	✓	↑
Conflict Resolution	2	2	100%	✓	↑
Infection Prevention (Level 1)	13	13	100%	✓	↑
Non-Inpatient Fire Safety	18	18	100%	✓	↑
Prevent Awareness - Level 1	13	13	100%	✓	↑
Safeguarding Adults (Level 1)	13	13	100%	✓	↑
Safeguarding Children (Level 1)	29	29	100%	✓	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Health and Safety (Slips, Trips and Falls)	427	421	99%	✓	↑
Manual Handling - Object	426	413	97%	✓	↑
Safeguarding Adults (Level 2)	414	401	97%	✓	↑
Equality and Diversity	427	407	95%	✓	↑
Safeguarding Children (Level 3)	414	393	95%	✓	↑
Information Governance	427	404	95%	✓	↑
Personal Safety Breakaway - Level 1	17	16	94%	✗	↑
Emergency Life Support	327	299	91%	✗	↓
Infection Prevention (Level 2)	414	378	91%	✗	↑
Physical Intervention	390	339	87%	✗	↑
Immediate Life Support	87	74	85%	✗	↓
Prevent WRAP	398	333	84%	✗	↑
Inpatient Fire Safety	409	337	82%	✗	↑
Breakaway	2	1	50%	✗	↑
Total	**4680**	**4317**	**92%**	**-**	↑

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed 68 patient records across all the acute wards. At the time of our inspection, the trust was in the process of transferring to a new electronic patient record system. Staff used a standard risk assessment tool that was part of the electronic patient record.
- At the last inspection in October 2016, we found that risk assessments did not include sufficient detail about risks and there was no information in care records about risk management. At this inspection, we found that staff completed a risk assessment for every patient on admission. In most cases, staff updated it regularly, including after any incident. Staff used a whiteboard to track risk assessment completion.
- The admitting doctor and nurse followed protocols in terms of the blood tests, screening tools and risk assessments that should be completed within the first 72 hours of admission. The trust had standardised risk assessment documentation, which included information about the patient's history, risks to self and others and physical and mental health risks.
- However, at Gordon Hospital we found four risk assessments in place for patients which were over six months old. These were from previous admissions, with no evidence of review. In one case the risk assessment had been completed a year ago. We also found that risk assessments had not always been updated with recent incidents, including no reference to an incident in which a patient had been absent without leave for a long period. The risks to patients from having out of date risk assessments was partly mitigated by a robust handover, and more up to date information recorded within their progress notes.

Management of patient risk

- Staff were aware of and dealt with any specific risk issues. For example, risk assessments highlighted specific risks such as vulnerability to assault, potential for violence and self-neglect.
- Staff managed risks specific to individual patients. For example, specialist mattresses were obtained for patients known to be at high risk of pressure ulcers.
- Staff identified and responded to changing risks to, or posed by, patients. For example, Park Royal staff used a recognised tool to rate each patients level of risk at regular intervals. Staff responded to changes in patient's risk level by adjusting the level of medication, exploring activities to provide a positive distraction, responding promptly to the patient's requests, reinforcing positive behaviour and changing the level of observation.
- The trust had policies and procedures in place for use of observation and for searching patients or their bedrooms. During the inspection period a serious incident took place at the Gordon Hospital following a patient's return from leave with a prohibited item. The investigation was still underway, but we heard from staff throughout the trust, not just in this service, that immediate lessons had been shared. Acute and PICU staff had refreshed their knowledge of search procedures. In addition, rooms had been identified at the Gordon Hospital where searches could be more easily and safely carried out in privacy and with dignity.

- There were measures in place to reduce the risks of banned substances and items coming onto the ward. Staff carried out drug tests on patients if this was indicated.
- In October 2016, we found some blanket restrictive practices, such as locked doors to quiet rooms, outside spaces and limited access to snacks and hot drinks. At this inspection, across all the wards, we found that improvements had been made and patients told us they could have hot drinks and snacks at any time. Patients could also use the quiet rooms whenever they wanted. Staff usually applied blanket restrictions on patients' freedom only when justified. For example, during the inspection, patients on Pond, Crane and Frays Wards did not have access to hot water because a patient had thrown hot water at other patients and staff with the intention of harming them. Staff provided other patients with hot water on request and gave an assurance that access to hot water would be reinstated once the risk had reduced.
- However, we found some blanket restrictions remained in place on the wards. On Frays Ward, we found that staff kept the sitting room doors locked at all times without considering if this was justified. We raised this during the inspection and the doors were unlocked. On Pond Ward there was restricted access to the garden and on Danube Ward all patients had weekly bedroom searches regardless of their risk level.
- Patients could not smoke in the hospital buildings but could smoke in the hospital grounds. The trust planned to have smoke-free hospital grounds in the future.
- Informal patients could leave at will and knew this. Staff reminded informal patients that they could leave the ward and conducted a risk assessment before they left, after informing patients of the reasons for this.

Use of restrictive interventions

- All the wards in this service participated in the trust's restrictive interventions reduction programme. Pine Ward had been an early implementer due to its involvement in a pilot. Following this initiative, there were 67 restraints on the ward 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 on the ward fell from 64 to 13 and the number of times seclusion was used fell from 76 to 40.
- This service had 1,439 incidences of restraint (involving 664 different service users) and 541 incidences of seclusion between 1 October 2017 and 30 September 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Amazon	9	24	16	3 (13%)	14 (58%)
Caspian	87	128	45	39 (30%)	62 (48%)
Colne	0	61	20	18 (30%)	34 (56%)
Crane	0	70	34	19 (27%)	55 (79%)

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Danube	14	62	35	27 (44%)	35 (56%)
Eastlake	72	53	47	32 (60%)	47 (89%)
Ebury	0	52	24	19 (37%)	31 (60%)
Ferneley	36	127	29	14 (11%)	18 (14%)
Frays	0	71	40	17 (24%)	25 (35%)
Ganges	1	14	11	1 (7%)	7 (50%)
Gerrard	0	39	20	12 (31%)	23 (59%)
Hazel	52	53	32	16 (30%)	9 (17%)
Nile	33	92	42	20 (22%)	45 (49%)
Pine	37	65	44	10 (15%)	15 (23%)
Pond	35	110	52	18 (16%)	54 (49%)
Shannon	47	144	43	37 (26%)	71 (49%)
Shore	49	103	50	27 (26%)	45 (44%)
Thames	6	49	28	22 (45%)	22 (45%)
Vincent	0	32	24	11 (34%)	17 (53%)
Willow	63	90	28	8 (9%)	27 (30%)
Core service total	**541**	**1439**	**664**	**370 (26%)**	**656 (46%)**

Restraint

- The number of restraint incidences (1,439) reported during the 12 month period was higher than the 1,255 reported for the year before.
- In October 2016, we required the trust to ensure that all records of physical restraint complied with the trust policy and procedure. At this inspection, we found that improvements had been made. Records of restraint included details of the circumstances that led up to the restraint. Records also demonstrated that when staff used force to restrain a patient, their actions were proportionate to the likelihood and seriousness of harm.
- There were 370 incidences of prone restraint, which accounted for 26% of the restraint incidents. Over the 12 months reviewed, incidences of restraint ranged from 22 to 43 per month. The number of incidences (370) had decreased from the previous 12-month period (595) and was a significant reduction since our last inspection in 2016 when prone restraint was used 614 times in a six month period and we required the trust to reduce it.

- Staff on Gerrard and Vincent Wards, including ward managers, advised that it was impossible to restrain a patient in the 'escalation rooms' safely and, if needed, to turn them over from the prone to the supine position (safer for the patient) due to the spatial constraints of these rooms. Two incidents of prone restraint had been carried out in the room on Gerrard Ward in recent months. The ward manager explained that prone restraints in this room were categorised as unavoidable, because it was impossible for the staff to restrain the patient any other way. The minutes of the bed management meeting for the trust in December 2018, recognised this and a member of the patient safety team was to advise staff about resuscitation and restraint in the escalation rooms, due to concerns about the restricted space for carrying out these activities.
- There were 656 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from 36 to 69 per month. The number of incidences (656) had increased from the previous 12-month period (606).
- In October 2016, we required the trust to ensure that physical observations following rapid tranquilisation were carried out consistently and recorded. At this inspection, we found that improvements had been made. We reviewed 20 records of rapid tranquilisation across all the wards. Staff followed National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. This guidance states that after rapid tranquillisation, staff should monitor side effects and the patient's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health. Where the patient refused to have observations taken this was clearly recorded.
- There had been no instances of mechanical restraint over the reporting period or during the previous 12-month period.

Seclusion

- There were 41 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from 33 to 54 per month. The number of incidences (541) had increased slightly from the previous 12 month period (474), except on Pine Ward, where seclusion had reduced by almost 50% following their involvement in a pilot project to reduce restrictive interventions.
- Staff used seclusion appropriately and followed best practice when they did so. Records showed that staff used seclusion as a proportionate response to prevent harm to patients. Staff kept records for seclusion in an appropriate manner. Staff completed paper records of seclusion reviews. When these were complete, staff scanned these and stored them on the electronic patient record. Records showed that nursing reviews were carried out every two hours. Doctors carried out and recorded medical reviews every four hours. Nursing staff recorded observations every 15 minutes.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. Across the acute wards, 97% of staff had completed mandatory training in safeguarding adults. Ninety-five percent of staff had completed mandatory training in

safeguarding children. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked in partnership with other agencies. Staff were all aware of different types of abuse. A senior member of staff was the designated safeguarding lead for each hospital site.

- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, staff intervened when a patient assaulted another patient and used racist language. Staff moved the patient who committed the assault to another ward and made a referral to the adult safeguarding team.

- Any safeguarding risks were discussed with the home treatment teams and community mental health teams to ensure that appropriate arrangements were in place for the patient's discharge.

Staff access to essential information

- During the inspection, the service was transferring all electronic patient records from one system to another (except in Milton Keynes). During this time, staff could access information on both systems. Staff were recording progress notes on temporary records that could be uploaded to the new system.

- All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. This included when patients moved between teams. Staff working across the trust had access to relevant electronic records and any paper records were scanned in to the system after completion.

Medicines management

- Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. Medicines were stored securely. Medicines required in an emergency were available. Medicines were administered in accordance with national guidelines. There were effective arrangements in place for medicine supplies and advice out of hours. Medicines incidents were reported, recorded and investigated. Staff we spoke with knew how to report incidents involving medicines. Learning from incidents was fed back to staff via ward meetings and a quarterly medicines safety bulletin.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication. When the service prescribed antipsychotic medicines, staff carried out an electrocardiogram. Staff regularly monitored the patient's pulse, temperature and blood pressure and recorded these on a standard form.

- However, at St Charles, the Campbell Centre and Northwick Park, ‘as required’ medicines were not reviewed regularly or when not used by the patient for whom they were prescribed for over 14 days. This was not best practice and did not follow NICE guidance on medicines optimisation.
- The new electronic patient record system aligned to the system used by GPs in some boroughs which would make medicines reconciliation on admission much easier to facilitate in those areas.

Track record on safety

- Between 19 October 2017 and 19 October 2018 there were 14 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was ‘Apparent/actual/suspected self-inflicted harm’ with six.
- There had been two recent serious incidents on Amazon Ward and one on Thames Ward. All of the serious incidents had involved patients assaulting staff. The incidents resulted in staff members having significant injuries. One of the assaults led to a patient being prosecuted. Following the inspection visit, a further serious assault on a staff member took place at the Gordon Hospital.

Reporting incidents and learning from when things go wrong

- Staff reported a range of incidents. These included violence and aggression, self-harm, medicine errors, data confidentiality breaches, accidents and patients absconding from the wards.
- Staff knew what incidents to report and how to report them using the trust’s electronic system. In the weeks before the inspection, the trust had reminded ward managers that patients section 17 leave being cancelled was an incident which required reporting, as this was not being consistently carried out.
- Learning from incidents across the trust was supported in various ways. The findings of serious incidents were discussed at ward manager meetings and care quality meetings. Ward managers then fed back findings to the ward in business and team meetings. On Danube, Ganges and Crane Wards, nursing staff had safety huddles. These were impromptu groups so that learning from any incidents could be quickly communicated to all staff. The flow of information and learning from incidents was undermined by the absence of regular team meetings on some wards.
- However, systems for feedback were less robust at Northwick Park and Park Royal, mainly because there was an over-reliance on passing on information at handover meetings. When we returned to Park Royal for an unannounced visit on 19 March 2019 we found that the systems used had been significantly enhanced and included a regular safety huddle to discuss learning from incidents across the trust. For example, staff had had the opportunity to discuss a recent serious incident on another site and had refreshed their knowledge of the trust’s search policy as a result.

- A ‘safer leave’ quality improvement project had been initiated at the Campbell Centre in response to incidents that occurred whilst patients were on leave from the ward. As a result, staff had a conversation with informal patients, as well as detained patients, before they went on leave to make sure they would be safe. They completed a form to confirm that all aspects of safety had been covered. Informal patients told us this delayed their trips out, but they appreciated why it was necessary. Senior staff were already looking at ways to speed the process up for informal patients. This was similar to the approach at Riverside where staff used the Oxford model questionnaire to promote the safe return of patients on leave back to the ward.
- Staff across all wards understood duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

Psychiatric intensive care unit (PICU)

Safe and clean environment

Safety of the ward layout

- Staff assessed risks to patients and staff and were aware of the risks associated with the layout of their ward. Staff understood how to mitigate these risks and made regular checks of the ward environment.
- On each PICU ward, staff were well-informed about potential ligature risks and how to keep patients safe. Staff had access to an up to date ligature risk assessment which fully explained the location of potential ligature anchor points on the ward and in the outside space or garden. The staff teams ensured staff who were new to the ward were told about ligature risks and they discussed these risks at staff meetings and shift handovers.
- The PICU wards were, for the most part, well-designed with clear lines of sight, enabling staff to see patients as they moved around the ward to ensure they were safe. However, during the inspection, we noted a blind spot at the entrance to the visitor room on Caspian Ward that had not been noted on the ward risk assessment. We raised this immediately with the trust and managers acted to manage this risk.
- All the PICU wards were single sex. The size of the PICU wards varied, but all met national guidance. 14 beds is considered the safe maximum and Caspian had 13 beds, Nile and Shannon both had 12 beds and Colne Ward contained 8 beds.
- The PICUs had appropriate operational procedures in place in relation to the security of the wards. Staff carried out regular safety checks and followed procedures in relation to the management of keys and the locking of rooms. Visitors to the PICU wards and staff were issued with personal alarms. Staff tested alarm systems to ensure they worked well. Staff responded appropriately to alarms. Staff on the PICU wards were supported by staff from other wards when they pressed the alarm.
- Fire risk assessments were in place. Staff conducted fire drills with patients. Wards had fire extinguishers and other equipment available.

Maintenance, cleanliness and infection control

- The PICU wards were clean and well-maintained. Domestic staff cleaned the wards according to a schedule and kept records to show what they had cleaned. Patients confirmed that the wards were well-kept, clean and tidy.
- Staff and patients told us that any minor faults or repairs were usually swiftly identified and put right. On Caspian Ward, staff were concerned about a delay since December 2018 in fixing damage to the ceiling of the visitor room. We raised this with the trust and the ceiling was repaired during the inspection.
- There were weekly infection control audits. In addition, there were audits to check for maintenance issues.

Seclusion rooms

- Caspian, Nile and Shannon Ward patients used seclusion rooms which fully complied with the standards detailed in the Mental Health Act Code of Practice.
- Colne Ward patients did not have access to a seclusion room as there was no seclusion room on the Hillingdon Hospital site. If the multidisciplinary team on Colne Ward assessed a patient as needing to be placed in seclusion, they arranged for the patient to transfer to Caspian Ward. This had happened only once in the six months before our inspection. The Colne ward manager said that some patients from their catchment area went directly to Caspian Ward if it was felt their needs could not be safely met on a ward without access to a seclusion room.

Clinic rooms and equipment

- All PICU wards had clean, tidy and well-equipped clinic rooms.
- Equipment used by staff used to monitor the health of patients, such as blood pressure monitors, was clean and appeared well-maintained. We noted that pieces of equipment did not always have a sticker to indicate when it was last cleaned or serviced, so staff did not have this information immediately to hand.
- Staff on all PICU wards had access to equipment to use in an emergency, including ligature-cutters, a defibrillator, an oxygen supply and medicines. Staff made regular daily checks to ensure this equipment was readily available and safe to use.

Safe staffing

Nursing staff

- The trust specified the number of registered nurses and healthcare assistants required on each PICU ward to ensure patient and staff safety. Safe staffing levels were maintained on the wards. The trust reported an overall vacancy rate of 29% for registered nurses and a vacancy rate of 10% for nursing assistants across all acute and PICU wards on 30 September 2018. At the time of the inspection, all the PICU wards had some vacancies for registered nurses. PICU ward managers reported that the trust had a rolling recruitment programme but the recruitment and retention of registered nurses continued to be a concern for them.

- PICU ward managers told us that they could easily arrange for experienced trust bank staff to cover vacancies and sickness. These bank staff had experience of working on PICU wards and knew the patients and ward routines. Most vacancies were covered by bank staff, but sometimes agency staff were used if bank staff were unavailable. Patients said that the same group of staff worked with them throughout their stay on the PICUs.
- Staff told us that it was unusual for staffing levels to be below those specified, but there were occasions when this happened. They said when this occurred more senior staff worked directly with patients and they arranged for additional cover from nearby acute mental health wards. This ensured the safety of staff and patients. We observed that staff from other wards immediately attended the PICU wards to assist if extra staff were required due to patient need.
- PICU ward managers adjusted staffing levels to safely meet the needs of patients. The wards had specified minimum staffing numbers for each shift, which reflected the size of the ward. Ward managers booked additional staff to ensure the safety of patients and staff. For example, when the staff team needed to provide close observation for more than one patient.
- We saw that staff spent time with patients in communal parts of the PICU wards, talking and interacting with patients and ensuring they were safe. Patients told us that staff spent time getting to know them and they were offered daily one-to-one time with a member of staff.
- Staff teams carried out physical interventions safely in line with trust policy. Staff had regular refresher training on physical interventions. Staff told us that the training courses were effective and gave them a full understanding of the trust's restraint procedures and the confidence to safely respond to incidences of potential violence and aggression. New staff received a comprehensive induction to the service.
- Staff were available to carry out escorted leave as planned. Staff met with patients at the start of the day to discuss their escorted leave plans. They sorted out when and how it would take place. If the ward was busy, and staff were required to stay put to ensure ward safety, escorted leave was sometimes postponed for a short period. If this occurred, staff rearranged the leave with the patient.
- Staff teams acted to reduce the risks of banned substances and items coming onto the PICU wards. Staff carried out drug tests and searches on patients in line with trust procedures.

Medical staff

- PICU staff told us there was always sufficient medical cover. A doctor could quickly attend the ward in an emergency. Out of hours, there was cover from a duty doctor and a psychiatrist. Each PICU ward had an allocated psychiatrist supported by other doctors. Where there were vacancies for medical staff, there was locum cover in place.

Mandatory training

- The service provided mandatory training in key skills to all staff and there were systems in place to make sure everyone completed it. PICU ward managers held data on staff completion of mandatory training which showed a level of compliance of over 80% against a trust target of 95%. Staff advised us they were reminded about courses they were required

to complete. Courses included basic and advanced life support, infection control and children's and adult safeguarding.

Assessing and managing risk to patients and staff

Assessment of patient risk

- PICU multidisciplinary teams thoroughly assessed each patient on admission and then continuously reviewed and updated risk assessments. We read 25 patient care and treatment records across the four PICU wards. We also attended three multidisciplinary meetings.
- Referral information detailed known risks. On admission to the ward, the admitting doctor summarised the patient's current risks on the progress notes. The risk summary included information on the severity of the risks that had led to the PICU admission, risks to self or others of a physical, psychological or sexual nature, risks of self-neglect or other vulnerabilities, details of any alcohol or substance misuse and physical health risks. Nurses then completed more detailed standardised documentation on physical and mental health risks.
- There was ongoing review of risk through multidisciplinary team meetings and handover meetings between shifts. At these meetings staff discussed each patient to clarify whether risks had changed. The staff teams used a whiteboard during meetings to ensure they systematically reviewed the risks for each patient. Whiteboards included information about the patient's legal status, current risks and the type of staff observation required.

Management of patient risk

- Staff were aware of the risks for each patient in relation to self-harm, leaving the ward and violence and aggression to staff, patients and others.
- The admitting doctor formulated an immediate risk management plan which outlined how staff should observe the patient.
- The multidisciplinary team continuously adjusted risk management plans to ensure that interventions kept patients and staff safe but were not overly restrictive. At multidisciplinary meetings and handover meetings, staff reported the patient's response to care and treatment, their mood and behaviour and any other indications of changed levels of risk. The staff team then made decisions about how current risks should be managed. For example, when a patient's mental health improved and risks were reduced, the staff team reduced the level of observation and arranged for the patient's discharge from the PICU.
- Patients were not allowed to use smart phones on the PICU wards, whereas they could on the acute wards. Staff told us this was because of increased risks due to the vulnerability and acuity of the patients on the PICU wards. At the time of the inspection, the trust was in the process of introducing new computers to the PICU wards for patients to use under supervision.
- The trust had a no smoking policy but patients could use e-cigarettes; they complained to us about the expense of these.

Use of restrictive interventions

- The table below shows restrictive interventions used on the PICU wards in the 12 months from 1 October 2017 to 30 September 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Caspian	87	128	45	39 (30%)	62 (48%)
Colne	0	61	20	18 (30%)	34 (56%)
Nile	33	92	42	20 (22%)	45 (49%)
Shannon	47	144	43	37 (26%)	71 (49%)

- At the previous inspection, in October 2016, CQC told the trust it must take further action to reduce the number of incidents of prone restraint and other forms of restraint across the service and reduce the variations in the use of restraint between different trust locations.
- At this inspection, across all acute and PICU wards, there was a decrease in the number of restraints in the 12 months from 1 October 2017 to 30 September 2018 compared to the previous 12 months. At this inspection, we found that for the PICU wards, the variations in the numbers of restraints were probably due to differences in the size and function of the wards, rather than significant differences in practice between wards. Staff we spoke with were committed to reducing the amount of restrictive practice used.
- The highest number of restraints and the highest number restraints resulting in rapid tranquilisation was on Shannon Ward, the female PICU ward. Staff on Shannon Ward attended conferences and events in relation to female PICU issues. Staff told us that conference speakers reported that national data showed that the use of all restraint is significantly higher in female PICUs, compared with male PICUs, and so are the rates of self-harm and violence to staff.
- At the previous inspection, in October 2016, CQC told the trust it must ensure that physical observations following rapid tranquilisation were consistently carried out and recorded. Since then, the trust had introduced new protocols for staff and a robust monitoring and governance arrangements.
- At this inspection, staff were well-informed about their responsibilities in relation to physical observations following rapid tranquilisation. Staff kept records which showed how they had attempted to avoid the use of restrictive interventions. There were full details about how the restraint had been carried out and how long the patient was restrained.
- Staff told us that the trust now had ‘zero tolerance’ of restraint in the prone position but had acknowledged the challenges that staff face on acute and PICU wards.
- Matrons audited all incidents of restraint to clarify the reasons for any use of prone restraint and whether it could be avoided. The trust had clarified the most common circumstances

which justified the use of prone restraint for the safety of patients and staff in a September 2018 quality and performance committee paper.

- Care and treatment records showed that staff followed trust procedures with regard to restraint. In addition, there were debriefs with the patient and the staff involved in the incident.
- Staff safely assessed and managed risks to patients, staff and others. Staff followed best practice in anticipating, de-escalating and managing behaviour that challenged. Staff told us that they were focused on preventing violence and aggression. They said they had received training on the use of de-escalation techniques and learnt from the way more experienced colleagues dealt with difficult situations.
- Staff said they were committed to understanding the reasons for disturbed behaviour. We observed that multidisciplinary meetings were used to analyse patterns of behaviour and to anticipate and prevent triggers for violence and aggression. For example, on Nile Ward at a ward round, staff spoke with a patient about reducing their current level of distress through improving contact with their family. Staff told us how they talked with patients and used distraction techniques to calm down volatile situations. Care plans included suggestions from patients about what staff should do if the patient was upset or angry. We observed that staff put these plans into action, for example by supporting a patient to move to a quieter part of the ward when they were becoming upset.

Safeguarding

- PICU multidisciplinary staff teams understood multi-agency procedures to protect patients from abuse and the service worked well with other agencies to do so. Wards had local safeguarding leads. There were trust leads for adult and children's safeguarding who staff could contact for advice.
- Staff ensured that patients were protected from bullying and harassment whilst on the ward. Patients told us they felt safe on the wards and were confident that staff would act to keep them safe from harm.
- Staff had received training on safeguarding children. Children could not come onto the PICU wards but there were designated visiting areas.

Staff access to essential information

- At the time of the inspection, the trust was in the process of introducing a new electronic patient record system. Contingency arrangements were in place to ensure that staff could access and record essential information on patient care and treatment during the changeover.
- From our review of care and treatment records completed prior to 25 January 2019, there were appropriate records in place. Records were clear and up-to-date. The trust used the same system throughout most of its services, therefore it was easy for staff to access the information needed when patients moved between services.

Medicines management

- PICU ward staff prescribed, gave, recorded and stored medicines well. Patients received the right medicines at the right dose at the right time. Staff followed trust procedures in relation to the safe management of medicines. These complied with National Institute for Health and Care Excellence (NICE) guidance.
- On each PICU ward, a registered nurse kept the keys to the clinic room, medicines cupboard, trolleys and controlled drugs cabinet. Fridge and clinic room temperatures were monitored to ensure that medicines were stored within the correct range. A full range of in-date emergency medicines was available for use if required. Medicine stocks were well-organised. For example, on Nile Ward, different types of medicines were stored in separate cupboards to minimise the possibility of a medicines error.
- We checked 33 prescription charts across the four PICU wards. Staff had fully completed the charts to show that patients had received their medicines as prescribed. In the case of 'as required' medicines, there were details of the maximum dose the patient should be given in 24 hours. Staff recorded the patient's allergies on the prescription chart in line with NICE guidance.
- Each PICU ward had an allocated pharmacist to support the safe prescribing and administration of medicines. The pharmacist attended ward rounds to offer advice and ensure best practice. For example, on Shannon Ward, a pharmacist had reviewed a patient's records when a query was raised during initial assessment about an adverse reaction to medicines. The pharmacist then gave advice about the safety of medicines for the patient.
- Some patients were on high doses of antipsychotic medicines. The prescribing of high dose antipsychotics was closely monitored by the trust to ensure best practice was followed. At multidisciplinary meetings pharmacists provided advice on safe prescribing and how patients' health should be monitored. Patients received the appropriate physical health screening tests when they were taking high dose antipsychotic medicines.
- All medicines related incidents were recorded on the trust database. These were followed up by the ward manager and then reviewed by the trust's medicines safety officer. Incidents were discussed at ward meetings and at the quality safety meeting. Any learning was circulated via the quarterly medicines learning bulletin.

Track record on safety

- There was one serious incident reported in the PICU wards between 19 October 2017 and 19 October 2018, this was on Nile Ward.

Reporting incidents and learning from when things go wrong

- Patient safety incidents were well-managed. PICU staff were trained in the trust's reporting procedures. They recognised incidents and reported them appropriately.
- Staff could explain to us what incidents should be reported and knew how to make a report. Ward managers had clear information on what incidents had occurred on their ward and the lessons learnt.

- Team meeting notes included information on incidents and the lessons learnt. Staff told us that, in addition, they received information on lessons learnt through trust newsletters, emails and briefing meetings for staff.
- Since the last inspection the trust had set up a PICU forum to enable trust staff from the different PICU wards to meet and learn from each other to improve practice.
- Staff understood the duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.
- Staff said ward managers, matrons and more senior staff had been responsive and caring when incidents had occurred.

Is the service effective?

Acute wards for adults of working age

Assessment of needs and planning of care

- Staff assessed patients' mental and physical health care needs on admission, completing mental health, physical health, risk and medicines care plans. We looked at 68 care and treatment records across the acute wards. Staff usually received assessment information from referrers prior to the patient's admission to the ward.
- Staff assessed patients' physical health needs in a timely manner after admission. These assessments included recording patients' pulse, oxygen saturation levels, respiration rate, weight, and review of electrocardiogram and blood test results. If staff were concerned that patients had been taking drugs or drinking alcohol, they carried out a urinary drug screen.
- At St Charles, patients with a first presentation of psychosis had a CT (computed tomography) or MRI (magnetic resonance imaging) scan. This was to exclude any physical causes for their symptoms before treatment commenced. The physical health assessments provided to patients on admission exceeded NICE guidance.
- Care plans were designed to be completed together with patients. On most wards patients' care plans were written in plain English. They were detailed, relevant to the patients' admission to hospital, and fully addressed all of the patient's needs. Patients' care plans were highly personalised and recovery-orientated. Staff developed care plans that met the needs identified during assessment. For example, care plans included steps to address assessed needs, such as homelessness and self-neglect.
- However, on a few wards, care plans were of variable quality. On Amazon Ward, some patients' care plans were incomplete. Important areas were left blank, or just contained the phrase 'explore further', 'no action' or 'none identified'. Sometimes these areas had been identified elsewhere as areas of potential need. Patients' care plans were not detailed, holistic or recovery-orientated. They did not describe how nursing staff should care for the patient.

- At the Gordon Hospital, some care plans lacked detail, many were generic, or descriptive, without clear instructions on the support to be provided. Overall, they were not recovery orientated, did not show meaningful involvement of patients, and were not reviewed on a regular basis. It was not always clear when care plans had been updated, as new information was not dated. We found that patients' progress notes included more up to date information, indicating that they might be used in place of care plans. Ward managers told us that care plans were an area for improvement. However, the handover process was used for risk management and ongoing care planning was visible in some of the progress notes.
- At the Gordon Hospital, for patients requiring intermittent observations, the form used contained tick box only, and did not include a space for recording which staff member had undertaken the observation. This was not robust in terms of ensuring staff accountability for the observations.
- In October 2016, we recommended that the trust should ensure that 'Modified Early Warning Signs' (MEWS) records, then in use, were monitored and appropriate action taken in response to changes in patients' physical health. At this inspection we found this had improved. Staff recorded physical observations and assigned scores which helped them to make a decision about the need for intervention.

Best practice in treatment and care

- Staff teams provided a range of personalised interventions which included medicines, psychological therapy and therapeutic and rehabilitation activities.
- Psychological treatments recommended by the National Institute for Health and Care Excellence (NICE) were available for most patients. Care records showed that patients could access cognitive behaviour therapy and other evidence-based psychological therapy, including toolbox coping skills, tree of life, music, art therapy and mindfulness groups. The service at Park Royal had recently employed three additional assistant psychologists to increase the amount of therapeutic support for patients and to facilitate reflective practice sessions with the staff teams.
- Psychological assessment and treatment for patients at St Charles was limited. There was one clinical psychologist for Danube, Ganges and Thames wards. However, there were plans to introduce assistant psychologists to each ward. Amazon Ward did not have an assigned clinical psychologist and we were told there were no plans to provide this.
- Occupational therapy groups had a strong therapeutic focus and changed on a regular basis to reflect patients' needs. At the time of the inspection, groups included 'understanding what works for me', 'understanding self- harm', 'stigma and discrimination' and 'introduction to stress'. These groups took place in the week and were generally held on or near the wards. All patients, unless risk assessed otherwise, could access these groups.
- Patients had access to specialist physical healthcare when needed. For example, two patients had been admitted to a ward following a period of severe self-neglect which had led to significant weight loss. These patients were seen by a dietician within the first 48 hours of their admission. The dietician created a diet plan for these patients to support them to regain weight they had lost.

- Patients told us they could ask to see a doctor if they felt physically unwell. Staff escorted patients to the local acute hospital when they required specialist care. Registered nurses ensured that there were appropriate physical health assessments and investigations recorded for each patient. The trust was planning to implement a new system for monitoring and recording physical health needs. Staff ran a physical health clinic for patients on all wards. All patients had their vital signs checked at least once a week. During our inspection, a patient with a heart condition had their vitals checked four times a day. Routine health screens were carried out and standardised risk assessments were completed, for example, for patients at risk of falls. Staff talked with patients and clarified any substance misuse issues. On Danube Ward, a dual diagnosis worker visited the wards regularly to work with patients with substance misuse problems.
- On all the wards, staff supported patients to live healthier lives. For example, staff at the Gordon Hospital received training called 'making every contact count'. Part two of this training covered how to support patients to live healthier lives. Patients told us staff supported them to be physically active and they had access to the gym and other opportunities for exercise. Staff had completed levels 1 and 2 of smoking cessation training. Staff provided various nicotine replacement therapies such as gum, patches and inhalators. Electronic cigarettes were available to buy from a machine on site.
- Patients were provided with enough food and drink to meet their needs and improve their health. Care plans showed staff confirmed with patients whether they had any dietary requirements related to their health or religion. Patients told us they could easily obtain food which satisfied them and met their needs.
- The service monitored the effectiveness of care and treatment and used the findings to improve it. The service used recognised tools to measure and monitor patient progress and outcomes.
- Staff were engaged in a range of quality improvement projects. For example, to promote safer leave for informal patients.

Skilled staff to deliver care

- On each ward in the service, staff from the full range of mental health disciplines provided input to the planning and delivery of patient care and treatment. This normally included consultant psychiatrists, doctors, nurses, healthcare assistants, occupational therapists, clinical psychologists and pharmacists.
- We spoke with a total of 121 staff from across the range of mental health disciplines during the inspection. Staff had the appropriate skills and qualifications to work on acute wards for working age adults. Some of the staff we interviewed had worked within the service for several years, whereas others were newly appointed. Staff said the trust supported them to develop their skills through formal training courses. There were also ward based learning events.
- The trust had increased its use of peer support workers who now worked across more wards. These were ex-patients who shared their lived experiences with the aim of encouraging current patients to reflect on their own recovery and make positive, long-lasting changes in

their lives. Feedback from staff and patients suggested that peer support workers had a positive impact on the wards and patient recovery.

- New bank staff members, working on a ward for the first time, had an induction to the ward. Staff followed a checklist to ensure new staff were given all appropriate information about the ward, the patients and key procedures.
- Staff at Northwick Park spoke particularly highly of their access to training. Local training opportunities for staff included sessions on professional boundaries and learning disabilities. The whole service was working towards becoming more 'psychologically minded'. In addition, using the skills and knowledge of addictions possessed by key members of staff within the service, staff had access to a programme of 'bite-sized' sessions on substance misuse. The first session was on correct use of a breathalyser.
- Informal non-clinical training also took place at the Campbell Centre. For example, staff from the local Department of Work and Pensions office had recently briefed relevant staff about universal credit prior to its introduction in Milton Keynes. This meant that staff could pass on information about the changes in benefits to patients.
- Danube Ward had piloted the role of 'extended practitioner'. This involved extending the usual role of a senior clinician. In addition to their usual role, the staff member used their knowledge, skills and experience for more in-depth work with patients. Papers were being written for Health Education England and journals, and there was interest in the role from health services in Australia.
- On some wards there was more than one consultant psychiatrist assigned, usually because they worked part-time. In some cases this worked well, but in other cases there was a need for more coordination between them to ensure clinical leadership.
- Staff were not always provided with regular supervision on a regular basis. We reviewed 40 supervision records. Staff told us they felt supervision to be helpful and supportive when it occurred. Half of all the supervision records we reviewed were detailed and meaningful and focused on patient care, staff performance and development needs. However, the others were limited to discussions about annual leave, sickness and training, with little mention of patients' needs or ward duties.
- Team meetings did not take place regularly on all wards and, when they did, they were not always recorded in a way that would help an absent staff member to catch up. In addition, we saw some minutes that read like a long list of reminders to staff and did not evidence any discussion. The infrequency of these meetings on some wards was partially mitigated by handover meetings between nursing staff as urgent information was shared there.
- At Riverside, the service manager led quarterly training and development forums for healthcare assistants within the unit.
- Managers dealt with poor staff performance promptly and effectively. Managers said that they addressed poor performance through goal setting and performance monitoring. The hospital matrons and the human resources department had assisted ward managers with this.

Appraisals for permanent staff

- The trust's target rate for appraisal compliance was 95%. At the end of last year (31 March 2018), the overall appraisal rate for staff within this service was 86%. This year it was in line to improve and stood at 91% on 31 October 2018.
- Staff working with the trust for over a year reported that they had appraisals on an annual basis.

Ward name	Total number of permanent staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 October 2018)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Thames Ward	18	18	100%	80%
Frays Ward	27	27	100%	50%
Ebury Ward	28	28	100%	94%
Shore Ward	22	22	100%	95%
Caspian Ward	17	17	100%	100%
Nile Ward	23	23	100%	94%
Ganges Ward	18	17	94%	95%
Pond Ward	17	16	94%	94%
Eastlake Ward	17	16	94%	80%
Ellington Ward	24	22	92%	96%
Shannon Ward	24	22	92%	92%
Crane Ward	11	10	91%	75%
Gerrard Ward	27	24	89%	89%
Hazel Ward	25	22	88%	85%
Pine Ward	16	14	88%	95%
Colne Ward	16	14	88%	100%
Willow Ward	28	24	86%	85%
Amazon Ward	19	16	84%	95%
Vincent Ward	24	19	79%	44%
Danube Ward	19	14	74%	100%
Ferneley Ward	22	16	73%	82%
Core service total	**442**	**401**	**91%**	**86%**
Trust wide	**4506**	**4163**	**92%**	**87%**

Multi-disciplinary and interagency team work

- All wards held a short multi-disciplinary meeting (whiteboard meeting) each weekday which was attended by all staff disciplines.

- Meetings were well conducted and effective. Each ward had a whiteboard listing all patients, with columns for the tasks to be completed. The whiteboard assisted the staff team to monitor progress in care and treatment which was important given the high turnover of patients on the wards. Representatives from the joint homelessness team, community mental health teams (CMHTs), home treatment teams and early intervention teams sometimes attended the whiteboard meetings to inform themselves about patients due for discharge.
- Ward rounds tended to be held quite frequently as many patients did not stay on the wards for long periods so needed to be seen quickly. On Ebury Ward at the Gordon Hospital, ward rounds were ad-hoc which meant it was difficult to prepare patients or invite carers or external representatives to attend. When possible, external teams attended ward rounds to exchange information and plan for the patient's discharge from the ward. There was representation from community teams.
- We attended eight handover meetings during the inspection. The meetings on most wards were efficient and effective (Thames Ward was the exception). In the handover meetings we observed, staff ensured that key information about each patient was shared. This included risk information and an update on the patient's current mental and physical health. Staff also shared information about any meetings or appointments the patient had in relation to housing or welfare benefits. Staff told us handover meetings were very useful and enabled them to start their shift with a clear picture of the priorities for their work with patients.
- We attended five bed management meetings where the ward managers, senior staff, community team representatives and discharge co-ordinators all attended. Each patient was discussed and information about potential issues affecting discharge was logged. Actions were discussed to prevent delayed discharges and placement issues. There was a multi-disciplinary approach to this meeting and staff appeared knowledgeable about patients' personal circumstances.
- The ward teams had effective relationships with community mental health services and other organisations. For example, at Park Royal, staff from the Citizen's Advice Bureau provided advice sessions for patients twice a week. Patients with substance misuse issues at Northwick Park could access a local independent provider of substance misuse services whilst on the ward and their treatment and support continued after discharge when appropriate.
- At Northwick Park, mental health staff were paired up with colleagues from the adjacent general hospital 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 on 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 mutually beneficial reciprocal training were seized by members of the staff team who raised awareness of mental health within a lot of local agencies in exchange for briefings on issues, such as housing.

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

- Training in the Mental Health Act 1983 (MHA) was not mandatory across the trust. An online training course on the MHA was introduced in July 2018. The trust's Mental Health Law office provided additional face-to-face training on subjects including patients' rights, capacity and consent to treatment and leave for detained patients.
- Staff were trained in and had a good understanding of the MHA, the Code of Practice and the guiding principles. During our interviews, staff explained the key areas of the MHA that applied to patients on their ward.
- Staff had easy access to local MHA policies and procedures and to the Code of Practice.
- Detained patients told us that ward staff encouraged them to take their authorised leave, although some advised that escorted leave was sometimes cancelled due to short staffing. On some wards it was postponed and taken at a later time or date.
- The whiteboard used by the multidisciplinary teams included information on the completion of tasks in relation to the MHA. For example, informing the patients of their rights.
- However, paperwork concerning patients' detention and treatment was not always available to staff at St Charles. Patients' detention papers were meant to be uploaded to their electronic patient record, but this did not happen reliably for medical recommendations and the approved mental health professional applications and reports.
- Also, at St Charles, certificates of consent (T2) or second opinion (T3) were not attached to patients' medicine administration records. Twice on Ebury Ward, and once on Vincent Ward, the certificates of second opinion (T3) did not cover the administration of a medicine (or the route of administration) on the medicine administration records. On the records of one patient for whom a T2 certificate was in place, there was no corresponding assessment recorded in the notes. These omissions contravened the MHA 1983 Code of Practice guidance. They increased the risk that staff could dispense medicines to patients without lawful authority. On the records of two patients for whom T3 certificates were in place, there was no evidence of the treating clinician's communication of the outcome of the second opinion appointed doctor's (SOAD) visit.
- We met with representatives from the Mental Health Law office at different sites. They sent prompts every week, by way of a spreadsheet, advising the ward staff of all legal matters that required attention.
- Staff completed regular audits to ensure that the MHA was being applied correctly and there was evidence of learning from those audits. Staff in the mental health law office completed an audit of records relating to staff giving information to patients about their detention each week.
- An Independent Mental Health Advocate (IMHA) visited the wards each week, more often if required. Contact information was displayed on the wards so patients could liaise directly with the IMHA.

- All of the acute wards had locked doors and signs were posted by all of the entrance doors of the wards to indicate that informal patients had the right to leave and could ask staff to open the doors for them.

Good practice in applying the Mental Capacity Act

- Training on the Mental Capacity Act 2005 (MCA) was not mandatory trust-wide. However, aspects of the MCA were covered in mandatory training on safeguarding adults. This training had been completed by 93% of staff.
- Staff had a good understanding of the MCA, in particular the five statutory principles.
- The provider had a policy on the MCA. Staff were aware of the policy and had access to it on the staff intranet.
- Staff knew where to get advice regarding the MCA. Local mental health law office staff provided initial advice to ward staff. If the matter was more complex, further advice was available from senior members of the mental health law team at the trust's head office or the safeguarding adults team.
- Across all the wards on the Park Royal site, we saw evidence to suggest that staff assessed and recorded capacity to consent for all patients who might have impaired mental capacity. They did this on a decision-specific basis with regard to significant decisions. Doctors routinely recorded assessments of patients' capacity to consent to admission and to treatment when patients were admitted. These assessments were reviewed during multidisciplinary team meetings.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. For example, a patient lacked capacity to reliably administer their insulin injections for diabetes. However, the patient wanted to continue administering injections themselves. In response, staff arranged to supervise the patient to ensure they did this at the right time and at the correct injection site.
- However, on all the other wards, there was little documentation relating to assessments of capacity to consent to treatment on the files examined. Where a patient had their treatment authorised by capable consent there was no supporting evidence to indicate how this judgement had been arrived at. We could not find clear records of the treating clinician's assessment of patients' capacity to consent following admission or before the first administration of medication.

Psychiatric intensive care unit (PICU)

Assessment of needs and planning of care

- The PICU wards provided care and treatment based on national guidance and evidence of its effectiveness. Staff assessed patients' mental and physical health care needs on admission. We looked at 25 care and treatment records across the four PICU wards. Staff received referral information from trust colleagues prior to the patient's admission to the PICU

ward. Referrals included an explanation of why the patient could not receive care and treatment on an acute ward.

- On admission to the PICU ward, a doctor made a mental and physical health examination of the patient and carried out routine blood tests. The doctor then made a brief interim care plan until a more detailed care plan was developed by nursing staff.

- Staff understood the importance of addressing physical health issues. Some patients on the wards had complex long-term health conditions, for example, kidney disease. Staff liaised with relevant specialist healthcare teams to make sure that the patients' needs were fully addressed. Care plans addressed any additional physical health monitoring that the PICU ward staff needed to carry out and detailed how patients would be escorted to specialist appointments in other hospitals.

- Staff teams were aware of the potential negative impact on the physical health of patients from the side effects of antipsychotic medicines. We observed that ward doctors asked patients about these issues, and, in conjunction with the ward pharmacist, planned how to minimise the impact on the patient.

- Staff completed a template assessment and care plan on the patient's physical health needs. Staff followed protocols in relation to making observations of patients' vital signs on admission and during their stay. The frequency of observations was kept under review and was varied according to the physical health care needs of the patients. Care plans specified how diabetes, asthma and other conditions were monitored and managed. Staff ran weekly clinics where they offered patients a range of physical health checks and monitored patients' weight. Staff gave patients advice on keeping healthy and maintaining a healthy body weight. Patients said they had access to a gym and could take exercise in the fresh air. They said they were offered help to stop smoking and to eat a healthy diet.

- Staff assessed patients' sleeping patterns and discussed with patients ways of improving their sleep. For example, on Nile Ward, a healthcare assistant told us how they had worked with a patient to develop their night time routine and supported them to use music as a form of relaxation before they went to bed.

- Staff developed personalised care plans together with patients and ensured they were updated weekly. Patients told us that they were aware of the content of their care plan and had been involved in their development and review. There was information on any advance directives from the patient and how staff would provide care and treatment during the patient's admission.

Best practice in treatment and care

- The staff teams on each PICU ward followed operational procedures which specified the criteria for transfer between the acute wards and the PICU wards. PICU ward staff liaised with colleagues in the acute wards to clarify issues and ensure that transfers to the PICU

ward were appropriate. We observed that, at multidisciplinary meetings, transfer back to an acute ward was discussed and planned at the earliest opportunity.

- Medical staff and pharmacists worked in close collaboration to optimise the medicines for patients, particularly for those patients who had been assessed as resistant to treatment. Multidisciplinary teams closely monitored how patients responded to medicines and changed treatment plans accordingly.
- Patients could participate in therapeutic activities. Occupational therapists and activity co-ordinators assessed patients' skills and interests and supported patients to occupy their time. Wards had kitchen areas which patients could use with staff supervision to practice life skills. Art and drama therapists provided sessions for patients.
- Patients were provided with enough food and drink to meet their needs and improve their health. Care plans showed staff clarified with patients whether they had any dietary requirements related to their health or religion. Most patients told us they could easily obtain food which satisfied them and met their needs. Some patients told us they did not like the food. At each PICU site there were arrangements for staff and patients to give feedback on the quality of the meals to the responsible contractor.
- The service monitored the effectiveness of care and treatment and used the findings to improve care and treatment. The service used recognised tools and rating scales to measure outcomes and monitor patient progress.
- Staff carried out a range of clinical audits. For example, matrons carried out a monthly audit at each site on rapid tranquilisation and restraint.

Skilled staff to deliver care

- Staff from a range of mental health disciplines provided input to the planning and delivery of patient care and treatment. This included consultant psychiatrists, doctors, nurses, healthcare assistants, occupational therapists, and pharmacists. Art therapists, music therapists and aromatherapists worked across the service. Staff teams could make referrals to clinical psychologists.
- We spoke with 19 staff during the inspection. Both permanent staff and bank staff had the appropriate skills and qualifications to work on a PICU ward. Some of the staff we interviewed had worked on PICU wards for several years, whereas others were newly appointed. New staff, and bank staff working on a ward for the first time, had an induction to the ward. Staff said the trust supported them to develop their skills through formal training courses. There were also ward based learning events. Some staff had attended national conferences and training courses specifically for staff working on PICU wards.
- The trust made sure staff were competent for their roles. Each staff member's work performance was appraised annually and they were monitored their competence to carry out their work role. Staff told us they found the annual appraisal helpful in terms of setting objectives to develop their skills and knowledge.
- Staff on all the wards told us they us they received supervision about once a month which they found supportive and helpful. On Colne Ward, supervisors completed a supervision

template which covered issues of relevance to staff working on a PICU ward, such as responding to difficult situations and one-to-one work with patients, as well as staff wellbeing. However, on the other PICU wards, supervision records were usually very brief and it was not clear what issues had been discussed or whether any goals had been set in terms of work with patients.

- Ward managers told us they could get advice from their managers and the trust human relations specialists in relation to any staff competence issues.

Multidisciplinary and interagency team work

- Staff of different kinds worked together as a team to benefit patients. On all PICU wards, doctors, nurses and other healthcare professionals worked effectively in partnership to plan and provide personalised care and treatment. All wards had a daily (Monday to Friday) short multidisciplinary meeting which was attended by all disciplines. We observed two such meetings. Whiteboards were used as a visual tool to ensure the multidisciplinary team reviewed levels of risk, care and treatment issues and how the patient was observed.
- All wards also held weekly ward rounds which patients attended. When appropriate, external professionals, such as care coordinators, and the patient's family also attended.
- There were effective handovers between outgoing and incoming nursing staff twice each day. Staff told us that handovers were used to update them on each patient's current mental and physical health and the management of risks. Staff described handover meetings as well-structured and said they clarified the issues for each patient and covered any safety issues.

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

Good practice in applying the Mental Health Act

- Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. MHA detention papers received by ward staff were checked by the mental health law office staff who also organised Mental Health tribunals and hospital managers' hearings. Mental health law office staff visited wards to complete audits and to provide advice. Staff informed patients of their rights and independent mental health advocates (IMHA) visited the ward to support patients at ward rounds and in relation to tribunals.
- Care and treatment records confirmed whether staff had explained the patient's rights. Patients told us they knew how to contact the IMHA.

Good practice in applying the Mental Capacity Act 2005

- Staff were trained in and had a good understanding of the Mental Capacity Act (MCA) and the five statutory principles of the Act. They understood the trust's policy on the MCA. Doctors admitting patients to the PICU wards made a brief record of the patient's mental capacity in relation to admission to the ward and consent to care and treatment.

Is the service caring?

Acute wards for adults of working age

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We saw staff engage with patients in a caring and thoughtful way.
- We received mixed feedback from patients about the care they received. Most patients spoke positively about the care and support they received from staff. For example, at Northwick Park, patients spoke positively about day and night nursing staff and members of the multi-disciplinary team. On Pine Ward, where we interviewed four patients, they all said the nurses treated them well. Patients on Danube Ward were extremely positive regarding the staff team; they said that staff took time to understand them and their needs and they appreciated the consultant psychiatrist's informal Christmas day visit. On Crane and Fray wards most patients were also positive about the care and support they received.
- We observed that most staff had good interpersonal skills and demonstrated their interest in what patients were saying through their body language and the way they spoke with patients. At the Gordon Hospital there was a high turnover rate of patients, and the named nurse system was used to ensure staff spent time talking and getting to know patients. Ward managers built 'protected time' into the daily routine for staff to spend time with patients in the afternoons.
- However, two patients we spoke with on Pond Ward said they were not treated with respect. One patient said staff were rude to them and another said there were often different staff on duty and they did not introduce themselves. At St Charles two patients made negative comments concerning how they felt after being restrained by staff. Two patients on Crane Ward said there were insufficient staff during the night shift. Two patients on Ebury Ward told us that staff did not always knock before opening the blind on their bedroom door, which did not respect their privacy.
- We met with the manager of the advocacy service for the Gordon Hospital. They noted that key issues raised by patients included having leave requests declined, staffing issues, communication and information, lack of activities at weekends, smoking restrictions, and ward environments. They said there had been recent improvements in communication and accountability from staff, who now ensured the least restrictive options were used to maintain safety.
- Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, at Park Royal, the Citizens Advice Bureau held advice sessions at the hospital twice every week. Staff supported patients to attend these sessions for advice on housing benefit and immigration matters. At Northwick Park, there was

information available on the ward from a national third sector organisation about mental health problems and information about a local day service and the trust's wellbeing recovery college.

- At Riverside, the occupational therapy team had collaborated with local organisations and businesses to provide food parcels for patients getting discharged from the wards.
- Staff on all the wards said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff maintained the confidentiality of information about patients.

Patient-Led Assessments of the Care Environment (PLACE)

- The 2018 Patient-Led Assessments of the Care Environment (PLACE) scored privacy, dignity and wellbeing at all six service locations higher than similar organisations. Some of the scores were inclusive of other wards on the same site.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Hillingdon Hospital (Riverside)	CHS - Community Inpatients MH - Acute wards for adults of working age and psychiatric intensive care units MH - Wards for older people with mental health problems MH - Long stay/rehabilitation mental health wards for working age adults	95.7%
Park Royal	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Secure wards/Forensic inpatient MH - Other Specialist Services	94.9%
St Charles	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Wards for older people with mental health problems	93.7%
Gordon Hospital	MH - Acute wards for adults of working age and psychiatric intensive care units	94.4%
Northwick Park	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Wards for older people with mental health problems	91.9%
Campbell Centre	MH - Acute wards for adults of working age and psychiatric intensive care units	93.3%
Trust overall		**93.4%**
England average (mental health and learning disabilities)		**91.0%**

Involvement in care

Involvement of patients

- There was evidence that staff tried hard to communicate with patients so that they understood their care and treatment, even though patients were often acutely unwell and found it very difficult to engage. We observed staff trying to engage patients and ascertain their views during multidisciplinary meetings and in activity sessions.
- We received mixed feedback from patients on the wards, regarding the admission process and orientation of patients to the ward and to the service. At Park Royal some patients said they had no orientation to the ward. We raised this with the trust and we found they had taken steps to provide an orientation when we made an unannounced return visit to Park Royal on 19 March 2019. At St Charles some patients were not always provided with information and orientated to the ward and the same applied to patients at Riverside.
- Staff involved patients in care planning and risk assessments. Patients' views were recorded in all the care plans we reviewed at Park Royal. On Ganges and Thames wards there was evidence that patients were involved in the development of their care plans as their patients' views were recorded and a patient spoke of being listened to when discussing their medicine with their consultant. On Danube Ward, patients were central to all aspects of their care and treatment. Patients at Northwick Park and Riverside were mostly involved in developing their care plans.
- However, on Amazon Ward there was little or no evidence that patients had input into their care plans. At the Gordon Hospital most care plans did not include the patient's views. Staff told us that some patients did not wish to work with them on their care plans or were too unwell to fully participate. It was not always clear if staff had offered patients a copy of their care plan.
- At St Charles patients co-designed the new patient café and patients were also part of the recruitment panels for senior staff. Peer support workers who were former patients were employed to work on Crane and Frays wards to support patients.
- Staff enabled patients to give feedback on the service they received through a variety of options. Patients could speak to their named nurse, or raise issues during their meetings with clinical staff, with support from the independent advocate if need be. In addition, patients attended weekly community meetings where issues relating to the running of the ward were discussed. Patients could also fill out patient feedback questionnaires. Some patients at Riverside told us that their feedback was not always responded to. For example, on Crane Ward, the television had not been working for over four weeks despite patients raising awareness of this.
- Each ward at the Gordon Hospital had a 'tree of hope' on a wall in the communal area where patients could leave messages about positive experiences and their recovery as a way of encouraging other patients to feel they too could recover and move on from the ward.
- The Campbell Centre's social recovery team had co-produced a number of resources with patients. A leaflet about what to expect from a ward round had been produced and a ward information booklet for patients was in production.
- Staff ensured that patients could access independent advocacy services across all sites.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. For example, at Park Royal family members attended multidisciplinary team meetings. On Pine Ward the consultant designated one day every week for appointments with patients' families. At Northwick Park and Riverside carers were invited to the ward round, with patients' consent. Most patients told us their relatives were generally involved in their care, particularly in relation to discharge planning.
- The Campbell Centre had a service user and carer improvement group. This was held every two months and involved current carers and patients and people who had left the service. We saw that patients were engaged in a pilot of the trust recovery college model in Milton Keynes and the development of the ward welcome pack.
- Staff enabled families and carers to give feedback on the service they received at all the locations we inspected. At St Charles a carers group was due to start shortly after the inspection. Park Royal facilitated a friends and family group once a month, and records showed carers discussed many concerns such as poor communication from hospital staff, care plans and a lack of follow up for after patients were discharged. The service also displayed 'you said, we did' notice boards to specifically show how they had responded to comments from patients' families and friends.
- However, at the Gordon Hospital family and carers were not routinely invited to ward rounds, unless specifically requested by a patient. Ward managers confirmed that there was no active carer involvement, although the ward manager on Vincent Ward had recently started holding family surgeries.

Psychiatric intensive care unit (PICU)

Kindness, privacy, dignity, respect, compassion and support

- PICU staff treated patients with compassion and kindness. Patients told us that staff were friendly, polite and respectful. We observed that staff communicated with patients in a calm and honest way when giving them information about their care and treatment. Staff interacted with patients in a professional way when unwell patients were verbally abusive towards them.
- Patients told us that staff respected their privacy and knocked before entering their bedrooms. The nurses' stations were well soundproofed and patient information was kept confidential with whiteboards in areas that were not visible to patients. Staff did not speak with each other about patients in communal areas.

Involvement in care

Involvement of patients

- The staff teams supported patients to understand why they were on a PICU ward. They involved patients in planning their care and treatment and moving on from the ward. For example, in a ward round, a psychiatrist talked with a patient about the reasons they had come into the PICU and the progress that the patient had made in terms of their mental

health. They talked with the patient about becoming an informal patient and transferring to an acute ward. The patient was encouraged to give their point of view and staff made sure the patient fully understood what was planned. We also observed that doctors and pharmacists asked patients about any side effects of their medicines and offered advice and treatment.

- Staff gave patients written information about the ward when they were admitted. This included information about community meetings, ward rounds and the roles of different staff members. The rules, routines and activities of the ward were set out. There was information on meals, behaviour towards others and visitors and making complaints. Patients could access information leaflets about medicines. Staff assisted patients to print the leaflets from the trust website. These were available in other languages, large print, and easy-read format.
- Staff told us that when a patient was admitted to the PICU they were usually too unwell to take an active part in discussing their care plans. Care and treatment records showed that staff tried to involve patients as much as possible in planning their care.
- On all the PICU wards, staff involved patients in giving feedback and planning improvements to the service. For example, on Caspian Ward, staff were conscientious about supporting as many patients as possible to complete 'friends and family' questionnaires during one to one sessions every week. Patients generally gave positive comments about the attitude and behaviour of staff, their care and treatment and the condition of the ward environment. Patient views on the quality of meals varied. On all the sites there were arrangements for patients and staff to meet with the contracted caterers to improve the meals service for patients.
- Patients on all the wards participated in daily planning meetings and community meetings. We read notes of community meetings which showed staff acted to address concerns raise by patients. For example, new computers and tablets were due to be delivered to the wards at the time of the inspection.
- Patients told us advocates attended each ward and contact details for advocates were on display on the wards. Nile and Shannon wards benefitted from the input of a service user and carer engagement worker. The postholder supported patients from Nile Ward to develop a community gardening project. They were working with patients and staff on Shannon Ward to improve the ward environment.

Involvement of families and carers

- Staff involved families and carers appropriately and provided them with support when needed. Staff told us that they aimed to involve the families and carers of patients as much as possible. Care and treatment records showed that staff encouraged and supported families to attend ward rounds and visit patients on the ward. Visitor rooms had information on local resources for carers.

Is the service responsive?

Acute wards for adults of working age

Access and discharge

Bed management

Bed occupancy

- The trust provided information regarding average bed occupancies for 20 wards in this service between 1 October 2017 and 30 September 2018.

Ward name	Monthly bed occupancy range	Annual average bed occupancy
Amazon Ward	109 - 151	122
Campbell Centre (Hazel Ward and Willow Ward)	89 - 113	98
Caspian Ward	62 - 99	86
Colne Ward	76 – 98	92
Crane Ward	98 – 122	108
Danube Ward	100 - 118	107
Eastlake Ward	104 - 115	109
Ebury Ward	100 - 118	110
Ferneley Ward	114 - 137	120
Frays Ward	104 - 134	119
Ganges Ward	106 - 121	116
Gerrard Ward	103 - 115	109
Nile Ward	88 - 102	96
Pine Ward	103 - 127	114
Pond Ward	85 - 118	98
Shannon Ward	39 - 103	73
Shore Ward	87 - 114	102
Thames Ward	98 - 120	108
Vincent Ward	110 - 128	118

- Ward managers said the wards were almost always fully occupied. All wards carried out daily bed management meetings to remove any barriers to discharge of patients. All but one of the wards within this service reported average bed occupancies above the nationally recommended threshold of 85% over the 12 month period from 1 October 2017 to 30 September 2018. Only Shannon Ward had an average occupancy below 85% for the same period. A bed occupancy rate above 100% shows that the ward admitted patients to beds allocated to other patients who were on overnight leave from the ward. At Northwick Park patients had access to an assessment lounge for short periods until a bed became available.

- Bed pressures meant that the escalation beds on Gerrard and Vincent wards were frequently in use for longer than one night, contrary to trust guidance. In addition, they were not always used for settled patients. This meant that patients who might be very unsettled were admitted to a very small bedroom, where, in the event of restraint, it was not always possible to do this in the supine (safer) position. We raised this with the trust and the escalation rooms were closed down. We confirmed this at a return unannounced visit on March 2019.
- Patients were sometimes admitted to wards other than those for their borough. When a bed became available on a ward catering for their borough they were usually transferred there. If no beds were available at a specific hospital site, a 'black alert' was raised, and this information was shared across the trust.
- Staff said transfers to the trust's male PICU wards occurred smoothly and happened in a timely manner. When PICU beds were not immediately available, patients were managed on the acute ward under 1:1 observation.
- At Park Royal, staff could transfer male patients to a PICU on the Park Royal site. However, commissioning arrangements meant that female patients requiring intensive care were transferred to a private hospital that was 25 miles away from Park Royal, instead of a PICU run by the trust that was four miles away. This meant that the continuity of care was more likely to be disrupted and it was more difficult for patients' families to visit them in intensive care. Staff explained that these arrangements meant they were often reluctant to transfer female patients to intensive care and, therefore, patients with a high level of acuity often remained on the ward which increased risks. When we returned to Park Royal on an unannounced visit on 19 March 2019 we found that Pond Ward was taking a more pro-active approach to referring women in need of intensive care to the private provider in order to maintain appropriate quality and safety standards on the ward.
- There was always a bed available when patients returned from leave. Responsible clinicians granted overnight leave to patients, usually with support from the home treatment team, in preparation for their discharge. For example, during the inspection, nine patients on Pine Ward and four patients on Pond Ward were on overnight leave. When a patient left the ward on overnight leave, the ward allocated their bed to a new patient. This created a risk that the patient would not be able to return to the same ward if they needed to come back before the end of the planned period of leave. However, staff explained that turnover of patients on the ward meant that beds became available each day. If a patient did need to return, they would be given priority when the beds were allocated.
- When patients were moved or discharged, this happened at an appropriate time of day. Staff made decisions about discharge at multidisciplinary team meetings each morning.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. At Park Royal, throughout the multidisciplinary team meetings and bed management meetings, staff demonstrated a detailed understanding of patients' lives and social circumstances.

Average Length of Stay data

- The trust provided information for average length of stay for the period 1 October 2017 to 30 September 2018.

Ward name	Monthly length of stay range	Annual Average bed occupancy
Amazon Ward	30 – 57	43
Campbell Centre (Hazel Ward and Willow Ward)	40 – 64	51
Caspian Ward	36 – 67	55
Colne Ward	29 – 88	59
Crane Ward	32 – 64	42
Danube Ward	17 – 51	31
Eastlake Ward	35 – 55	45
Ebury Ward	58 – 76	69
Ferneley Ward	33 – 57	46
Frays Ward	83 – 109	95
Ganges Ward	38 – 81	54
Gerrard Ward	46 – 78	59
Nile Ward	48 – 86	66
Pine Ward	38 – 58	45
Pond Ward	23 – 45	34
Shannon Ward	21 – 42	32
Shore Ward	24 – 43	32
Thames Ward	38 – 71	52
Vincent Ward	38 – 54	46

Out of Area Placements

- The number of out of area placements attributed to the service had significantly reduced in the last 12 months. For example, in the six months from April to October 2017, the service at Park Royal recorded 2,517 out of area days for its patients, with an average of 210 bed days per month. In the same period for 2018, the service recorded 271 out of area days, with a monthly average of 23 bed days per month.

Discharge and transfers of care

- Between 1 October 2017 and 30 September 2018 there were 3,189 patient discharges within this service. This amounted to 66% of the total discharges from the trust overall (4,832).
- Staff planned for discharge, including good liaison with care co-ordinators. The service tracked the progress of every patient each day to identify and monitor any potential difficulties in relation to discharge. Senior staff from the community mental health teams, home treatment teams and the local authority housing department attended the wards and bed

management meetings each day. These staff addressed any barriers to discharge and made arrangements for care and support in the community.

- Staff used the 'red to green' system, to ensure that all patients were taking positive steps towards discharge. This included checking that patients had appropriate identity documents, access to benefits, a care coordinator if applicable, and a discharge destination, whilst taking account of physical and mental health needs, risks, and safeguarding issues. Where necessary trust staff supported patients to be returned to their country of origin, liaising with relevant mental health services there. Some embassies were quick to support and transfer home their nationals, whereas others were difficult to engage with. The patient flow co-ordinator supported ward staff when they were experiencing challenges working with other organisations. This was particularly relevant to Riverside, which had Heathrow airport nearby and dealt with numerous international patients.
- Managers informed us that delayed discharges were usually due to a lack of suitable onward placements for patients. Borough directors and management staff worked with housing organisations to identify suitable homes for patients and to try to increase capacity. Delayed discharges across the 12 month period ranged from three to 14 per month, which amounted to 3% of the total discharges from this service.
- Patients were only moved between wards during an admission episode if it was justified on clinical grounds or it was nearer their home and the move was in the best interests of the patients. For example, transfers from a mixed sex ward to a single sex ward.
- Staff supported patients during referrals and transfers between services. For example, if patients required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit (PICU). We noted that when a patient required an admission to an eye clinic, staff accompanied the patient, and stayed with them until they were ready to return.
- Staff carried out home visits with patients, when needed, prior to their discharge. Pharmacists also met with patients to speak about their medicines during the discharge process, and ensured that there were arrangements in place to provide patients with their prescribed medicines to take away on departure.

Facilities that promote comfort, dignity and privacy

- Some of the wards contained dormitory accommodation, but funding had been identified for the elimination of dormitories, other than at the Campbell Centre in Milton Keynes.
- Dormitories aside, not all premises offered complete privacy and dignity for patients. For example, patient bedrooms located on one side of the Gordon Hospital were within sight of private dwellings across the street. Curtains were provided, however as the rooms had clear glass windows, we were concerned the privacy and dignity of patients could still be compromised, as members of the public could see into rooms with ease. In addition, a whiteboard used for patient information was within sight of one of these windows overlooked by private dwellings and included full names of patients. There was no cover available for this board when not in use. We discussed these issues with senior management. When we made an unannounced return visit to the Gordon Hospital on 25 March 2019 we saw that frosted film had been applied to the lower sections of the relevant windows.

- The décor of Danube Ward was bright and colourful and Ganges Ward had recently been redecorated. Other wards were generally light and bright. In contrast, Amazon Ward and Thames Ward were drab and the balcony and lounge area on Amazon Ward were uninviting. Dormitories on Pond Ward were particularly sparse and lacked any homely touches. At St Charles, there were rips in the sofas on Danube and Thames wards.
- All bedroom doors on Willow and Hazel wards at the Campbell Centre were fitted with an observation panel with integrated blinds that could be operated by patients with an external override feature that staff used. On other wards, the observation panels could only be operated by staff. This might compromise patients' privacy and dignity.
- On Ganges Ward, a quiet room had been converted to a bedroom. This bedroom was used when no other beds were available overnight. There was a bathroom next door which was locked due to ligature risks. A patient using this bedroom would have to ask staff to unlock the bathroom if they wished to use it. Use of this bedroom did not follow the Mental Health Act Code of Practice. Following a Mental Health Act visit in 2017, the trust had advised that the use of this room as a bedroom would eventually be discontinued, but it was still in use.
- Similarly, at the Gordon Hospital site, the design, layout, and furnishings of the service did not always support patients' privacy and dignity. No rooms had ensuite facilities and there were recurrent plumbing problems in the shared bathrooms and toilets. There were insufficient private rooms available for meetings between patients and clinicians. Although the lounges had hot water facilities, tea, coffee and cups were all stored in the main area at the other end of the ward. The female lounges did not have an operational television at the time of the inspection. Staff on each ward told us that the female lounges were rarely used. Storage facilities were so limited that some patients' belongings had to be stored in the doctor's office. However, when we made an unannounced return visit to the ward on 25 March 2019 we saw there were more storage options on the wards with the closure of some beds.
- On all other wards, staff and patients had access to the full range of rooms and equipment needed to support treatment and care. All the wards had clinic rooms, an activity room, gym access and interview rooms. Patients could meet with visitors in lounges and interview rooms on the wards. The service also had designated family rooms where patients could meet visitors, including children when appropriate, away from the ward environment.
- Patients could personalise bedrooms to some extent. For example, some patients displayed photographs on their bedroom walls. At community meetings, patients on Pond Ward frequently complained about belongings being stolen or going missing. This caused some patients to feel upset and unsafe. When we made an unannounced return visit to Pond Ward on 19 March 2019 we found that patients were receiving more support to access their lockers and to familiarise themselves with the keypad lock.
- Patients had limited access to outside space at Park Royal, the Gordon Hospital and Riverside Centre. Patients there told us that there were often not enough staff to take them outside. On most wards, patients were only able to use gardens if they were supervised by staff.
- Patients were generally satisfied with the quality and choice of food. The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at all six locations was higher than similar trusts. Patients told us they could make or had access to hot drinks at any time.

- Patients could keep their own mobile phones unless there were specific risk-related reasons they could not. For patients who could not keep their mobile phones the ward had a pay phone.
- Not all wards had access to computers for patient use. While wifi connectivity was available within the Gordon Hospital, staff and patients were not aware of the password. Patients told us that they thought the wifi was not working.
- During the week patients were provided with a range of activities on each ward. Activities available to patients ranged from book clubs, walking groups, baking, cooking, pottery, creative groups, gardening, morning stretches, yoga, and women's groups. Not all activities were available on all wards as staff took account of patient preferences. However, although we raised this at the previous inspection, there was still very little available for patients at weekends and in the evenings.

Patients' engagement with the wider community

- Patients could attend sessions at the trust's wellbeing and recovery college whilst staying at the hospital, with a view to continuing after discharge. As most patients were only on the ward for a short time, occupational therapists advised patients about work and leisure opportunities which the patients could access on discharge.
- The service user engagement lead at St Charles arranged for various community organisations to become involved with the patients. Staff from a local volunteer centre met with patients to discuss a wide range of volunteering opportunities when they were discharged from hospital. The producer and director of a local theatre company had read through plays with patients whilst they were developing productions. This culminated in patients attending one of the shows at the theatre. The play-reading group was continuing, and a further group was planned for when patients were discharged from hospital.

Meeting the needs of all people who use the service

- Staff assessed the cultural and spiritual needs and preferences of patients and planned care and treatment to meet their diverse needs. The pastoral care team came to the wards regularly and had representatives from different faiths. Patients could access faith room facilities from all wards. Appropriate food was available to accommodate religious needs and personal preferences. Meal times and medicines were adjusted to accommodate periods of fasting.
- The service took steps to create an environment where lesbian, gay, bisexual and transgender (LGBT+) patients felt welcomed and able to talk about their sexuality. For example, the service had provided training for staff and staff who could offer support to patients who identified as LGBT+ had rainbow coloured lanyards so patients knew who to approach.

- When the service admitted international patients or those seeking asylum, staff liaised with the Home Office and local organisations that provided support.
- All of the wards had designated rooms and bathrooms for patients with mobility problems. These included wider doors so wheelchair users could be accommodated.
- Staff ensured that patients could obtain information about treatments, local services, patients' rights, how to complain and so on. Across the wards information was displayed about how patients could complain about the service, how patients could contact the independent mental health advocate, activity timetables, smoking cessation help and menus. Much of the information could be made available in different languages or accessible formats on request.
- Managers ensured that staff and patients had easy and prompt access to interpreters and/or signers. Staff booked interpreters to assist patients during assessments, at ward reviews and to help patients understand their detention and rights under the Mental Health Act.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

- Staff knew how to handle complaints and supported patients to follow the complaints procedures. This included helping them to write a formal complaint. Information about making complaints was available on the wards and provided to new patients as part of their orientation to their ward. Patients were aware of the ward manager's role and told us they would raise a concern with a ward manager in the first instance. Patients said they felt that the staff team listened to them when they raised a concern.

- Ward managers said they received support to deal with complaints in line with the trust's policy. They said that if there were learning points from a complaint they discussed these with the individual staff member concerned or the whole team as appropriate.

- When patients complained or raised concerns, they received feedback. When patients made a formal complaint they received a response from the relevant divisional director. Responses included full details of the findings of any investigation and the reasons why the complaint had been upheld or not upheld.

- This service received 72 complaints between 1 November 2017 to 31 October 2018. Six of these were upheld, 18 were partially upheld and 26 were not upheld. One was referred to the ombudsman.

Compliments

- This service received 109 compliments between 1 November 2017 to 31 October 2018. Some of them were on display in the wards.

Psychiatric intensive care unit (PICU)

Bed management

- The three male PICU wards (Caspian, Nile and Colne) provided beds according to catchment areas. Ward managers said that sometimes, due to bed management issues, a PICU ward admitted a patient from outside their catchment area. Two of the beds on Colne ward were commissioned by the immigration removal centre.
- Shannon ward was used by female patients from all trust catchment areas. Four beds on Shannon ward were available for other trusts to purchase. At the time of the inspection, only two of these beds were in use. Shannon Ward had the lowest average bed occupancy rate of the acute and PICU wards at 73%.

Discharge and transfers of care

- Staff told us that transfer from the PICU wards to trust acute wards generally went smoothly. However, during the inspection we observed that a patient became very distressed when they were told they could not go to an acute ward as planned, because there was no bed. We also heard of a two-week delay in transferring a patient on a different PICU to an acute ward. Staff felt this delay was due to the PICU admitting this patient from outside their usual catchment area. The process for transferring the patient back to their 'home' acute ward was not running smoothly.
- Multidisciplinary teams were mindful of the additional restrictions placed on patients on a PICU ward and were proactive in planning for patients to move off the ward once risks had reduced. Staff made timely referrals to external teams to begin the process of arranging for patients to go to other care and treatment settings.

Facilities that promote comfort, dignity and privacy

- The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. Patients on PICU wards had their own bedroom and bathroom.
- Wards were clean and well maintained with suitable furniture.
- Patients could ask staff to lock their rooms to keep their possessions secure. There were rooms for patients to talk with visitors in private. There were communal rooms on wards with televisions, computers and games available. Patients had access to a gym. Patients could access outside space.
- Patients gave different views about the quality and choice of food. There was ongoing liaison between staff, patients and the contracted caterer for the hospital sites to improve patient satisfaction with food.
- Each ward had a kitchen for patients to prepare their own food with staff support. Patients told us they could make hot drinks at any time.

Patients' engagement with the wider community

- Occupational therapists and occupational therapy assistants were included in the ward staff teams, although there were some vacancies. On Colne Ward, the ward manager had arranged for a healthcare assistant post to be re-designated as an activities coordinator post. Staff and patients said this was working well and contributed to patients being more involved in purposeful activities. Wards had a set programme of activities which included weekend activities. Most patients told us there were enough activities available to prevent them getting bored. Patients said they enjoyed the groups and activities on offer which included art and music therapy, yoga, tai chi, gym, pampering and relaxation groups and creative writing.

Meeting the needs of all people who use the service

- Staff assessed the cultural and spiritual needs and preferences of patients and planned care and treatment to meet their diverse needs. Cultural and religious needs were addressed in care plans. Patients had access to meal options which met their religious and dietary needs. Religious leaders visited the PICU wards if staff requested this. Staff accessed an interpreting service when this was needed.
- Staff could give examples of how they would support patients in relation to lesbian, gay, bisexual and transgender issues (LGBT+). Wards displayed posters to state they were safe places for LGBT+ patients. Staff were alert to the possibility of bullying and harassment on the ward. Staff were aware of patients who may be vulnerable and had plans in place to manage risks. Patients reported that they felt safe on the wards.

Listening to and learning from concerns and complaints

- Concerns and complaints from patients and carers were treated seriously. Managers investigated concerns and complaints. Lessons were learnt from the results of investigations and the complaint investigator and ward manager shared these with staff.
- Patients told us they knew how to raise a complaint. They said they were given information on how to make a complaint when they were admitted to the ward. Patients said they could raise concerns easily at community meetings or directly with the ward manager. Patients said they felt that the staff team listened to them when they raised a concern. They said they could ask to speak to a doctor, nurse or the ward manager in private. Issues raised by patients were followed up, for example, in relation to complaints about the food menu.
- Ward managers told us their line managers supported them to deal with formal complaints in line with the trust's policy. Any learning points from a complaint were discussed with the individual staff member concerned or the whole team as appropriate.

Is the service well led?

Acute wards for adults of working age

Leadership

- Leaders at all levels had a very good understanding of local services and the needs of the diverse local population. The senior management teams at all six sites were very visible and could describe how, in most instances, the quality of care was being maintained and improved. The leadership team at the Gordon Hospital was being strengthened and new appointees were well-regarded. Staff said managers encouraged them to raise any concerns and they provided 'hands on' support when required. Patients told us ward managers and matrons were approachable and they could talk to them informally and at meetings.
- Staff said that the trust's most senior staff visited the wards on occasion and spoke with patients and staff. Senior borough directorate staff were based on the sites which they managed.
- Leaders had a good understanding of the services they managed. In particular, new managers at Gordon Hospital were aware of a wide range of improvements needed there. All managers had access to leadership training at various levels, and aspiring leaders training could be accessed by certain categories of junior staff.
- The service managers held a weekly operations meeting, which was used to discuss service improvements, such as reducing restricting interventions.
- Ward managers said they received good support from modern matrons who knew the staff and patients well.
- Patients told us ward managers and matrons were usually on the ward and they could easily talk with them informally and at meetings. Staff said that managers encouraged staff to raise any issues with them and provided 'hands on' support when required.
- However, we found that there were several issues which had not been noted or addressed by the management teams and senior leaders across the service. For example, recurrent issues regarding the environment at Park Royal had been raised through various means, but not resolved. Similarly, management were unaware of the mixed-sex accommodation breaches within Vincent and Gerrard Wards.

Vision and strategy

- The trust's senior leadership team had successfully communicated the trust's vision and values and staff knew how they were applied to the work of their team. Staff were aware of the trust's values of compassion, respect, empowerment, and partnership. Staff at the Campbell Centre expressed that they felt very much part of the trust, despite being outside London.

- Staff could explain how they were working to deliver high quality care within the budgets available. For example, managers were able to explain how they had saved money by reducing the number of out of area placements, whilst ensuring that patient care was not compromised.

Culture

- Different professions worked well together and respected each other's roles. Staff were empowered to make decisions and to take responsibility.
- Most staff felt respected, supported and valued by their line manager and their colleagues. However, staff morale was low at the Gordon Hospital was low following a safeguarding incident on one of the wards which meant there were some changes to staffing. Recognising the dip in morale, senior managers had offered to meet with staff individually or in groups, but there had been little take up. Staff on Thames Ward also had low morale, but this was mainly linked to trying to run the service without a ward manager and with a number of vacancies. Senior managers were working to fill the posts.
- Most staff felt positive and proud about working for the provider and their team. The majority of staff across different wards felt that the trust supported new initiatives and was keen to drive improvement.
- Most staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian.
- Managers dealt with poor staff performance when needed. Ward managers gave examples of how they had addressed poor performance by setting objectives and monitoring the employees' progress towards achieving these objectives.
- On Danube Ward, there was a strong culture of teamworking, continuous improvement and innovation. A universal 'can do' attitude permeated throughout the staff team. Staff were free to develop ideas to improve the safety and care of patients. It was similar on Pine Ward, at the Campbell Centre and at Northwick Park.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff said that in past, senior staff had not been ethnically diverse, unlike the rest of the trust employees, but this was changing. Staff said there were now more staff from black and minority ethnic groups in senior positions.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.
- The provider recognised staff success within the service. For example, the trust had invited patients and carers to nominate staff for annual awards.

Governance

- At a senior level, there were strong governance arrangements in place. Managers met each month to review serious incidents, complaints, lessons learned from incidents, action plans and feedback from patients and their families. On the whole there was good feedback to the wards from these meetings, but the information flow was hampered by the lack of regular team meetings or similar on some wards.
- Managers had taken action to address some significant concerns. For example, they had succeeded in reducing out of area placements. Managers had worked closely with clinicians and colleagues in community teams to address this issue. The progress made in being able to discharge patients more easily had also led to the service being able to close some beds on Pond and Pine wards to facilitate the elimination of dormitories.
- However, staff on some wards felt that senior management was not always as responsive as it could have been. We found that whilst issues were often in the process of being addressed, staff were not always kept informed of progress or explicitly told when nothing could be done. For example, when repairs were not forthcoming or when staffing levels were not reviewed.
- Managers did not all have systems in place to monitor the quantity and quality of staff supervision was in line with the trust policy.

Management of risk, issues and performance

- Staff knew how to escalate issues, including to the risk register. Safer staffing information was completed daily so that senior management could monitor and have an overview of the staffing requirements on each ward.
- The service held a quarterly meeting around learning from serious incidents. This meeting was open to all staff and lessons shared were circulated to all staff through meetings and newsletter bulletins. However, we found the infrequency of team meetings and staff supervision impacted on information flow within some wards.
- Senior managers had ensured that contingency plans were in place for an emergency, such as adverse weather conditions. Each site worked with their local clinical commissioning group (CCG) and nearby acute hospitals to make sure plans were robust.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives. Nurses on each ward completed regular audits of infection control, the ward environment and care plans. The governance team audited restraint and rapid tranquilisation. This helped improve practice and address risks on many wards. On some wards there was insufficient evidence of action following audits. For example, on Pond Ward in response to environmental audits. Some new ward managers told us they did not have access to audit information for their ward.
- The elimination of dormitories was a top priority for the service and funding had been secured and plans made to do this for all but one inpatient site.

Information management

- At the time of the inspection, the trust was moving to a new electronic patient record system which would better enable staff to record important clinical information, such as the outcomes of physical health checks. Although staff were still getting to grips with the new system, the service had the benefit of it already being in use at the Campbell Centre in Milton Keynes, so they could be assured that, once staff were familiar with it, the new system would meet the needs of acute inpatient wards.
- The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff had improved access to the equipment and information technology needed to do their work as the new electronic patient record system was more compatible with mobile working which benefitted senior staff and clinicians who moved between sites or wards.
- Patient confidentiality was maintained by robust electronic systems, including smart cards to control access.
- Ward managers had access to live online information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information provided to them was accessible, timely, accurate and identified areas for improvement.
- Staff made notifications to external bodies as needed. For example, the service notified the local authority of safeguarding concerns.

Engagement

- The senior leadership teams at all sites visited the wards often. Staff and patients told us they were visible and approachable.
- There were systems in place to gather feedback from staff, patients and carers. Various methods were employed to make it as easy as possible for people to pass on their views. For example, community meetings with patients, staff surveys and the friends and family test.
- This feedback was discussed in management meetings and actions were planned in response. On some wards, the action taken or planned was not well-communicated back to staff or patients, but the system worked effectively on most wards.
- Patients and carers had access to up-to-date information about the work of the trust through regular news items on the trust's website. Staff also had access to an excellent intranet site.
- Managers always met with patients to explain when something had gone wrong. For example, a manager had met with a patient to apologise for staff response times.
- The wards acted on carers' suggestions. They had introduced a 'you said, we did' board, which covered issues raised by carers and how they had been addressed. For example, on one ward a carer had suggested that a board with staff photos and their names should be placed in the visitor's room and we saw that this had been put in place.

- Leaders engaged effectively with external stakeholders. For example, at Park Royal commissioners were involved in discussions about arrangements to discharge patients with complex needs on a weekly basis. This helped to ensure that decisions about funding placements for these patients were made quickly.
- Similarly, leaders at Riverside attended police liaison meetings alongside other key agencies to resolve identified issues and plan improvements for multi-agency working. They had also worked with staff at Heathrow airport and local agencies working with homeless people to improve the admission pathways for people requiring an acute bed.

Learning, continuous improvement and innovation

- Management within the Campbell Centre had facilitated the development of the innovative social recovery team which was engaged in coproduction activities with patients and proactive discharge planning. Managers supported creative problem solving.
- Clinical psychologists at the Campbell Centre organised an annual conference to enhance learning and development. In 2018 the theme had been compassion in care, with keynote speakers presenting the latest research and insights from practice and lived experiences. We noted that this had had an impact on the way staff thought about their role, as staff told us they tried to demonstrate compassion in their daily contact with patients and families.
- Staff had excellent access to training and development. This included tailored leadership courses for staff who identified as Black, Asian or minority ethnic (BAME). We spoke with some staff who had trained as mentors and were using these skills on the wards. At Riverside the service manager led a series of forums for healthcare assistants. These forums were full day training and development sessions where healthcare assistants from across the hospital got together on a quarterly basis to share learning. At Northwick Park the wards were working towards having a more psychologically informed approach to all aspects of patient care and staff were engaged in a training programme.
- Staff across most wards were involved in quality improvement (QI) projects in order to improve the service. For example, the safer leave project which helped to minimise the risks when informal patients went on leave from the ward. They had received training in the QI approach and it was becoming embedded in practice.
- Ad-hoc safety huddles were increasingly used to discuss incidents and learning from them. On Pond Ward, where this initiative had just started, a staff member took the lead for safety huddles and brought incidents from other parts of the trust to staff attention, alongside local incidents, whenever there was some learning to be had.
- The service sought to make good use of staff skills and knowledge. For example, some managers at Northwick Park had previously worked in addictions services; they offered staff systematic ‘bite-sized’ learning opportunities where they passed on their expertise in this area of work as it was also applicable to the acute wards.
- Physical health leads were in charge of overseeing the physical health audits and were given protected time to do this. This ensured the response to patients’ physical health needs was monitored.

- Wards worked jointly for the benefit of patients, when needed. For example, on the Team Working Is Safer Together (TWIST) project An extensive piece of work involving team building and consultations with staff over the course of a year. The project had achieved significant results on the wards where it was used with a 40% reduction in restraint, an 80% reduction in prone restraint and a 47% reduction in seclusion.
- Wards were encouraged and supported to achieve accreditation. The Campbell Centre and Crane Ward at Riverside had achieved the Accreditation for Inpatient Mental Health Services (AIMS). Other acute wards were working towards achieving this accreditation. We noted that the associated peer reviews had brought benefits. For example, one of the wards at the Campbell Centre had purchased new equipment so patients' mobiles could be charged safely and securely after seeing it in use on another ward.

Psychiatric intensive care unit (PICU)

Leadership

- The PICU wards had managers with the right skills, knowledge and experience to perform their roles. Ward managers, matrons, and consultant psychiatrists had experience of working in acute and PICU mental health inpatient services. Staff had relevant professional qualifications. Ward managers said they received close support and guidance from the matrons, who they described as very 'hands-on' and knowledgeable. Both patients and staff said that ward managers and matrons were approachable and open to listening to their point of view.
- Ward managers could clearly explain the role of the PICUs and how the care pathway operated in relation to admission and discharge from the PICU. They could explain to us how they worked with the staff team to encourage good communication and supportive behaviour. Staff teams were positive about working on the PICUs and told us had confidence in the leadership of the PICUs to develop and improve the service.
- Staff said the trust provided them with a lot of opportunities to develop their skills. Nurses and healthcare assistants had lead roles for key areas on the PICUs and developed their expertise in areas such as physical health, staff wellbeing and personality disorders. Staff said they had been supported to attend internal and external learning events and to share their knowledge with the wider team to improve practice.

Vision and strategy

- Staff knew and understood the trust's vision and values and how it applied to their work. For example, they could explain how they showed compassion and respect when they worked with patients. Staff told us that the trust provided Christmas presents for patients which demonstrated compassion towards patients who otherwise may not have received presents.

- Staff said the trust was working to continually improve the service. For example, on Shannon ward the trust had recently provided funding to enhance the ward environment. Staff had the opportunity to participate in awaydays or discussions to discuss the service strategy and the improvements that were being considered.

Culture

- Staff felt respected, supported and valued. They said that the trust promoted equality and diversity. Staff said managers took their caring responsibilities and other issues into account when organising duty rotas. They said their managers encouraged their personal development and career progression. Healthcare assistants and nurses told us they were supported to develop specialist areas of knowledge through trust training programmes.
- Staff knew about whistleblowing procedures and said they would feel able to raise any concerns without fear of retribution. No staff reported bullying or harassment on the wards we inspected.
- Staff told us that managers asked for their views. They felt that managers treated them with respect and took their views into account. All the PICU staff we spoke with said team morale was high on the ward they worked on and said they were proud to work in the service.
- Managers reviewed staff performance through supervision, appraisals and audits. Managers took the necessary action to deal with any competency issues. The trust celebrated success through a staff awards scheme.

Governance

- Our findings from the other key questions demonstrated that, for the most part, the trust's governance processes operated effectively at ward level on the PICU wards and that performance and risk were managed well. Ward teams included a full range of mental health professionals. The service had clear admission criteria and well-developed discharge processes.
- Staff carried out audits to check the maintenance of the wards, the implementation of the trust's procedures on restrictive practices, record-keeping and the management of medicines. Wards staff had access to trust specialist staff who ensured compliance with safeguarding procedures and the Mental Health Act. However, we found that supervision records were variable in quality and better systems were needed to monitor the quality and quantity of supervision to make sure it was in line with trust policy.
- There was a framework of community meetings with patients, handover meetings, ward rounds and multi-disciplinary meetings. Ward managers attended meetings with matrons and the acute mental health ward managers in their catchment area. A PICU forum was now in place which staff found useful in terms of developing good practice. Staff had the opportunity to learn from incidents and complaints.

Management of risk, issues and performance

- Ward managers were aware of the key risks on their wards and these were reflected in the risk register. Risks recorded included risks in relation to the recruitment and retention of registered nurses and the financial implications of using agency nurses.

Information management

- At the time of the inspection the trust was in the process of introducing a new electronic patient record system for the PICUs and other wards.

Engagement

- The service engaged well with staff, patients and carers to obtain feedback about the service and make improvements. Each ward displayed a list of actions taken following requests by patients in the patient community meetings in the form of 'you said - we did' posters. Additionally, patients were encouraged by staff to complete surveys about the ward. There was generally a good level of satisfaction with the wards.

Learning, continuous improvement and innovation

- Staff on the PICUs were had the opportunity to learn from other PICUs in the trust through the PICU forum. They also attended events organised by the PICU national association. Colne Ward was due to participate in a national research programme on reducing restrictive practice. Caspian Ward had been awarded with an accreditation from the Royal College of Psychiatrists' Quality Network for PICUs (QNPICU).

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

Is the service safe?

Safe and clean environment

- The environment in which care was delivered met the needs of patients and staff. We visited services in a range of locations from new purpose-built buildings shared with a GP practice to converted buildings and buildings leased from the local authority.
- All the sites and services we visited were visibly clean, had adequate furnishings and were well-maintained. Cleaning records were up-to-date and premises were cleaned regularly.
- Fire risk assessments had been completed in the services. Where actions had been identified in the risk assessments, they had either been completed or action plans had been developed to address them. Staff carried out regular fire alarm checks.

- Access to all buildings was controlled. In some buildings, this included books to sign visitors in and out, so services were aware of the number of people in the building. Access to buildings after hours was restricted to members of staff. Each building had waiting areas for members of the public coming to visit staff. The psychosis teams in Milton Keynes had a small waiting area which was shared with the child health visitor clinic. The risk of a joint waiting area had been raised internally, but actions taken as a result were not clear.

- Staff had access to alarm systems whilst seeing patients in team bases. At our last inspection in August 2017, staff in Milton Keynes did not have access to an appropriate alarm system. At this inspection, staff in all services we visited could access alarms. The specialist therapies team (STT) and urgent access team (UAT) had access to audible personal alarms. Elsewhere across the trust, there were panic alarms available to use in patient interview rooms. The use of these had been risk assessed. Across the service, there were no routine tests of the panic alarms to provide regular assurance that the system was working. This was actioned during our inspection visit.

- Staff could access emergency equipment when required. Defibrillators were available in each team office. Staff in the services knew where the emergency equipment was stored. In Milton Keynes, the psychosis service was based next to a GP surgery which had a defibrillator. This was clearly sign-posted to ensure staff could access it in an emergency. Emergency equipment, including first aid materials and emergency medicines, was checked on site and all equipment had been calibrated.

- Clinic rooms used in the team bases we visited were clean and contained the necessary equipment for physical examinations. However, in Milton Keynes, the service had ordered a new electrocardiogram machine because the current one had a fault. This meant that patients were temporarily unable to have their heart activity monitored. The urgent access

team in Milton Keynes did not have access to a treatment room. This meant that they could not complete any physical health assessments so they relied on GPs to complete any physical health examinations.

- Staff adhered to infection control principles, including handwashing. A quarterly hand hygiene audit was completed, during which the staff member completing the audit observed whether other staff followed the hand washing process. Posters detailing the correct hand washing technique were displayed at each sink area for staff to refer to.

Safe staffing

- Managers within each borough had a good understanding of the staffing requirements in their localities. Staffing levels varied significantly across the teams we visited. This was due to the different team functions and the organisation of services which varied between the boroughs.
- The provider was in the process of reviewing the provision of community mental health teams (CMHT) for adults of working age across the trust. Some changes had taken place in the six months prior to our inspection. For example, in Brent, the service had split from two CMHTs covering north and south Brent, into three teams which covered specific localities which were aligned to GP practices. The trust was committed to learning from change programmes that had taken place in different parts of the organisation.
- The service as a whole reported a vacancy rate for all staff of 15% as of 30 September 2018.
- Vacancies varied between the teams we visited. Staff across Brent and Hillingdon told us that they felt stretched due to the staffing levels. We saw that in some teams the vacancy levels were at risk of impacting on care delivery. For example, at the time of our inspection, at the Harness (Harlesden and Neasden) CMHT in Brent there were seven full-time equivalent (FTE) vacancies out of an establishment of 12 FTE care coordinators (usually nurses or social workers). These posts were covered by locum staff who were booked long term, but there was the risk that this would impact on the continuity of care for patients.
- In the urgent access team in Milton Keynes, where the establishment was 6.6 FTE mental health practitioners, there were three vacancies at the time of our inspection and two of the team were on long term sick leave. Managers had succeeded in covering one post with a long-term agency member of staff, which meant there were 2.6 FTE mental health practitioners covering 6.6 FTE posts. They had attempted to recruit to these posts but had not been successful. The team prioritised screening referrals to maintain safety, but assessment times for routine referrals had increased. This meant that there were some parts of the service where the staffing levels were having a significant impact on service delivery, particularly in the area of recording and updating assessments.
- In addition, in Hillingdon, some of the establishment levels for nurses were not sufficient to meet the needs of the local population, but this had been recognised by the trust and there were plans in place to address this. For example, in Hillingdon North there was an establishment of only three nurses.

- Caseloads varied across the service. For example, in Brent we were told that care coordinators had approximately 30 cases which were a mix of people who required care coordination and those for whom they were lead professional contact. However, four care coordinators we spoke with told us they had caseloads in excess of 30. They said they found their workload difficult to manage in the time available. In Hillingdon there was a distinction between nurses who held caseloads of 30 and social workers who held caseloads of 20. This was because social workers in the teams held additional functions, such as leading on safeguarding investigations. Staff told us that it led to additional pressure, particularly around staffing the duty system. In the recovery and rehabilitation team in Milton Keynes, care coordinators' caseloads averaged 40. However, this included patients who were allocated to attend depot clinics and did not require care coordination. In Harrow, we were told that some caseloads were high due to the number of patients who did not need care coordination, but who still needed to be allocated to practitioners. Work had taken place across all the boroughs to better identify people who did not need to be allocated to a care coordinator in a bid to improve caseload management.
- In our previous inspection in May 2017, we found that there was additional work the trust needed to do regarding recruitment of permanent staff, particularly in Brent and Hillingdon. At this inspection, we saw that there were more permanent staff in these boroughs. The trust had taken part in several recruitment initiatives, including employing newly qualified nurses as part of the 'Capital Nurse' programme, which provides additional support to nurses at the start of their career and gives them experience of different nursing settings. Services also employed newly qualified social workers who were completing their assessed year in practice. Staff employed under these schemes had capped caseloads.
- The early intervention services (EIS) had sufficient staff to meet the needs of their patients. Caseloads for patients in the three EIS we visited were smaller to allow for more intensive work.
- All teams had access to medical support. In Milton Keynes, the EIS had a part-time consultant. Staff in this team told us that they could contact their consultant when required, but it limited their input to the team. In Brent, the CMHTs had reconfigured to align with GP practices, along with the caseload of most members of the multidisciplinary teams. The medical staff had not yet transferred their caseloads to align, so teams were temporarily working with multiple doctors, but this was a short-term situation.
- During our last inspection in May 2017, we identified there were shortfalls in staff completion of basic life support training. We found this was not the case during this inspection. Across the service, including teams we did not visit during this inspection, 92% of staff had completed adult basic life support training.
- The trust set an annual target of 95% for completion of mandatory and statutory training. The compliance for mandatory and statutory training courses at 31 October 2018 was 94%. This was higher than the 91% reported for the previous year.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Conflict Resolution	19	19	100%	✓	↑
Immediate Life Support	13	13	100%	✓	↑
Safeguarding Adults (Level 1)	132	130	98%	✓	↑
Safeguarding Children (Level 3)	648	638	98%	✓	↑
Safeguarding Children (Level 1)	132	129	98%	✓	↑
Prevent Awareness - Level 1	132	128	97%	✓	↑
Manual Handling - Object	780	755	97%	✓	↓
Health and Safety (Slips, Trips and Falls)	779	754	97%	✓	↑
Equality and Diversity	780	740	95%	✓	↑
Information Governance	780	736	94%	✗	↑
Safeguarding Adults (Level 2)	648	610	94%	✗	↓
Non-Inpatient Fire Safety	780	725	93%	✗	↑
Adult Basic Life Support	132	122	92%	✗	↑
Infection Prevention (Level 1)	132	122	92%	✗	↓
Emergency Life Support	635	582	92%	✗	↑
Personal Safety Breakaway - Level 1	739	672	91%	✗	↓
Infection Prevention (Level 2)	648	585	90%	✗	↑
Prevent WRAP	648	576	89%	✗	↑
Total	**8557**	**8036**	**94%**		↑

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed and updated risk assessments for each patient and used these to manage risks individually. We checked 58 care records across the services we visited. During our last inspection in May 2017, we found that staff did not always comprehensively complete and review patient risk assessments. During this inspection, we found an improvement. Most risk assessments had been updated with current risk, and where there were gaps, staff were able to demonstrate a good understanding of patient need and key risks. For example, we found some risk assessment documents did not contain all the risk information. However, this information was available elsewhere in the care records, so a member of staff picking up the work would be able to access information about key risks. Hillingdon was the weakest service with regard to recording and updating current risks.

- Staff completed crisis plans with patients, which ensured patients knew how to get help in an emergency. At our last inspection in May 2017, we found that not all patients had individual crisis plans in place. During this inspection, we found an improvement. Patients had individual crisis plans in place which had been tailored to their circumstances and contained relevant information about emergency contacts and what to do in case of relapse or emergency.

Management of patient risk

- 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. These were commonly called ‘zoning’ meetings as services assigned levels of risk to each patient and discussed the patients who were at the highest risk levels or those whose levels were changing. There were additional clinical meetings where broader discussions took place. This meant that the teams were aware of the key risk areas daily. It also meant that managers had oversight of developing situations and risks within the team.
- In Harrow, staff did not always produce detailed risk management plans to address identified risks. We reviewed five records for patients who were being seen by lead professionals because they had been assessed as presenting higher risks or needing greater support. In four of the five records, staff had not developed plans to address risks identified in the risk assessments. This meant that staff could not easily refer to information about strategies to manage risks. For example, staff had not developed a risk management plan to support a patient at risk of overdose and using illicit drugs, despite their risk assessment identifying this need.
- Staff in the teams effectively managed changes to risk. They responded to and prioritised patients presenting with the highest levels of need. Teams operated duty systems in which assigned members of staff picked up unscheduled work and provided cover for staff who were on leave. These systems operated differently in the teams we visited. For example, in Brent there were dedicated staff who picked up new referrals and carried out assessments, whereas in Hillingdon, initial assessments, which were referred from the single point of access, were picked up on duty.
- Managers demonstrated learning from incidents by making changes to processes relating to management of risk when necessary. In Hillingdon, the team had made changes to the duty system, which demonstrated learning from an internal incident. Each day, an assigned duty senior reviewed the work the duty workers needed to complete and checked throughout the day to ensure they prioritised the highest areas of risk.
- The trust had systems in place to ensure staff were safe when working alone, but staff did not always adhere to them. At our previous inspection in May 2017, we found that staff did not use the lone working processes consistently. At this inspection, this continued to be the case. In Harrow and Brent, staff were not always clear about the code words they should be using or the processes in place to ensure their safety in the community. We immediately raised our concerns with the trust. Following this, the trust circulated a clinical risk alert to remind staff about safe lone working practices. During the second week of our inspection in

Milton Keynes and Hillingdon, we found there was greater staff awareness, suggesting staff had taken notice of the reminder.

Safeguarding

- Staff across the services we visited knew how to identify adults and children at risk of or suffering significant harm. In the records we reviewed, staff identified safeguarding referrals appropriately.
- Staff discussed safeguarding referrals and updates in zoning meetings and clinical review meetings. Managers had oversight of adult safeguarding referrals and progress through a tracker database. In Hillingdon the borough social work lead tracked all safeguarding adults' referrals whereas in Brent, the team managers tracked these referrals. During our last inspection in May 2017, staff in the Milton Keynes community teams did not always track and monitor safeguarding referrals, but this issue had been resolved.
- The trust did not collect information about referrals relating to children's safeguarding. Staff we spoke with were aware of the steps to take and ensured that referrals were made appropriately but this information was not collated centrally. This meant that there was no management oversight of all referrals made and their outcomes although this information was collected by individual care coordinators. This meant the service was not able to demonstrate the overall impact of actions that staff had taken in relation to safeguarding children.

Staff access to essential information

- Staff kept detailed records of patients' care and treatment on electronic database systems. During our last inspection in May 2017, we found that temporary staff did not have timely access to all patient care and treatment records. This meant that there was an additional strain on permanent staff. During this inspection, staff in Harrow told us that the trust's clinical support team now set up new login details for agency staff more quickly than had been the case in the past. However, in Brent we were told that this had not improved. There were fewer agency staff used than during our previous inspection, so the impact of this was not as significant.
- During our inspection, the trust was in the process of changing between two different electronic patient records systems. Additional support had been provided to teams during the change period. However, particularly in Hillingdon, we saw that staff were not always offered speedy responses when there were difficulties with working the new system. Staff told us that while they had received training in the new system, it had been some months before implementation and they would have benefited from refresher training.
- The new record system would improve communication between community mental health services and GP surgeries in most boroughs as both now had access to the records.

Medicines management

- Staff followed good practice when administering medication. Medicines were transported to patients' homes in secure, lockable rucksacks. Medicines were stored at correct temperatures.
- Staff checked and monitored storage temperatures. In Brent, one of the fridges used to store medication was broken and the other available fridge had a faulty thermometer. Replacement fridges had been ordered. However, at the time of our inspection, there was no medication stored that needed to be refrigerated.
- We checked prescription charts across the service and they had been completed appropriately. Prescriptions were within the limits of the British National Formulary (BNF) guidance.
- We saw that medicines information was available for patients in the waiting areas of most teams.
- Prescriptions were stored safely and scanned onto the trust electronic patient record system. An annual audit of prescriptions was carried out by the trust's pharmacy team to monitor the use of prescriptions and account for their use.
- Staff in the teams had good support from trust pharmacists and pharmacy technicians. They regularly visited the team bases, but staff knew how to contact them for advice at other times.
- Staff regularly reviewed the effects of medication on patients' physical health. Across the service, staff supported patients who attended clozapine clinics and carried out physical health checks. Clozapine is an antipsychotic medication which requires strict monitoring due to the possibility of serious side effects and their impact on physical health.

Track record on safety

- Staff reported incidents. Between 19 October 2017 and 19 October 2018 there were 35 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Apparent/actual/suspected self-inflicted harm' with 24.
- We reviewed the serious incidents reported by the trust to the Strategic Information Executive System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system corresponded with STEIS. Some of the data related to teams that had since been reconfigured and renamed.

	Number of incidents reported							
Team Name	**Apparent/ actual/ suspected self-inflicted harm**	**Sub-optimal care of the deteriorating patient**	**Disruptive/ aggressive/ violent behaviour**	**Accident e.g. collision/ scald (not slip/trip/fall)**	**Medication incident**	**Apparent/ actual/ suspected homicide**	**Pressure ulcer**	**Total**
Brent Early Intervention Team	5		1					**6**
Brent North Community Mental Health Team (CMHT)	2		1					**3**
MK Recovery and Rehabilitation Team	2	1						**3**
MK Specialist Therapies Team	1							**1**
MK Rapid Response Team					1			**1**
Harrow & Hillingdon Early Intervention Team	1							**1**
Harrow East Community Mental Health Team (CMHT)	1							**1**
Pembroke - Clinical & Medical Team (CMHT)	1							**1**
MK Rapid Assessment and Intervention Team (RAIT)				1				**1**
Westminster South	1							**1**

	Number of incidents reported							
Team Name	**Apparent/ actual/ suspected self-inflicted harm**	**Sub-optimal care of the deteriorating patient**	**Disruptive/ aggressive/ violent behaviour**	**Accident e.g. collision/ scald (not slip/trip/fall)**	**Medication incident**	**Apparent/ actual/ suspected homicide**	**Pressure ulcer**	**Total**
Community Mental Health Team (CMHT)								
MK Assessment & Short Term Intervention Team (ASTI)	1							**1**
MK Early Intervention in Psychosis Team	1							**1**
Total	**24**	**5**	**2**	**1**	**1**	**1**	**1**	**35**

Reporting incidents and learning from when things go wrong

- Staff had a good understanding of learning from incidents within their teams. Staff could give examples of incidents that had taken place within the teams and boroughs they worked in and how the learning had been embedded. We saw in minutes from business meetings that learning from incidents was discussed locally, as well as at borough and divisional level. However, staff did not have a broad awareness of relevant incidents, where there may have been learning, from similar teams in other parts of the trust.
- We checked incidents which had been reported across the team. These showed that staff knew the types of incidents that should be reported. Staff we spoke with knew how to report incidents.
- Most staff across the services we visited told us that they had opportunities to debrief following serious incidents and felt supported. Two members of staff in Brent told us that while they had received support locally and could not fault the support they received from their managers, the process of investigation by the trust had not felt supportive.
- Following serious incidents, staff were provided with additional training specifically related to learning from those incidents. For example, in the Brent Early Invention Service, where a small cluster of patients had died unexpectedly, additional training had been offered. In the recovery and rehabilitation team in Milton Keynes, there had been an incident regarding the management of lithium. In response to this, the team had established a lithium group which covered all the patients on lithium seen by the team and made sure they were monitored.

Staff had received updated training on lithium management and the team had implemented a new system to ensure staff could review blood results. In Hillingdon East and West, a new duty system had been introduced following an incident where an action on duty had not been picked up in a timely manner. The senior on duty used a priority checklist of tasks at the beginning and throughout the day to ensure that the most important issues were addressed daily.

- In Milton Keynes, following the death of patient who had previously been assessed by the service, the trust identified that it needed to provide more support to patients awaiting treatment by the specialist therapies team who did not meet the referral criteria for the psychosis teams. At the time of the patient's death, these patients did not receive care co-ordination. In October 2018, the trust established a psycho-social pathway to support patients awaiting therapies. At the time of the inspection, 3.3 full-time equivalent staff supported 70 people. The team had also established a consultation clinic to review new referrals, so staff could assess patients for risk.
- Staff received an annual summary about learning from medication incidents across their division. The meant they could learn from events that had taken place in other teams within the division.
- Staff demonstrated a good understanding of the duty of candour, including being open with patients if a mistake had been made, and maintaining close contact with patients or relatives during any investigation of a complaint.

Is the service effective?

Assessment of needs and planning of care

- Staff assessed the physical and mental health of all patients who accessed the service. They developed individual care plans and updated them when needed. At our last inspection in May 2017, we found that some care plans were not person-centred and that patient involvement was not always recorded consistently in care plans. During this inspection we found that there was an improvement. We checked 58 records across the teams we visited. Most records we checked were holistic and reflected patients' views about their care and treatment.
- Staff were clear about the circumstances in which they needed to refer patients to other services, including specialist substance misuse services, and explained to us how they worked collaboratively with these services to support patients' mental health needs whilst they were undergoing treatment elsewhere.
- Physical health needs formed part of the assessment process when patients were taken on by the teams and these were included in care plans. This was an improvement since the last inspection in May 2017. We saw that where patients had specific needs regarding their physical health, for example, diabetes, this was included in their care plans.

Best practice in treatment and care

- Staff provided a range of treatment and care for patients based on national guidance and best practice. Doctors followed best practice guidelines when prescribing medicines and patients reported they had discussed their treatment and medicines with staff and had a good understanding of them.
- The trust had different team structures in different areas. For example, in Milton Keynes the recovery and rehabilitation and assertive outreach teams supported patients who had a diagnosis of psychosis, and a specialist therapies team offered support to other patients who needed secondary mental health input. Whereas in the community teams in London, the scope was broader and there was not a specific distinction made on the basis of diagnosis.
- We visited three early intervention in psychosis (EIP) teams, in Brent, Milton Keynes and the cross-borough Harrow and Hillingdon team. These were set up separately with a dedicated staff team and included family therapy. However, in Brent at the time of our visit, there was no family therapist available, although an appointment had been made and a new member of staff was due to start shortly. EIP teams also had dedicated clinical psychology resources.
- Staff supported patients with their physical health needs. A specific template requesting information was sent to GPs to ensure the teams received annual physical health check results in a timely manner. The template supported GPs to complete appropriate physical health monitoring for people with severe mental illness, including use of the Lester tool. In addition, there were specific physical health clinics run in some boroughs. In Brent and Harrow, the wellbeing team focused on supporting patients with physical health needs. In Milton Keynes, the psychosis teams had two bank nurses employed to improve staff knowledge of physical health and to complete any physical health checks for patients. We saw evidence that physical health checks had been completed in the records we looked at across the service.
- Patients had access to psychological interventions. At our previous inspection in May 2017, we identified that patients did not readily have access to psychological therapies in line with best practice guidance. At this inspection we saw that there had been some improvements. Patients were referred for psychological therapies if needed. The trust had undertaken specific work on the model of psychological therapy in community mental health services. Different boroughs had different models in place. However, the trust was working on a cohesive strategy to bring more consistency to the provision of psychological therapies across the service.
- In Milton Keynes, the specialist therapies team offered psychological therapies to patients who were on the non-psychosis treatment pathways. The team structured its work around four clinical pathways: personality disorder, complex trauma, complex mood and psycho-social interventions. The team offered a range of tailored interventions to support people, including cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), mentalisation-based therapy (MBT), eye movement desensitisation and reprocessing (EMDR) and art therapy. In other boroughs, psychological support was accessed through

the community mental health teams (CMHTs) and referrals were managed by the clinical psychology leads within these services. In Brent, the psychology team and CMHT managers met on a weekly basis to check referrals and prioritise them. This included referrals for psychotherapy. In Hillingdon, the service was reviewing the model used and managers had decided to pause individual referrals to the psychology team for a three-month period, so the waiting list could be reduced. Those referred in this period were reviewed and prioritised and the team was providing some groupwork to ensure that those who were waiting for treatment had additional options to pursue.

- Patients who were allocated within the team were seen regularly by key professionals. At our previous inspection, in May 2017, we found that some patients who had care coordinators and were seen under the care programme approach (CPA) did not have regular monthly contact with the service as specified in the trust's standard operating policies for CMHTs for adults of working age. At this inspection, we saw team managers could now monitor local performance in this area, and it could be further checked through the governance systems within the divisions and trust.

- Services undertook a range of audits including clinical audits and audits of management processes. Most of the audits were completed by management. There had been an initiative to include more clinicians in audits at Brent using peer risk assessment audits, but this was work in progress. In Harrow, assistant psychologists completed monthly audits of patient care and treatment records. Managers recognised the value of clinician involvement in audit but told us that sometimes the caseload sizes stopped it from happening.

- Patients in London had access to the trust's wellbeing and recovery college which ran a number of courses and sessions focused on education and development for patients and carers. While there was no recovery college in Milton Keynes, at the time of the inspection, a pilot project was underway to offer some co-produced sessions with a focus on supporting people into employment and support for carers.

- Staff supported patients to lead a healthy lifestyle. For example, smoking cessation was available for all patients. Some staff were trained in smoking cessation and the service was able to prescribe nicotine replacement therapies. Staff at Harrow West community mental health team had plans to set up a healthy diet group and gentle exercise group for patients.

- Patient outcomes were routinely measured using health of the nation outcome scales (HoNOS). The data from this was reported to commissioners and it helped map patient progress by taking snapshots of patient need at different points throughout their treatment, including on referral and at discharge from the service.

- Staff used technology to support patients' care and treatment. For example, staff had access to mobile technology which enabled them to access records remotely, including on home visits. This meant patients could review their care and treatment records with staff. In some services, for example, in Harrow, text messages were used to remind patients of their appointments. However, staff in Hillingdon and Harrow told us that the telephone systems in place had created difficulties and that patients could not always get through to the service. The trust was aware of this issue and it was on the respective risk registers. Work was being carried out on the telephone systems to rectuify this problem.

Skilled staff to deliver care

- Managers made sure that they had staff with a wide range of skills, including a full range of specialists, to provide high quality care. In most community mental health teams, we visited, there were nurses and social workers who acted as care coordinators. In some teams, for example, in Hillingdon and Harrow, occupational therapists were also employed as care coordinators. Early intervention in psychosis (EIP) teams had a range of professional input including psychiatrists, nurses, social workers, occupational therapists, family therapists and clinical psychologists, as well as assistant psychologists and support workers. Pharmacists visited each team regularly to provide additional support, providing advice about medicines. Referrals to other specialists, including dieticians and speech and language therapists, were made when necessary.
- Peer support workers were employed across the service at different levels and used to a different extent. For example, in Hillingdon East and West, each team had a peer support worker, and in Brent, there was one peer support worker across the borough. Staff across the services told us that the input of peer support workers was valuable.
- Managers provided new staff with inductions when they started in the service. This included a corporate induction and a local induction. Some managers told us that there had been delays booking new members of staff onto the corporate induction in a timely manner. Staff told us that they had received thorough inductions when they started in the teams.
- Staff we spoke with said they received clinical and managerial supervision regularly (usually monthly or six-weekly). However, each manager collated information about supervision in their own way and it was the responsibility of each supervisor to monitor compliance with supervision levels. This meant that it was not possible to gather information across the service about the frequency or quality of supervision. For example, one member of staff in Brent told us that they had not had regular supervision, and there was no record clearly stating when their supervision had taken place. Supervision usually included discussion about clinical practice. Staff updated clinical notes with relevant discussions which had taken place in supervision. Staff across the service told us that they felt supported and could access their managers for informal support and supervision when necessary.
- Managers dealt with poor staff performance promptly and effectively. Managers explained how they proactively used achievable targets with staff, which they reviewed during supervision, to help staff improve their performance. At Brent, human resources (HR) staff attended seniors' meetings monthly and provided advice and support as necessary. Managers told us this was helpful.
- Some teams, for example, the Brent EIP team and the Hillingdon North community mental health team, used regular reflective practice for additional discussions. These were facilitated by staff who were not part of the team and staff told us these sessions were useful.
- Each team had a monthly business meeting where learning from incidents, complaints and audits was discussed. We checked the minutes of the meetings of the teams we visited. While they were variable in quality and detail, there were set agendas and the key issues were covered. This ensured staff had information about the main issues within their service.

- Some staff told us that they had access to specialist training relevant to their roles. For example, in Brent community mental health teams there had been a recent training event for care coordinators who had a role as social supervisors. Staff in Brent told us they had asked for additional time for professional development. In response, the service had developed weekly brief learning slots on specific issues of interest to the staff team. These took place at the end of team meetings so that all staff could attend.

Multi-disciplinary and interagency team work

- Staff from different disciplines worked together as a team to benefit patients. Staff attended weekly multidisciplinary meetings. In some teams, additional meetings were also held to update staff around clinical issues and team members came together to discuss developments or emerging risks with the patients on their caseloads.
- The teams had good working relationships with colleagues in other teams within the trust. For example, staff attended regular pathway interface meetings. These operated differently in each local authority area. In Harrow and Brent these took place weekly, but in Hillingdon they were monthly. These meetings were attended by inpatient services, crisis teams and representatives from the single point of access and meant that staff in the different services could discuss transfers of patients between teams. In Hillingdon, staff from the community mental health team attended ward rounds in the local inpatient unit. In Brent, a manager from the service went to the inpatient wards daily to ensure information was shared. These systems meant that information could be passed quickly between services in the same borough.
- Across the London boroughs, there were specialist employment support workers embedded in the teams. These workers worked with local employers to embed an individual placement and support (IPS) network. They were supported by the trust to facilitate this. One employment support worker was a peer support worker in Hillingdon.

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

- Staff told us that they had a good understanding of the Mental Health Act (MHA). Services provided MHA training to staff. This training was renewed on a three-year basis and did not form part of the trust mandatory training programme. In Harrow, 56% of staff in the teams we visited had up-to-date MHA training, and this was 46% in Brent, 42% in Hillingdon and 62% in Milton Keynes. This meant that there was a risk that all staff may not have the key information necessary regarding their responsibilities under the MHA. However, informal training had taken place within teams on an ad-hoc basis. For example, in Harrow and Brent, staff had received additional training regarding the scope of section 117 aftercare.
- Each team base had a copy of the MHA Code of Practice. Staff knew where and how to access advice and support regarding any issues relating to the MHA.

- During our last inspection, we identified that some patients who were subject to community treatment orders (CTOs) did not have their rights routinely explained in line with the MHA code of practice. At this inspection, we saw that this continued to be the case. We saw that in Harrow, this had been completed and was recorded. But in Brent and Hillingdon there was no record of this. Prior to the inspection, we were told that there was a system in place for the MHA administrators to inform team managers when this action was due. We found this was not happening in practice. This meant that there was a risk that patients who were subject to CTOs were not aware of their right to appeal.
- Patients who required aftercare under section 117 of the MHA had access to this under the Care Programme Approach (CPA). Patient care plans referred to section 117 when it was relevant.

Good practice in applying the Mental Capacity Act

- Staff had training related to the Mental Capacity Act (MCA) as part of their safeguarding training. Additional ad-hoc training was also arranged in individual teams, for example, in Harrow the teams had accessed a session on MCA and Deprivation of Liberty Safeguards (DoLS) at a business meeting.
- Staff had a good understanding of the MCA and knew the circumstances in which a decision-specific capacity assessment would need to be completed. Staff discussed issues relating to patients' capacity during clinical meetings and handover meetings where relevant.
- Staff recorded information about mental capacity in patient records as necessary. Staff we spoke with had a good understanding of capacity and situations where assessments of mental capacity would be necessary and how they should be conducted and recorded.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

- Patients and carers told us that staff treated them with kindness, compassion and dignity. They told us that staff were supportive and that they felt respected. They also said staff made an effort to understand their culture.
- We observed interactions in waiting areas and in some clinical appointments which we were invited to observe. We saw that patients were treated with kindness and thoughtfulness.
- Staff recognised the individual needs of patients and took these into account when allocating care coordinators whenever possible. For example, staff in Harrow told us about their efforts to allocate patients to staff members from a similar culture or with the same gender if requested.

- Staff always maintained confidentiality of patients, including when completing operational records, incident reports or meeting minutes.

Involvement in care

Involvement of patients

- Staff involved patients in making decisions about their care and made records of these discussions. During our last inspection in May 2017, staff did not always clearly record patients' views in care records. During this inspection, we found that staff discussed care and treatment options with patients and involved them in decision-making. This was documented this in most records we checked. However, the outcomes of the discussions could have been recorded more clearly in some patients' records.
- Staff offered most patients copies of their care plans; this was an improvement. During our last inspection in May 2017, staff did not always give patients their own copy of their care plan. This time most patients confirmed they had been offered a copy of their care plan. Except in Harrow where nine out of the 15 patients we spoke with told us that they had not been offered a copy.
- Patient involvement in the services varied. In Hillingdon, for example, patients were involved in all staff interviews at every level, but in Brent and Harrow this was not the case. This meant that patients from different boroughs did not receive the same opportunities for involvement.
- Patients were encouraged to provide feedback about the service using the friends and family survey. Staff aimed to provide patients with a survey form whenever they attended appointments. Alternatively, boxes were situated in the reception areas for patients to leave their own feedback.
- Patients had access to independent advocacy. Contact details were clearly displayed in the waiting areas and staff signposted patients to the advocates if necessary.

Involvement of families and carers

- Staff involved carers in care planning when patients consented to this. Carers were invited to relevant meetings, including care programme approach review meetings. Staff also gave carers updates on the progress of their relative or friend and organised carers assessments to help ensure carers received the support they were entitled to.
- The trust helped carers to link up with local support. Carers' support and feedback groups were held in each of the boroughs. In Hillingdon, the teams liaised with a local carers' group and referred people to this group for support and for carers' assessments.
- Carers we spoke with told us that they felt involved and supported.

Is the service responsive?

Access and discharge

	Median waiting time from Referral to Assessment 01/07/2018 - 31/12/2018
Brent - Community Mental Health Team (CMHT) North	21 days
Brent - CMHT South	23
Brent - Early Intervention Team	11
Harrow - CMHT East	16
Harrow - CMHT West	26
Hillingdon - CMHT East & West	42
Hillingdon - CMHT North	29
Hillingdon & Harrow - Early Intervention Team	7
Milton Keynes - Assertive Outreach Team	38
Milton Keynes - Recovery & Rehabilitation Team	14
Milton Keynes - Early Intervention Team	8
Milton Keynes – Urgent Care Team	10

- People could access care near to home when they needed it. During our last inspection in May 2017 we identified that the trust needed to continue to work to reduce its average waiting time from referral to assessment. During this inspection we found a variation across the services in relation to the waiting times from referral to assessment. The target times were 28 days for the CMHTs and 14 days for the early intervention services. We saw that the trust had taken specific actions to address delays identified in the previous inspection between referral and assessment. For example, in Brent, the single point of access was piloting a new process whereby they could book patients in for face-to-face assessments with the assessment team. This ensured that people calling the service would know when their appointments were and minimised the risk of lengthy waits for assessments.
- The service did not use a target time for assessment to treatment.
- The teams were able to see urgent referrals quickly. Urgent referrals were flagged by staff working at the trust's single point of access which worked across the London boroughs. Staff working at the CMHTs then screened referrals and identified patients who needed to be seen sooner than the 28-day target time. Some patients were also intermittently contacted whilst they were waiting for their initial assessment. This was to help safely manage their risks whilst they were waiting and ensured that patient appointments could be brought forward if needed. We saw that in the services in London, there were systems in place to ensure that referrals were monitored and prioritised. In Hillingdon, for example, team managers audited all referrals on a weekly basis to ensure that they were followed up and had been triaged after being passed on from the single point of access.
- Some patients in Milton Keynes did not have timely assessments. In Milton Keynes, the urgent access team (UAT) acted as a single point of access for the local community mental health services. They received all referrals from health care professionals in the community.

There was a duty system to review all referrals when they came in, and, after an initial call, the duty worker triaged them based on risk. The waiting times for the UCT in Milton Keynes had increased between August 2018 and January 2019. In January 2019, the data showed that 50 patients had waited more than six weeks to be assessed. Eleven of these patients had waited more than 12 weeks. In August 2018, 12 patients had been waiting for more than six weeks, but no patients had waited for more than 12 weeks. The team offered some support and interventions to patients whilst they waited. However, the delay in completing assessments meant that there was a risk that patients' full needs did not get identified in a timely manner. Staff told us that this was due to vacancies within the team.

- Staff ensured that patients who were waiting to be assessed were monitored. Staff explained how they engaged with patients who were reluctant to attend appointments or failed to attend. Plans were put in place according to the individual's needs, including increased reminders about appointments, or swapping appointments for home visits. Each service had a specific policy to address any concerns around patients who did not attend appointments and monitored whether these patients needed to be followed up or whether they could be discharged, based on risk and knowledge of the individual patients.
- Patients were offered flexibility in appointment times where possible, although the service did not operate into the evening or at weekends.
- Patients had access to psychological therapies, but there were significant delays in some areas. At the time of our inspection, the median waiting times for the psychological therapy services we visited was 24 weeks in Hillingdon, 40 weeks in Milton Keynes for assessment by the specialist therapies team (although many waited in the region of 75 weeks for planned interventions to start and the team did not work with those on the psychosis pathway), 13.5 weeks in Harrow and 29 weeks in Brent.
- Some CMHTs held waiting lists for care coordination if it was not possible to allocate a patient immediately. The reasons for this waiting list related to the availability of care coordinators. For example, in Hillingdon West, there were 33 patients on the waiting list and in Hillingdon East there were 19. The patients who were waiting for care coordination were monitored by the team managers and this was prioritised on the basis of urgency and risk. This meant that the people who were deemed to be at the highest level of risk were prioritised for allocation. We checked these lists and found most people who were waiting for care coordination were transferring from other teams or services. However, some people who had been assessed to need care coordination were not allocated in a timely manner.
- Staff in the early intervention teams told us that some patients had been delayed in their transfer to CMHTs due to the lack of availability of care coordinators. We asked the trust how many people this affected at the time of our inspection and this was eight patients in Harrow and Hillingdon EIS, nine in Brent EIS and 17 in Milton Keynes EIS.

The facilities promote comfort, dignity and privacy

- All the premises we visited were well-maintained and well-furnished. At our previous inspection in May 2017, we noted that some patients reported privacy and dignity concerns

in the Harrow community mental health team reception area as other patients could hear discussions taking place about confidential matters. At this inspection, this issue had been resolved with the use of privacy screens. Some staff in Brent told us that some meeting rooms were not soundproof. However, there were other meeting rooms available which were soundproofed which ensured that meetings could take place in confidence.

- The services had a range of rooms and equipment to support treatment and care including clinic rooms in most of the team bases.
- There were enough chairs in the waiting areas, as well as private consultation rooms, group rooms for group activities and staff meeting areas.
- Staff could see patients in rooms which were accessible for people with mobility difficulties.

Patients' engagement with the wider community

- Staff supported patients with activities outside the service, such as work, education and family relationships. Each borough in London had an embedded employment support worker who worked to an individual placement and support (IPS) model. This was part of the trust-wide employment service which liaised with employers to facilitate training and placements and helped patients to develop work-finding skills. The IPS service within the trust was recognised as a national centre of excellence.
- While the employment service had not been implemented in Milton Keynes, the early intervention service in Milton Keynes had arranged for two employment advisors to hold a weekly job club in the service. This session supported patients to compile CVs and make job applications.
- We some excellent examples of community involvement. In the Brent early intervention service (EIS), a support worker had established a successful project with a local football club. This had received recognition from the Football Association as an exemplar in community engagement. It involved patients from the EIS receiving football training and skills development and gave staff opportunities to engage with patients in non-clinical settings. We also saw that there was a popular allotment project in Hillingdon where patients could develop gardening skills. These projects improved patients' quality of life.

Meeting the needs of all people who use the service

- People with mobility issues could access consultation rooms at all the team bases and home visits were made if necessary.
- Information about treatments for various conditions, local support groups and rights was available to patients and displayed in reception areas.
- Staff within the services had a good understanding of the local needs of the communities in which they worked. They linked with community groups for advice and support and to

ensure that people from specific communities were able to build networks if they wished to. Staff also came from diverse backgrounds, reflecting the areas they worked in.

- In Harrow staff had received training in supporting patients with autism. This was not always the case in other boroughs. This meant that there was a risk that some patients with specific needs may not be provided with support by a member of staff who had training to understand their needs.

- Easy-read crisis cards were made available in Milton Keynes so patients knew who to contact if their mental health deteriorated..

- Staff reported that they accessed interpreters with ease, and, if needed, at short notice; a telephone interpreting service was used.

- Staff within the service were committed to supporting colleagues and patients who identified as lesbian, gay, bisexual or transgender (LGBT+). The trust had an established LGBT+ network for staff. Staff wore rainbow lanyards to signal that they were available to discuss LGBT+ issues or provide support to people who wanted it. Some staff told us they felt supported by the organisation in being open about their sexual orientation and that it was a welcoming organisation regarding diversity. Staff considered patients' gender identity needs when planning their care. We saw evidence in Harrow and Brent that staff had considered the needs of patients who identified as transgender or non-binary.

Listening to and learning from concerns and complaints

- This service received 164 complaints between 1 November 2017 and 31 October 2018. Twenty-five of these were upheld, 56 were partially upheld and 42 were not upheld. Six were referred to the ombudsman.
- Patients were supported to make complaints. We received mixed feedback from patients about their knowledge of the complaints process. While some patients reported that they did not know how to make a formal complaint, most told us they felt confident approaching staff if there was something they were unhappy about. Leaflets explaining the complaints process were available in waiting areas.
- Staff knew how to handle complaints appropriately. Responses were sent to patients in a timely manner. Each aspect of the complaint was carefully considered and addressed in the response letter, which was written with compassion. Response letters also detailed how the complainant could contact the parliamentary and health service ombudsman if they were dissatisfied with the response.
- Staff learnt from complaints. Staff routinely discussed recent complaints and learning from at the staff business meeting.

Is the service well led?

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. We met with leaders at various levels throughout the service and within different boroughs and divisions. We found that managers had a good understanding of their responsibilities and knew their teams, or the areas for which they had responsibility, well. They were aware of the key risks and challenges and were open in sharing them.
- Staff reported that leaders at team, borough and divisional levels were present and approachable. Staff across the organisation told us that they felt supported by their immediate managers. Managers we met were very positive about the staff teams who worked for them, often commenting on the positive team working and that the quality of staff employed made a significant positive difference. They were appreciative of the hard work and commitment displayed by staff across the service.
- Staff had access to leadership development training within the trust. Some social work staff in Brent told us that they had access to local authority leadership training. Leaders reported that they were encouraged to attend various in-house training courses on topics such as managing change and dealing with complaints, which helped them develop their skills. The trust had invested in developing the leadership capacity internally.

Vision and strategy

- Staff had a good understanding of the trust's values of compassion, respect, empowerment and partnership, and explained how they demonstrated the values in their day-to-day work. Staff had attended training in the trust's values, and the values were clearly displayed across the service, including in patient waiting areas.

Culture

- Staff felt respected, supported and valued. Staff reported that leaders were open and honest with them and had involved them in recent discussions about potential service transformation plans.
- Staff reported they could raise concerns openly and they understood the whistleblowing policy.
- There was little awareness in the service about the role of the trust's freedom to speak up guardian. Some staff told us they were aware of the role but most of the staff we spoke with were not familiar with the term or the role within the trust. Therefore, they were not aware of how to contact them to raise any concerns.

- Managers dealt with poor staff performance in a positive way to promote improvement. Staff discussed their career development goals during their appraisals and they told us they felt that the trust supported their career development. For example, numerous staff had been awarded funding and study leave to complete masters degrees or to attend specialist training which supported them to fulfil their roles.
- Staff could access support for their physical and emotional health needs at work through the trust's occupational health department. Staff told us that when they had been absent from work for personal reasons including sickness, they had been supported by their managers and had felt that this support was helpful.
- Some staff across the services we visited told us that they often worked more than their contracted hours in order to complete their work. Managers told us that they had a good understanding of the hours staff worked and were able to ensure staff did not work excessive hours. Where this had been identified as an issue, it was raised in supervision.
- Staff success was recognised. Staff were aware of internal recognition schemes and some members of staff told us that their work had been acknowledged. An annual 'shining star' ceremony also took place. These awards were aligned to each of the trust's values.

Governance

- The trust had robust governance structures which ensured that key risks were recognised and addressed. The trust consisted of three divisions based on service lines and geography. Each division had a governance structure which oversaw the operations at a local level. Managers in all the teams we visited had a good understanding of the governance structures within their respective division and they were aware of how information was shared through the division. Each borough also had a borough lead and deputy lead who oversaw the community and inpatient mental health services. There was a clear framework about what to discuss at service level during staff meetings, including learning from incidents and complaints. Some staff were not so clear on information flow between divisions, but there were some local arrangements in place to ensure that information was shared at senior managerial level. For example, the borough director in Hillingdon told us that they attended some operational meetings within a different division in a neighbouring borough to ensure information was shared.
- The services conducted audits and acted on the results of audits to improve their services. During our last inspection in May 2017, we identified that some audits did not include an action plan to address issues identified. During this inspection, we found a range of clinical audits were in place, covering care plans, risk assessments, use of the Mental Health Act and other areas of work. Each of these audits resulted in an action plan, which meant that issues identified were remedied. For example, the findings from one audit had prompted staff to review patient records which were overdue for a routine update to the risk assessment. However, the system of audits did not assess whether risk management plans were in place for patients receiving care under the lead professional contact (LPC) programme.

- Staff in the service were keen to learn from peer review processes. Peer reviews had been undertaken across the services. For example, managers in the Harrow services had visited the Brent services and produced a report and managers in Milton Keynes visited Hillingdon services and vice versa. We checked the reports which had been produced for the service and saw that these audits had been robust, highlighting pertinent issues. Staff we spoke with who had been part of these reviews told us that they found the experience of visiting other teams very useful.

Management of risk, issues and performance

- A service-level risk register was maintained and was accessible to staff. Staff had a good knowledge of the top risks to the service.
- A service continuity plan had been established. This meant that the service could continue to operate in the event of a major incident, such as building failure. The plan highlighted which functions could be carried out by staff members who could work remotely, and which responsibilities would need to be transferred to the local general hospital.

Information management

- The trust used systems to collect data from the service that were not over-burdensome for staff. Most of the performance data was collected automatically from the electronic patient records system. We checked the dashboards which all staff had access to and saw that there was significant performance data that staff were able to access to assist them in their work.
- The trust switched between electronic patient record systems during our inspection, so staff were using two records systems. Most staff told us they felt the new system would be an improvement.
- Staff had access to the appropriate technology to support them to do their work, including tablet computers they could take on home visits. However, the main telephone system at the Harrow and Hillingdon community mental health teams had ongoing problems and patients and others were sometimes unable to get through to the service. The trust was considering how to resolve this issue at the time of the inspection. In the meantime, each patient was provided with contact details for the trust’s single point of access so they could contact them if they required urgent help.

Engagement

- Staff, patients and carers could access updates about the work of the trust on the its website. Patients and carers predominantly provided feedback through the friends and family survey and managers had access to this feedback.

- Patient engagement varied between the boroughs. In Hillingdon, patient representatives sat on all interview panels. However, in Brent this was not common practice apart from interviews for senior staff. This meant that some opportunities for involvement were dependent on where the patient lived.

Learning, continuous improvement and innovation

- Staff had started to use quality improvement (QI) methodologies to make changes within the service. For example, in Hillingdon an initiative was underway to look at waiting times for patients who attended depot clinics. This topic had been chosen following negative feedback from patients and carers. In Brent some QI work had been carried out to improve physical health monitoring. There were opportunities for staff to acquire QI skills through training and there were support structures in place to help staff achieve the objectives they had set for the project.

MH – Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Hillingdon Hospital Mental Health Centre	Oaktree Ward	17 (male and female beds)	Mixed
Northwick Park Mental Health Centre	Ellington Ward	23 (2 female, 9 male and 2 swing male/female beds)	Mixed
St Charles Mental Health Centre	Kershaw Ward	14 (4 male, 8 female and 2 swing beds)	Mixed
St Charles Mental Health Centre	Redwood Ward	17 (5 male, 10 female and 2 swing beds)	Mixed
TOPAS Waterhall Care Centre	TOPAS	20 (male and female beds)	Mixed
3 Beatrice Place	3 Beatrice Place	24 (8 male,16 female beds)	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

- At the last inspection, there were no overall environmental risk assessments on Kershaw and Redwood wards. At this inspection, this was no longer the case. Staff on all older adult wards completed regular environmental risk assessments of the ward. The ward managers and the trust's risk assessors completed annual environmental ward risk assessments. However, the environmental risk assessment on Redwood Ward had not identified all potential risks. We identified four blind spots on Redwood Ward that had not been picked up by the risk assessment. These blind spots made patient observation difficult. This was raised with the ward manager during the inspection.

- The ward layout of Kershaw Ward and Redwood Ward did not allow staff to observe all parts of the ward. For example, on Kershaw Ward, the female lounge was situated a long way from the main ward area, nursing station and communal lounge. The corridor joining the two was very long and curved so that it was impossible for staff to observe the length of the corridor and see patients in the female lounge. This was largely mitigated by staff carrying out hourly safety checks, observations, the use of convex mirrors and engagement with patients. To minimise risk to patients, staff closed half of the ward during night time and remained present in the bedroom areas. However, on Kershaw Ward, during our inspection we observed that staff were not always present in areas of the ward due to its large size. This left patients unattended in the female lounge.
- Ward managers completed regular ligature risk assessments of the wards. However, on Kershaw Ward, the ligature risk assessment was not available on the ward so that staff could familiarise themselves with potential ligature anchor points. This was raised with the manager during the inspection who ensured it was made available to all ward staff.
- Ligature cutters were available on all wards and staff were aware of their location.
- Wards complied with guidance on same-sex accommodation. All wards had separate bedroom areas, bathrooms and lounges for male and female patients.
- Wards, including bedrooms, had wall alarms so staff and patients were able to summon staff assistance if required. At Ellington Ward, Oaktree Ward and Beatrice Place, the wall alarms emitted sounds of birds. This meant that patients were not distressed by a loud or high-pitched alarm when the call alarm was pressed. At Ellington Ward, Oaktree Ward and Beatrice Place, staff wore personal alarms that, if pressed, informed other staff members of their location if they requested assistance. However, on Kershaw and Redwood Ward, staff did not have personal alarms and told us they would like access to them in the event they were not able to reach a wall alarm in a timely manner. Staff had access to personal attack alarms, but staff rarely wore these as they made a high-pitch sound and did not alert staff to their exact location.

Maintenance, cleanliness and infection control

- All ward areas were clean, had good furnishings and were well-maintained.
- The most recent patient-led assessments of the care environment (PLACE), the locations scored higher than similar trusts for cleanliness and scored higher than similar trusts for condition, appearance and maintenance. In some cases the scores were inclusive of other wards on the same site.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Hillingdon Hospital Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units, Long stay/rehabilitation mental health wards for working age adults.	99.8%	95.9%
Northwick Park Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	99.8%	97.8%
St Charles Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	100%	97.4%
TOPAS Waterhall Care Centre	Wards for older people with mental health problems.	100%	98.5%
3 Beatrice Place	Wards for older people with mental health problems.	99.7%	97.3%
Trust overall		**99.8%**	**96.4%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

- Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. Ellington Ward had a cleaning board on display with the cleaning schedule and pictures of cleaning activities taking place on the ward.
- Staff adhered to infection control principles, including handwashing. A member of nursing staff was the infection control lead on each ward.

Seclusion room

- Seclusion facilities were not provided on any of the wards we visited.

Clinic room and equipment

- The clinic rooms on the wards were clean and organised.
- Clinic rooms did not have examination couches. If patients required physical examinations, staff conducted them in their bedrooms.

- Staff checked the contents of the emergency bags regularly and emergency drugs were in-date.
- Staff maintained equipment well and kept it clean, with visible “I am clean” stickers in place. However, on Kershaw Ward, the ward wheelchairs did not have “I am clean” stickers. The “I am clean” stickers provided reassurance that equipment had been cleaned.

Safe staffing

Nursing staff

- This service reported a vacancy rate for all staff of 23% as of September 2018.
- This service reported an overall vacancy rate of 22% for registered nurses at September 2018 and an overall vacancy rate of 21% for healthcare assistants.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Hillingdon Hospital Mental Health Centre	Oaktree Ward	3.2	11.8	27%	6.1	11.7	52%	10	23.1	43%
3 Beatrice Place	3 Beatrice Place	2.4	13.4	18%	5.1	26.4	20%	10.8	41.4	26%
Northwick Park Mental Health Centre	Ellington Ward	4	13	31%	2.8	17.4	16%	6.4	29	22%
TOPAS Waterhall Care Centre	TOPAS	5.9	16.3	36%	2.3	22.7	10%	7.2	36.6	20%
St Charles Mental Health Centre	Kershaw Ward	3.4	13.4	25%	2.6	15.2	17%	4.8	28.4	17%
St Charles Mental Health Centre	Redwood Ward	-1.6	12.4	-13%	4.4	16.8	26%	2.9	27.9	10%
Core service total		**17.3**	**80.2**	**22%**	**23.4**	**110.2**	**21%**	**47.0**	**205.0**	**23%**
Trust total		**532.3**	**2546.2**	**21%**	**283.0**	**1846.8**	**15%**	**1165.8**	**7256.6**	**16%**

NB: All figures displayed are whole-time equivalents

- This service had 166 (14%) staff leavers between 1 October 2017 and 30 September 2018. This was higher than the 10% reported at the last inspection (from 1 Jan 2016 to 31 December 2016).
- At the time of inspection, vacancies for registered nurses were low. Kershaw Ward and Redwood Ward had no registered nurse vacancies. Beatrice Place, Oak Tree and Ellington Ward had two registered nurse vacancies each.
- At the time of inspection, vacancies for healthcare assistants were low. Kershaw Ward had no healthcare assistant vacancies. Redwood Ward, Ellington Ward and Beatrice Place had two healthcare assistant vacancies each. However, Oak Tree had six healthcare assistant vacancies.
- The ward manager on Kershaw Ward, which had the highest staff turnover rate at 23%. reported this was mainly due to a high turnover of healthcare assistants who were psychology graduates and had moved into training posts or other roles for developmental reasons. Other ward managers reported that staff mostly left due to attaining promotions or enrolling into nursing studies.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff leavers over the last 12 months	Average % staff leavers over the last 12 months
St Charles Mental Health Centre	Kershaw Ward	23.6	5.6	23%
TOPAS Waterhall Care Centre	TOPAS	33.4	7.1	21%
3 Beatrice Place	3 Beatrice Place	31.2	4.8	14%
St Charles Mental Health Centre	Redwood Ward	28.4	3.2	11%
Hillingdon Hospital Mental Health Centre	Oaktree Ward	19.8	1.0	4%
Northwick Park Mental Health Centre	Ellington Ward	23.6	1.0	4%
Core service total		**22.7**	**166.1**	**14%**
Trust Total		**4723.7**	**967.1**	**21%**

- The sickness rate for this core service was 4.2% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 4.6%. This was higher than the trust's annual total of 3.4%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Hillingdon Hospital Mental Health Centre	Oaktree Ward	6.0%	8.0%
TOPAS Waterhall Care Centre	TOPAS	4.2%	4.5%
Northwick Park Mental Health Centre	Ellington Ward	6.1%	4.4%
St Charles Mental Health Centre	Redwood Ward	1.0%	3.3%
3 Beatrice Place	3 Beatrice Place	6.5%	3.0%
St Charles Mental Health Centre	Kershaw Ward	4.6%	2.6%
Core service total		**4.6%**	**4.2%**
Trust Total		**3.0%**	**3.4%**

- Managers had calculated the number and grade of nurses and healthcare assistants required to provide safe staffing for each ward. For example, on Ellington Ward, managers recently increased the establishment of healthcare assistants to ensure adequate staffing levels on the day shift. Each ward had a minimum of a registered nurse and two healthcare assistants on duty. Managers said they could adjust staffing levels daily to take account of case mix.
- At the last inspection, staffing levels on Ellington Ward did not always allow staff enough time to take breaks from their work. During this inspection, this was no longer the case. Staff and patients told us that there were sufficient numbers of staff on the ward, and staff got their breaks.
- When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Wards said they rarely used agency staff, and mostly used regular bank staff. Using regular bank staff helps to promote consistency of care to patients.
- Between 1 November 2017 and 31 July 2018, of the 156,951 total working hours available for registered nurses, 22,350 hours were filled by bank staff to cover sickness, absence and, predominantly, vacancies.
- Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. There were also sufficient staff on each ward to carry out restraint of a patient, if required.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

- The trust set a target of 95% for completion of mandatory and statutory training.
- The compliance rate for staff attendance at mandatory and statutory training courses at 31 October 2018 was 94%. Of the training courses listed, nine failed to achieve the trust target and of those, all scored above 75%.
- The most recent training compliance reported for this service was higher than the 88% reported in the previous year.
- The trust's learning and development team emailed managers weekly reports on staff compliance with mandatory training. Managers reminded staff to complete their mandatory training during supervision and team meetings.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Adult Basic Life Support	9	9	100%	✓	↑
Conflict Resolution	2	2	100%	✓	↑
Infection Prevention (Level 1)	9	9	100%	✓	↑
Manual Handling - Object	13	13	100%	✓	↑
Non-Inpatient Fire Safety	21	21	100%	✓	↑
Personal Safety Breakaway (Level 1)	8	8	100%	✓	↑
Prevent Awareness (Level 1)	9	9	100%	✓	↑
Safeguarding Adults (Level 1)	9	9	100%	✓	↑
Safeguarding Children (Level 1)	9	9	100%	✓	↑
Health and Safety (Slips, Trips and Falls)	148	145	98%	✓	↑
Information Governance	148	143	97%	✓	↑
Infection Prevention (Level 2)	139	134	96%	✓	↑
Safeguarding Children (Level 3)	139	132	95%	✓	↓
Equality and Diversity	148	139	94%	✗	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 2)	139	131	94%	✗	↓
Personal Safety - MVA	25	23	92%	✗	↓
Manual Handling - People	135	123	91%	✗	↑
Emergency Life Support	111	97	87%	✗	↓
Inpatient Fire Safety	127	110	87%	✗	↑
Prevent WRAP	139	121	87%	✗	↑
Physical Intervention	106	88	83%	✗	↓
Immediate Life Support	28	22	79%	✗	↑
Total	**2693**	**2518**	**94%**		↑

Assessing and managing risk to patients and staff

Assessment of patient risk

- Most risks to patients were assessed, monitored, updated regularly and managed on a day-to-day basis. Individual risks were discussed in multi-disciplinary meetings, individual reviews, handovers and best interest meetings.
- The inspection team reviewed 24 patient care records across the wards. Staff completed a risk assessment for every patient on admission and updated it where necessary, apart from for one patient on Kershaw Ward. Staff on Kershaw Ward could not find a risk assessment for one patient who had been admitted in January 2019, however, their care plan addressed important risks such as chronic physical health issues and risk to self. Patients' risk assessments included historical and current risks, which included risks of self-harm or suicide, risks towards others and patients' physical health.
- A few patients were at risk of receiving unsafe care because staff did not complete a falls risk assessment for all patients on admission. On Kershaw Ward, Redwood Ward and Beatrice Place, we found six patients did not have a falls risk assessment completed on admission. Staff completed a falls risk assessment for all patients on admission to Oaktree and Ellington wards.
- On Kershaw Ward, staff had completed a falls risk assessment for one patient only after they had fallen on the ward. On Redwood Ward, staff had recorded that one patient had a history of poor mobility but had not completed a falls risk assessment. At Beatrice Place, a patient had had a fall, but the falls risk assessment was not updated. The trust's policy for prevention and management of falls stated all patients over 65 years, irrespective of underlining conditions or frailty, must have a falls risk assessment completed on admission and it must be reviewed if a fall occurs.

Management of patient risk

- Staff were aware of and dealt with specific risk issues such as pressure ulcers. Nationally recognised assessment tools were used such as the malnutrition universal screening tool (MUST) and the Waterlow pressure ulcer assessment tool which gives an estimated risk for the development of a pressure ulcer in a given patient. Staff were able to provide patients with pressure relieving equipment such as mattresses and cushions. Managers were able to seek advice and refer patients to the tissue viability nurse specialist when required. Patients were also assessed for the risk of venous thromboembolism (VTE) on admission.
- Although we found staff did not complete falls risk assessments for all patients, we did find some good examples of staff managing patients who were at risk of falls. They were provided with walking aids and non-slip socks, where required. Wards used falls mats. These were mats with built-in sensors to alert staff if a patient was moving towards the edge of their chair and may have been about to fall; it was linked to their call bell. Height adjustable beds were also offered to patients at risk of falls. Where patients were at risk of falling out of bed, staff used bedrails and low-rise beds to mitigate the risk. Staff completed a specific bedrail risk assessment where necessary.
- Where patients required the use of a hoist, they all had individual slings in line with infection control procedures.
- Staff identified and responded to changing risks to, or posed by, patients. This was undertaken through daily handover meetings, multidisciplinary team reviews, incident reviews and one to one meetings with patients.
- Staff followed good policies and procedures for use of observation.
- Staff applied blanket restrictions on patients' freedom only when justified. At the time of the inspection there were some restrictions in place such as accessing the kitchen and laundry areas. These could only be accessed with staff supervision for patient's safety. We saw staff offered patients a choice of drinks and snacks throughout the day.
- The trust had a smoke free policy. Smoking cessation programmes were available if required.
- Staff ensured that informal patients understood their right to leave the ward when they wished. Information was displayed on the notice boards.

Use of restrictive interventions

- There had been no instances of seclusion over the reporting period. The number of incidences (none) was the same as the previous 12-month period (none).
- There had been no instances of long-term segregation over the 12-month reporting period. The number of incidences (none) was the same as the previous 12-month period (none).
- This service had 73 incidences of restraint (involving 27 different service users) and no incidences of seclusion between 1 October 2017 and 30 September 2018. These were the highest on TOPAS ward, with 38 episodes of restraint, involving seven patients.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Oaktree Ward	0	3	1	0 (0%)	0 (0%)
Ellington Ward	0	7	5	0 (0%)	2 (29%)
Kershaw Ward	0	5	4	0 (0%)	0 (0%)
Redwood Ward	0	19	9	0 (0%)	7 (37%)
TOPAS	0	38	7	0 (0%)	3 (8%)
3 Beatrice Place	0	1	1	0 (0%)	0 (0%)

- The wards participated in the trust's restrictive interventions reduction programme. The trust did not have a specific policy for the use of restraint of older people.
- Staff used restraint only after de-escalation had failed. On Oaktree Ward, we observed verbally de-escalation of a patient who became aggressive towards a staff member. The staff member remained calm, maintained the patient's dignity and reassured the patient with good effect.
- The number of restraint incidences reported during this inspection was higher than the 88 reported the previous 12-month period. However, there were no incidences of prone (chest down) restraint. The number of incidences (zero) had decreased from the previous 12-month period (13).
- There were 12 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from zero to two per month between 1 October 2017 and 30 September 2018. The number of incidences (12) had decreased from the previous 12-month period (28). Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We checked two records of patients who had been administered rapid tranquilisation, which demonstrated that staff carried out the necessary nursing and medical observations to ensure the safety of the patients.
- There had been zero instances of mechanical restraint over the reporting period. The number of incidences (zero) was the same as the number of incidences from the previous 12-month period (zero).
- At the last inspection, staff on Kershaw Ward and Redwood Ward were not clear about the requirements for reporting of incidents of restraint when used to deliver personal care. At this inspection, improvements had been made. Staff completed a reporting form for "supporting people with personal care" on every occasion they needed to restrain someone for personal care. Patients who required restraint for personal care also had a care plan in place detailing

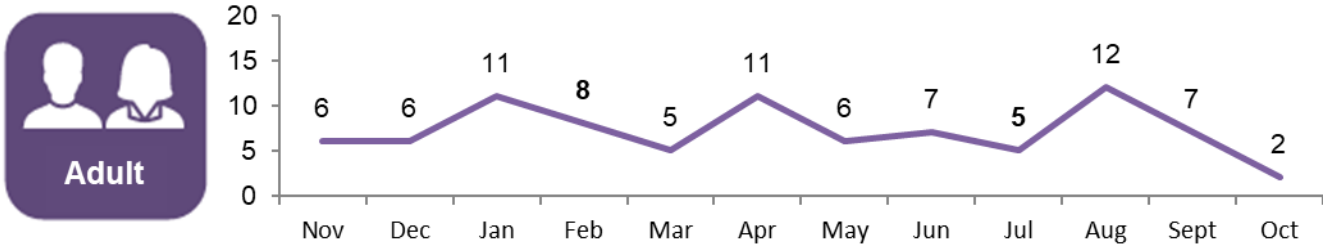
this. The matron for Kershaw and Redwood wards completed monthly audits of restraints used for personal care and fed this back to the trust's restrictive interventions reduction programme for assurance.

Safeguarding

- This service made 86 safeguarding referrals between 1 November 2017 and 31 October 2018, of which 86 concerned adults and none concerned children. The number of safeguarding referrals reported during this inspection was higher than the 77 reported at the last inspection.
- Staff had received training around safeguarding adults and children. They had a good understanding of the different types of abuse and possible harm patients could experience. Staff took appropriate steps to report and record any safeguarding concerns.
- Staff took appropriate measures to ensure that patients were kept safe. For example, on one ward there was supervised contact for a patient's relative during a current safeguarding investigation.
- Staff were able to give examples of how they had worked with other external agencies, such as the local authority, when safeguarding concerns had been raised.
- Staff followed safe procedures for children visiting the ward. Children were not allowed onto the wards, but there was a family visiting room for patients to use.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
Wards for older people with mental health problems	86	-	86

- The number of adult safeguarding referrals in month ranged from 2 to 12 (as shown below).



Staff access to essential information

- Staff used a combination of electronic and paper records.
- The trust had migrated to a new electronic patient record system during the time of our inspection. The inspection team could not always easily find information as some information was not yet stored in the correct place. Certain staff members were identified as “super users” of the new system and were available to support staff during the transition period.

Medicines management

- The service had good systems in place to safely support people with the management of their medicines. For example, where staff administered covert (hidden) medicines to patients, we saw evidence that it was part of a best interests decision.
- Staff told us that the pharmacist regularly visited the ward to check on the management of medicines. This included checking of medicines’ expiry dates. The trust had an on-call pharmacist available 24 hours, seven days a week.
- On Kershaw Ward, we found staff did not administer medicines in line with the Nursing and Midwifery Council (NMC) guidance and trust policy. During the inspection we observed a nurse signing prescription charts before administering each patients’ medicines. This was raised with the ward manager who said that this was trust policy and was in line with the training they had received. This was raised with the trust, who confirmed it was not in line with the trust policy and would ensure staff are aware of the correct practice.
- Staff reviewed the effects of medication on patients’ physical health regularly and in line with National Institute for Health and Care Excellence (NICE) guidance, especially when the patient was prescribed a high dose antipsychotic. Staff rarely used anti-psychotic medication on this patient group.

Track record on safety

- The number of serious incidents reported during this inspection was lower than the five reported at the last inspection. Two pressure ulcers had been reported and one slip/trip or fall.

Reporting incidents and learning from when things go wrong

- Staff knew how to record and report any accidents, incidents or near misses.
- Staff reported all incidents that they should report. Including falls, episodes of restraint and pressure ulcers. On Ellington Ward, staff had achieved 150 days without a pressure ulcer, which was recognised by the trust as a positive achievement.
- Not all staff understood the term ‘duty of candour’. This is where every professional must be open and honest with patients when something goes wrong with their care and treatment.

However, staff talked about examples where they were open and transparent with patients and carers. The record of incidents showed that staff apologised to patients and family members when things went wrong.

- At the last inspection, staff were able to give us examples of incidents on their wards and within their own services and the shared learning. However, there were no arrangements in place to share learning across all the wards for older people to improve practice. At this inspection, we found the situation was the same. Staff received feedback from investigation of incidents that occurred on the ward, and within the borough. However, there was no broader understanding of incidents across the wards for older people within the trust.
- We saw examples of changes in practice as a result of learning from incidents that were known to the staff team, for example, there had been a delay in staff recognising that a patient had suffered a fracture following a fall, as a result, staff now routinely referred patients for an x-ray following a fall. This was unless the doctor could justify that it was not appropriate.
- Staff on Ellington Ward and Oak Tree Ward discussed lessons learnt in the handover, which was part of a trust wide weekly briefing. This meant that staff were aware of any incidents that had occurred in the trust and any lessons to be learnt for future practice. For example, staff shared that they should ensure that there is better communication before a patient is discharged to a community team, due to an incident occurring in another in-patient service.

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

Is the service effective?

Assessment of needs and planning of care

- We reviewed 24 care and treatment records during our inspection. Staff completed a comprehensive mental and physical health assessment of patients' needs in a timely manner at, or soon after, admission. Patients had a comprehensive physical assessment after admission to the wards. This included a physical examination, blood testing, electrocardiogram (ECG) and other investigations when required. At the time of our inspection, the wards had started using the national early warning score 2 (NEWS2) system. Staff had not received training in NEWS2 and were not filling in the forms correctly. NEWS2 is a system to help staff to identify a patient with physical deterioration and standardises the response.
- Staff developed care plans that met the needs identified during assessment. Care plans were individualised and updated regularly. Care plans supported a wide variety of patient needs, including mental health, physical health (including dysphasia or speech impairment, skin integrity and falls risk), use of equipment (including bedrails) maintaining dignity in personal care, sleep and medicines.

- Care plans were personalised, holistic and recovery-orientated. For example, care plans were developed around activities important to patients, which included gardening, art, music and sensory therapy. On Oaktree Ward, patients had one-page care plan summaries on their bedroom walls. This detailed essential information, such as their primary nurse and any mobility needs.
- At Beatrice Place, we saw excellent life story information in patients' care plans, which included the patient's personal history, important relationships, hobbies and interests. This helped to promote person-centred care. All patients at Beatrice Place had an end of life care plan, which included their religious needs and what they wanted to wear when they passed away.
- Staff developed care plans for the use of restraint for one patient who required it for personal care. The care plan detailed the number of staff required to ensure restraint was carried out safely. Staff clearly recorded when restraint was used in the patient's progress notes and restraint incidents were reviewed at every ward round.

Best practice in treatment and care

- Medical and nursing staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions, for example, medicines were prescribed within appropriate limits. Staff provided a range of care and treatment interventions suitable for the patient group.

- At the last inspection, at Beatrice Place and Redwood Ward it was difficult for patients to access psychological therapies promptly as there was no clinical psychologist in the multidisciplinary team. At this inspection, Beatrice Place still did not have a dedicated clinical psychologist. If patients required psychological input, staff referred them to the borough psychologist. This issue was on the service's risk register, and the borough director told us that they were planning to recruit a substantive clinical psychologist for the team. On Redwood Ward, this was no longer an issue. A dedicated clinical psychologist was available for two days a week. On Kershaw Ward, a clinical psychologist was available for one day a week, Oaktree Ward and Ellington Ward shared a full-time clinical psychologist.

- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. We saw examples where staff referred patients to hearing clinics, podiatrists, dentists, speech and language therapists and tissue viability nurses. We saw an example on Oaktree Ward, where staff referred a patient to a neurologist to support their cognitive needs. Staff worked collaboratively with acute hospitals and hospices to ensure that patients' physical healthcare needs were met in a timely manner.

- At Beatrice Place, staff reported that management of patients' physical health had improved since the team employed a registered general nurse (RGN) who coordinated physical health care, and worked closely with GPs. The RGN offered physical health care training to the other nursing staff.

- Staff assessed and met patients' needs for food and drink. Individual weight monitoring was carried out. Food and fluid intake was monitored for those patients who were vulnerable to poor nutrition. Staff as Beatrice Place, Oaktree Ward and Ellington Ward had access to a dietician for input regarding nutritional needs. However, Kershaw Ward and Redwood Ward did not have dietetic input due to the service level agreement being withdrawn in November 2018.

- At Beatrice Place, feeding aids such as specialist bowls and cutlery were in use. Food choices included specialist options such as soft or pureed foods. Staff had access to thickener to aid swallowing, and dietary supplements.

- Staff supported patients to live healthier lives. For example, through participation in smoking cessation schemes. Staff encouraged patients to carry out gentle exercise to aid them with their mobility, via walks and chair-based movement.

- Staff used recognised rating scales to assess and record severity and outcomes. Staff used health of the nation outcome scales (HoNOS) to record the severity of each patient's needs and their outcomes as their treatment progressed. Staff used the Addenbrooke's cognitive examination to assess for cognitive impairment, and the model of human occupation screening tool (MoHOST) to assess the patients occupational functioning.

- Staff used technology to support patients effectively. For example, staff were able to access GP test results and medicines information.

- Staff participated in clinical audits, such as a controlled drugs audit, a covert medication audit, a falls audit, a physical health audit and an infection control audit.
- At the last inspection, regular audits were taking place, though on Oaktree Ward action plans and timescales to address audit findings were not present. During this inspection, this was no longer the case. Designated nurses on all wards completed care plan audits, alongside action plans when shortfalls were identified.
- Staff worked in collaboration to improve the quality of the service. For example, all of the older adults wards were involved in the dementia-friendly ward initiative, which looked at ways to improve the ward environment so patients could orientate themselves better.

Skilled staff to deliver care

- Patients had access to a range of professionals through multidisciplinary working, including medical, pharmacy, occupational therapy, activity co-ordinators, social workers, healthcare assistants and nursing staff. Domestic and administrative staff supported the wards. There were some exceptions to this.
- The locum consultant psychiatrist on Kershaw Ward was due to leave during the week of our inspection. The permanent consultant was on maternity leave. The consultant from

Redwood Ward was working jointly with a community-based consultant to cover Kershaw Ward until the permanent consultant psychiatrist returned in March 2019.

- Kershaw Ward and Redwood Ward did not have access to dieticians. The service level agreement for the dietician was withdrawn in November 2018, and a replacement had not been found. This meant the wards lacked specialist support for patients' nutrition and hydration needs. We saw that one patient on Kershaw Ward was in urgent need of dietetic input due to their low body weight. The ward team were concerned about the risks of refeeding syndrome as they were not specialised in eating disorders. The patient had been accepted for transfer to an eating disorder unit, but there was no agreed date for this to happen. The issue around a lack of dietetic input was on the service's risk register and we raised it with the borough director during the inspection who confirmed they were liaising with the clinical commissioning group (CCG) to arrange dietetic support within the borough. In the interim, senior managers said they were in the process of arranging for a bank dietician via a local community NHS trust.
- Kershaw Ward and Redwood Ward did not have a dedicated physiotherapist or speech and language therapist (SALT), and used an agency physiotherapist when required. This meant that patients who required SALT and physiotherapy input could not always access it in a timely manner.
- Beatrice Place had a physiotherapist available for three days per week. Oaktree Ward and Ellington Ward accessed physiotherapists and SALTs through referral. Staff reported that physiotherapists were able to assess patients promptly following a fall, however routine referrals for SALTs could take up to three weeks.
- Staff were experienced and qualified, and mostly had the right skills and knowledge to provide care and treatment. Staff we spoke with had a good knowledge and understanding of the needs of older people. However, not all staff had received training in dementia awareness as recommended by the National Institute for Health and Care Excellence (NICE). Most patients on the wards had dementia. Dementia training was not mandatory. The trust's learning and development system had an e-learning module for dementia training. Managers did not have oversight of or prioritise staff compliance with dementia training as it was not mandatory. However, managers across the wards were dementia specialists and offered support and guidance to staff. However, there was a risk that not all staff had received the necessary training to underpin their skills and knowledge in this area.
- At Beatrice Place, the registered general nurse (RGN) provided in-house training on physical health issues, such as catheter care. The physiotherapist had provided falls training.
- Managers provided new staff with appropriate induction. Managers signed off a competency checklist that ensured staff were safely orientated to the ward and understood the purpose of the ward.
- The trust's target rate for appraisal compliance is 95%. For the period 1 April 2017 to 31 March 2018, the overall appraisal rate for staff within this service was 88%. This year, the overall appraisal rate was 97% on 31 October 2018. The ward with the lowest appraisal rate at 31 October 2018 was Beatrice Place with an appraisal rate of 94%.
- The rate of appraisal compliance for staff reported during this inspection was higher than the 91% reported at the last inspection.

Ward Name	Total number of permanent staff who have had an appraisal	% appraisals (as at 31 October 2018)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Oaktree Ward	15	100%	79%
Redwood Ward	25	100%	96%
TOPAS	32	97%	97%
Kershaw Ward	19	95%	96%
Beatrice Place	29	94%	71%
Core service total	**120**	**97%**	**88%**
Trust wide	**4163**	**92%**	**87%**

- The service reported an overall compliance rate of 82% for supervision, which was in line with the trust's compliance rate. At the last inspection, staff at Beatrice Place were not receiving supervision in line with trust policy. The system for recording supervision was not embedded across the service. During this inspection, improvements had been made at Beatrice Place. The ward manager kept a log of who had received supervision and completed an audit of this. There had been a slight drop in compliance for supervision during December 2018 due to the previous ward manager leaving. Supervision records at Beatrice Place demonstrated high quality discussion around safeguarding, risk assessment, training and capacity.
- The system for recording supervision varied across the wards. Managers used their own spreadsheets to monitor supervision, with some wards separating clinical and management supervision. On Redwood Ward, the ward manager only had a system to record and monitor the supervision sessions they directly provided, it did not cover supervision sessions provided by more junior members of the nursing team, therefore we could not be assured that this was taking place. The discussion during supervision on Redwood Ward was poorly recorded and did not evidence discussion around patient care or practice development.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Kershaw Ward	277	277	100%
Redwood Ward	302	301	100%
Ellington Ward	90	73	81%
3 Beatrice Place	378	291	77%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Core service total	**1047**	**942**	**82%**
Trust Total	**6944**	**8431**	**82%**

- Named staff were champions for specific areas such as safeguarding, infection control, complaints and tissue viability.
- Managers dealt with poor staff performance promptly and effectively. Human resources within the trust provided support where appropriate.
- Beatrice Place had recruited a volunteer who supported people with activities. All volunteers were trained and supported for the roles they undertook. The trust service user and carer engagement worker had recruited more volunteers to support patients on Beatrice Place, Kershaw Ward and Redwood Ward, and they were due to start in March 2019.

Multi-disciplinary and interagency team work

- Staff held regular and effective multidisciplinary meetings. Staff attended monthly team meetings where they discussed topics such as incidents, safeguarding, lessons learnt and training.
- Staff shared information about patients at effective handover meetings within the team. Teams had daily handover meetings at the start of each shift. We observed a whiteboard meeting on Kershaw Ward, where the multidisciplinary team reviewed each patient, including safeguarding concerns, discharges and section renewals. Staff demonstrated good working relationships and excellent knowledge of the patient group.
- The wards had effective working relationships with other relevant teams within the organisation. The older adult's community mental health teams and home treatment teams regularly attended ward rounds, which demonstrated joined up working.
- Staff worked together 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. This included when patients moved between services or when discharges were being planned. Staff invited patients' carers, and relevant professionals from other services to ward rounds and other meetings, where appropriate.

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

- Mental Health Act (MHA) training was not mandatory training for all staff, but staff completed the training when it was essential to their role.
- Staff demonstrated a good understanding of the MHA and the key principles of the MHA Code of Practice.
- The wards had access to a MHA administrator who was available for guidance, training and support.
- Policies and procedures regarding the MHA were available on the trust intranet.
- Patients on the wards had access to advocates, including independent mental health advocates (IMHA). There was information on the ward indicating how patients were able to contact advocates and advocates visited the wards regularly.
- Staff explained to patients their rights under the MHA in a way that they could understand, repeated is as required and recorded that they had done it.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Staff signed a leave form each time the patient used Section 17 leave.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of patients' detention papers and associated records correctly so that they were available to all staff that needed them. However, on Kershaw Ward, for one patient it was not clear if there was a valid section in place. The patients' section 2 had expired the day before our visit, and during our inspection staff spoke about them being on a section 3, however we could find no record of the section on their electronic record. This was raised with the trust during the inspection to gain assurance that they were legally detained.
- Wards displayed a notice to tell informal patients that they could leave the ward freely. This information was in patients' welcome packs too.
- Staff carried out regular audits to ensure the MHA was being applied correctly. For example, checking that patients had been informed of their rights about the section of the MHA under which they were detained. On Kershaw Ward, the most recent audit showed 100% of detained patients had been informed of their rights.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act (MCA) training was not mandatory training for all staff, and staff completed the training when it was essential to their role. On most wards, staff had good knowledge and practice in applying the MCA.
- The trust told us that 62 Deprivation of Liberty Safeguard (DoLS) applications were made to the local authority for this service between 1 October 2017 to 30 September 2018. This was lower than the 75 reported at the last inspection. The greatest number of DoLS applications within a month was 17 in March 2018. The trust advised all DoLS applications made were urgent.

- CQC received 32 direct notifications from the trust between 1 October 2017 and 30 September 2018 of authorised DoLS that had been put into place. Some wards had not notified the CQC and the trust had reminded them of the need to do this.

	Number of 'Urgent' DoLS applications made by month October 2017-September 2018												
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Total**
Urgent applications made	0	0	16	3	2	17	4	3	9	2	2	4	62
Urgent applications approved	0	0	10	3	0	8	1	0	2	2	1	2	29

- At the last inspection, the legal status of one patient on Kershaw Ward regarding their DoLS application had been incorrectly recorded. The patient did not have a current authorisation in place, although staff believed that it was in place. At this inspection, improvements had been made. Managers had good oversight of the status of DoLS application. They used a DoLS tracker to monitor applications and whether DoLS were legally authorised or if they were due to expire. Managers sent this information monthly to the trust adult MCA lead practitioner who oversaw all applications.
- The trust had a policy on the MCA, including DoLS. Staff knew where to get advice from within the trust regarding the MCA, including DoLS. The trust adult MCA lead practitioner provided bespoke DoLS training to staff. Care records showed detailed mental capacity assessments and best interests decisions being recorded, such as in relation to covert medication and do not attempt cardio pulmonary resuscitation orders (DNACPR). These were appropriately documented and the patient's wishes and views were obtained, as well as their family's views. Staff usually tried to engage and communicate with patients and present information in a simple format if they were having difficulty understanding information.
- However, there was room for improvement at Beatrice Place. At the last inspection, two capacity assessments at Beatrice Place contained very brief information and lacked detail about any assessment or discussion that had taken place. At this inspection, 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 that the patient lacked the mental capacity to make it. For example, for one patient, care records stated that they were unable to comment or provide a perspective due to cognitive impairment and therefore had no capacity to make a decision. Another patient care record stated that a decision was made about the capacity of a patient to consent to personal care without obtaining the assistance of an interpreter. The patient had a poor understanding of English. This meant that patients at Beatrice Place were not being supported to make their own decisions as the MCA requires.

- Patients had access to an independent Mental Capacity advocate (IMCA) if they did not have families or friends involved in their life to consult when specific decisions about serious matters had to be made.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

- Staff supported patients and carers with help, emotional support and advice at the time they needed it. Patients and carers confirmed that staff were consistently respectful towards them. On Oaktree Ward, one patient commented that staff would always find the time to sit and talk with them. At Beatrice Place, one carer said staff provided exemplary care to their mother, and another carer said there was good consistency in terms of staff and that staff understood their mother's needs. On Ellington Ward, one relative reported that staff went the extra mile to support patients and another said that their relative's mental cognition had improved after the advice and treatment received.
- Staff supported patients to understand and manage their care, treatment or condition through one to one sessions and care programme approach (CPA) meetings. Consultants met with individual family members as requested outside of the ward round.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, on Oaktree Ward, staff supported a patient to their chosen place of worship.
- Patients said staff treated them well and behaved appropriately towards them.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.
- Staff maintained the confidentiality of information about patients.
- The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at five service location(s) scored higher than similar organisations. Two locations, TOPAS Waterhall Care Centre (86.1%) and 3 Beatrice Place (89.4%) scored lower when compared to other similar trusts for privacy, dignity and wellbeing. Some of these scores included other wards on the same site.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Hillingdon Hospital Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units, Long stay/rehabilitation mental health wards for working age adults.	95.7%

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Northwick Park Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	91.9%
St Charles Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	93.7%
TOPAS Waterhall Care Centre	Wards for older people with mental health problems.	86.1%
3 Beatrice Place	Wards for older people with mental health problems.	89.4%
Trust overall		**93.4%**
England average (mental health and learning disabilities)		**91%**

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service. Staff gave patients welcome packs on admission. This included helpful information such as who their named nurse was, plus an explanation of physical health checks, meal arrangements and visiting times.
- We observed a lunchtime at Beatrice Place, where staff engaged patients and created a friendly and relaxed atmosphere. Staff were mindful of the environment, closing doors to prevent noise entering the dining area from other areas of the ward, and played music to create a relaxed atmosphere. Staff knew the patients well, and had a good knowledge of their individual preferences, histories and behaviours. Staff respected patients' personal preferences in relation to food and drink choices.
- Patients and people that were important to them were involved in the development of their care plans. All the patients we spoke said they were aware of their care plan and most told us they had a copy. On Oaktree Ward, patients received a 'my care plan' document, which included a copy of their care plan and other helpful information, such as a physical healthcare leaflet.
- On Kershaw Ward and Redwood Ward, patients were not invited to their ward rounds. They were asked for their views before the meeting, and staff met with them after the meeting to provide feedback. Managers expressed their wish to give patients the opportunity to attend in future. The ward welcome packs for these wards contained incorrect information, as they stated patients would be invited to attend their ward round.
- Staff enabled patients to give feedback on the service they received. Wards held community meetings for patients, where patients provided feedback on their experience of the ward. Patients were supported to fill out a 'you said, we did' form. This was an opportunity for patients to feedback about how the service could be improved. For example,

on Ellington Ward a patient had commented that some of the chairs in the communal lounges were wobbly, so new chairs were ordered.

- Staff enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate. We saw an example of this at Beatrice Place, where a patient had an advance decision in place to refuse treatment.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. We saw evidence that staff emailed and telephoned families and carers to update them on their relative. Carers were involved in care planning, decision-making and information sharing about the patient as outlined in individuals' care plans. At Beatrice Place, carers met with the consultant every six months to review their relative's care and treatment.

- Opportunities for carers to give feedback on the service they received varied. On Oaktree Ward, the ward manager and the occupational therapist facilitated weekly drop-in sessions for carers. This was an opportunity for carers to learn more about the service, gain support and provide feedback. At Beatrice Place, carers told us they felt involved and were able to feedback to staff if they needed to and they had the opportunity to attend a quarterly carers meeting. At Kershaw Ward and Redwood Ward, there were no formal forums for carers to feedback on the service they received. However, the service user and carer engagement lead was in the process of setting up a carers forum for both wards, which was due to start in March 2019.

- On Oaktree Ward, the ward psychologist offered one-to-one sessions to carers and families if they required extra support.

- Family members were offered help to access carers assessments and information when required. For example, on Kershaw Ward, they liaised with the community mental health team to assist with this.

Is the service responsive?

Access and discharge

Bed management

- The trust provided information regarding average bed occupancies for the six wards in this service between 1 October 2017 to 30 September 2018.
- Six of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 October 2017 to 30 September 2018) (current inspection)
Oaktree Ward	95% - 100%
Ellington Ward	95% - 108%
Kershaw Ward	89% - 106%
Redwood Ward	85% - 98%
TOPAS	52% - 98%
3 Beatrice Place	87% - 100%

- Staff told us there was always a bed available on the wards for older adults when patients returned from leave.
- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interest of the patient. For example, patients were moved to acute general hospital wards when medical attention was required.
- When patients were moved or discharged from the wards staff facilitated this at an appropriate time during the day whenever possible.
- The trust provided information for average length of stay for the period 1 October 2017 to 30 September 2018.

Ward name	Average length of stay range (1 October 2017 to 30 September 2018) (current inspection)
Oaktree Ward	84-160
Ellington Ward	68-166
Kershaw Ward	66-156
Redwood Ward	57-93
TOPAS	87-188
3 Beatrice Place	917-1157

- The trust reported no out of area placements for this service.
- This service reported 11 readmissions within 28 days between 1 October 2017 and 30 September 2018. Four of the readmissions (36%) were readmissions to the same ward as discharge. The average number of days between discharge and readmission was 12 days. There were two instances of patients being readmitted on the same day as being discharged but there were none where patients were readmitted the day after being discharged.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Oaktree Ward	2	0	0%	4-8	24.5
Ellington Ward	5	3	60%	2-28	13.6
Redwood Ward	3	0	0%	0-28	16.3
3 Beatrice Place	1	1	100%	0-0	0.0

Discharge and transfers of care

- Between 1 October 2017 to 30 September 2018 there were 282 discharges within this service. This amounts to 6% of the total discharges from the trust overall (4,832).
- Staff planned for patients' discharge upon admission. Patients' care co-ordinators attended ward rounds to ensure they were involved in discharge plans.
- The wards had weekly discharge planning meetings to ensure that the appropriate support was in place before a patient was discharged. The managers reported that delayed discharges had reduced.
- On Ellington Ward the occupational therapist completed a home assessment to ensure that the property was suitable for the patient prior to their return, this included installing minor adaptations.
- The ward manager on Ellington Ward attended a twice monthly bed management meeting to discuss the current admissions. For example, one patient had been admitted for over 400 days because of their housing situation involving the Court of Protection.
- Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital. Care records showed that staff liaised with the acute hospital team when patients were transferred due to physical health deterioration to ensure that all required information was shared.
- Delayed discharges across the 12-month period ranged from 0 to 21 per month. The total number of delayed discharges within this service was 52, which amounted to 18% of the total discharges from the service as a whole.
- The proportion of delayed discharges reported during this inspection was lower than the 173 reported at the time of the last inspection.
- Delayed discharges of care were escalated to senior managers. Kershaw Ward and Redwood Ward had access to an older adults home treatment team, which helped with discharge and ensured patients had the support they needed when they went home.

Facilities that promote comfort, dignity and privacy

- On most wards, patients had their own bedrooms. At Oaktree Ward there were two dormitories which were each shared by four people of the same gender. During our inspection the manager reported that funding had been secured to change these rooms into single bedrooms.
- Wards were in a good decorative condition and bedroom and communal areas were clean. Patients could personalise their bedrooms and had somewhere secure to store their possessions.
- On Redwood Ward, there were not enough seats in the living room and dining area for the number of patients on the ward. This was raised with the manager during the inspection who informed us that additional seats had been ordered.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care. For example, on Kershaw Ward and Redwood Ward, there were gender specific lounges. On Ellington Ward, patients had access to an occupational therapy kitchen.
- There were quiet areas on each ward and a room where patients could meet visitors. Patients could make a phone call in private if needed using their phone or a ward phone. Patients had access to outside space.
- The feedback on the quality of the food was mixed. For example, on Ellington Ward, three patients told us the food was of a good quality, but on Oaktree Ward, six out of the seven patients we spoke with said the food was of a poor quality. A choice of food was available and staff were aware of where patients who needed additional support to eat. Where required there was access to dietary supplements, a soft diet and other alternatives, such as vegetarian, gluten free, kosher or halal meals. On Oaktree Ward, staff used different colour mats during meal times to help identify patients who required additional support with eating or drinking. Patients had access to hot drinks and snacks at any time requested.
- The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations was higher than similar trusts. Beatrice Place (91.7%) scored lower than other similar trusts for ward food. Some of these scores included other wards on the same site.

Site name	Core service(s) provided	Ward food
Hillingdon Hospital Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units, Long stay/rehabilitation mental health wards for working age adults.	96.1%
Northwick Park Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	94.3%
St Charles Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	93.6%
TOPAS Waterhall Care Centre	Wards for older people with mental health problems.	100%
3 Beatrice Place	Wards for older people with mental health	91.7%

	problems.	
Trust overall		**95.4%**
England average (mental health and learning disabilities)		**92.2%**

- At the last inspection, menus were not provided in accessible formats to support people with dementia. At this inspection, only Beatrice Place had made improvements to their menus, which were in larger font with pictures. On Redwood Ward, Kershaw Ward, Ellington Ward and Oaktree Ward, the menus remained in small print. This was raised with managers who said the catering company provided them in this format only.
- Patients had access to a programme of therapeutic activities on each ward to provide stimulation and support. Activities included weekly pet, art, music therapy and chair-based exercise groups. Each patient had an individualised activity timetable created for them. At Beatrice Place, staff had implemented the 'namaste' care programme for people with advanced dementia. The programme involved sensory stimulation activities, such as hand massages and aromatherapy oils. Also at Beatrice Place, staff arranged for a choir to attend the ward during the Christmas period. The trust's service user and engagement worker was working hard to improve the amount of activities and patient/carer engagement.. They had secured a garden plot at the St Charles' site so patients from Redwood Ward and Kershaw Ward would be able to use it for gardening.
- Wards had input from art therapists, music therapists and drama therapists, who carried out group and one-to-one sessions with patients.

Patients' engagement with the wider community

- Patients' engagement with the wider community was mostly through their family and friends, who were warmly welcomed on the wards. Staff supported patients to attend important appointments off the ward and escorted people to religious services when required.

Meeting the needs of all people who use the service

- The wards for older people were designed to be accessible for people with a physical disability. The wards were spacious and wheelchair users were able to move freely. Assisted toilets, bathrooms and shower rooms were available for people with mobility issues.

- Moving and handling equipment was available such as hoists and height adjustable beds so that staff could support people with their mobility needs safely.

- To minimise the risk of falls, handrails and grab rails were installed and other adaptations, such as raised toilet seats, were provided.

- At the last inspection, we found that some ward environments did not fully support patients with dementia or cognitive impairment. At this inspection, we found improvements had been made to make them more dementia-friendly. For example, on Kershaw Ward and Redwood Ward there was now pictorial signage on the doors to indicate the function of the room. Doors and flooring had contrasting colours to make it easier for people to see. The wards also had dementia-friendly clocks to assist patients to orient themselves to the date and time. Staff wore yellow name badges with their names in large font to make it easier for patients to identify them. On Oaktree Ward, the garden was dementia-friendly and contained different herbs which some patients were encouraged to smell to help increase their appetite for food.
- Patients and carers were provided with a range of information relating to activities, treatment, safeguarding, patients' rights and complaints. Information on mental health conditions, support groups, smoking cessation and the Mental Health Act (MHA) was also available. These could be made available in specific languages if needed. At Beatrice Place, where some patients first language was not English, we saw evidence of information about their care and treatment being translated into their own language to help them understand.
- At the last inspection, information which was provided to patients was not routinely available in easy-read, large print or other accessible formats. At this inspection, some progress had been made on the wards, but there was still room for improvement. On Ellington Ward, the welcome pack for patients was provided in large font. However, for the other wards, the welcome pack was not in an accessible format. On Oaktree Ward, staff provided patients with easy-read leaflets to help them understand their conditions and treatments. However, on the other wards, this was not routinely made available. This was not in line with the accessible information standard, which states patients with an impairment should receive information and correspondence in formats they can read and understand, for example easy-read or large print.
- Staff told us interpreters were easily obtainable. They were able to get information for patients and carers translated if necessary. For example, on Ellington Ward, an Irish sign language, interpreter was provided for a patient who was deaf and could only communicate in this language.
- Patients were able to select food that met their religious and cultural needs. Staff ensured that patients had access to appropriate spiritual support. Spiritual leaders came to the wards to meet with patients who were unable to leave the ward. In other instances, staff supported patients to leave the ward to attend services and events which met their spiritual needs. At Kershaw Ward and Redwood Ward, there was a multi-faith room that patients could use.

- For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the location(s) scored higher than similar trusts for the environment being dementia-friendly and scored higher than similar trusts for the environment supporting those with disabilities. Some of the scores included other wards on site.

Site name	Core service(s) provided	Dementia friendly	Disability
Hillingdon Hospital Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units, Long stay/rehabilitation mental health wards for working age adults.	92.9%	85.9%
Northwick Park Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	96.2%	90.3%
St Charles Mental Health Centre	Wards for older people with mental health problems, Acute wards for adults of working age and psychiatric intensive care units.	94.2%	85.9%
TOPAS Waterhall Care Centre	Wards for older people with mental health problems.	90.3%	95.4%
3 Beatrice Place	Wards for older people with mental health problems.	91%	95.8%
Trust overall		**92.8%**	**86.7%**
England average (Mental health and learning disabilities)		**88.3%**	**87.7%**

Listening to and learning from concerns and complaints

- This service received nine complaints between 1 November 2017 to 31 October 2018. Two of these were upheld, two were partially upheld and one was not upheld. One was referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Ellington Ward	4	0	1	0	0	3	0	1

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Redwood Ward	3	1	0	1	0	0	1	0
TOPAS	2	1	1	0	0	0	0	0

- Complaints were received, recorded and managed appropriately by staff. Staff knew how to handle complaints and followed the trust's complaints policy and procedures.
- Patients and carers reported that they knew how to complain or raise concerns. They were not worried about doing so.
- Patients received feedback in response to any complaints or concerns they made. For example, we saw that complaints had been acknowledged and appropriately responded to.
- At the last inspection, there was no tracking of informal complaints. At this inspection, some wards had made progress, and others had not. Ellington Ward and Oaktree Ward kept a log of informal complaints. However, Kershaw Ward and Redwood Ward did not. This meant that there was a risk that themes which emerged through informal complaints were not resulting in learning and improvement to the service.
- Staff actively reviewed complaints with the aim of improving people's experience of the service. Staff received feedback on the outcome of investigation of complaints through their team meetings.
- This service received 28 compliments during the last 12 months from 1 November 2017 to 31 October 2018 which accounted for 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. They had experience of working in older people's care and were passionate about delivering high quality care.
- Leaders had a good understanding of the services they managed. They could describe clearly how the teams were working to provide high quality care. They spoke about the challenges and priorities relating to the quality of the service.

- Leaders were visible in the service and approachable for patients and staff. For example, the Kensington and Chelsea borough director completed their return to practice nursing at Beatrice Place, which included working night shifts alongside the team.
- Staff on all wards said leaders visited the wards regularly. Staff reported that ward managers were supportive and provided inclusive leadership.
- Leadership development opportunities were available for staff, including opportunities for those who aspired to leadership roles. On Ellington Ward, the trust had supported a staff member to enrol on a university masters course. Leadership mentoring was due to take place in February 2019 for ward managers and deputy ward managers on Redwood and Kershaw wards.

Vision and strategy

- The trust's senior leadership had successfully communicated the trust's vision and values to the frontline staff in this service.
- Staff knew and understood the trust's vision and values and how they applied to the work of their team and promoted good outcomes for patients. Staff demonstrated the values in their responses to patients, carers and their approach to delivering care and treatment. Staff spoke about respecting each other, working together and caring for patients and other staff members.
- Staff had the opportunity to contribute to discussion about the strategy for their service, especially where the service was changing. For example, long shift patterns had been introduced on Redwood Ward, Prior to this change, managers sent questionnaires to staff to get their feedback, and the borough director visited the ward to discuss the change to working patterns.
- Managers could explain how they were working to deliver high quality care within the budgets available.

Culture

- Staff said they felt respected, supported and valued. They were proud to work for the trust. They reported that the trust was a good employer, which provided opportunities for training and development.
- Staff said they felt able to raise concerns without fear of victimisation. They said they knew how to use the whistle-blowing procedures and felt confident raising issues with managers. No individual concerns were raised regarding bullying or harassment.
- Two of the ward managers did not know about the role of the Freedom to Speak Up Guardian (FSUG), and thought the role existed to support patients. On Kershaw Ward, there was a poster on display in the entrance to the ward describing how to contact the FSUG. The poster was surrounded by information for patients, which made it look as

though the role involved supporting patients. However, it only does this indirectly by providing an avenue for staff to raise concerns about issues such as poor care and treatment.

- Managers dealt with poor staff performance when needed.
- Teams worked well together and where there were difficulties managers dealt with them appropriately.
- Staff appraisals included conversations about career development and how it could be supported.
- At the time of inspection, the service's staff sickness and absence rate was higher (4,2%) than the average for the trust (3.4%).
- Staff had access to support for their own physical and emotional health needs through the trust occupational health service and employee assistance programme.
- The trust recognised staff success within the service. Teams could nominate individual staff for an annual award. The trust had launched a staying well at work service to offer tailored employment related support to staff with severe and enduring mental health problems. Staff and patients on the ward, as well as carers, could also access a range of workshops and courses at the trust's wellbeing and recovery college.

Governance

- Governance arrangements were in place within each division that supported the delivery of the service, identified risk and monitored the quality and safety of the services provided. Staff cared for patients in a clean and safe environment. There were sufficient staff on duty to meet patients' needs safely. A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- However, we found that there were differences in practice and management between the older adult inpatient teams which led to inconsistency across the service. For example, there were differences in managers' oversight of supervision, logging of informal complaints and the routine availability of accessible information on the wards. Learning from incidents and complaints took place within the boroughs, but not across the boroughs. There were no regular meetings between the older adults' matrons or ward managers. Staff we spoke with said there was room for improvement in sharing learning across the wards.
- It was not clear who had taken responsibility to respond to the recommendations from the last inspection in January 2017. We found a few instances where the recommendations had not been acted upon.
- On Kershaw Ward, the manager reported challenges with booking new staff members onto the trust induction. For example, two staff members started in January 2019, and were not due to start the trust induction until May 2019. This meant they were unable to take part in any restraint on the ward as this training formed part of the induction.

- The staff team worked in collaboration with internal and external teams, professionals and stakeholders to meet the needs of patients. This included home treatment teams, community mental health teams and service commissioners.

Management of risk, issues and performance

- Staff said they could escalate issues of concern through their team meetings, clinical governance meetings and supervision. All the staff we spoke to said they would raise issues without delay and felt confident to do so.
- Leaders were familiar with the service risk register and the key areas of risk for the service. Staff concerns matched those on the risk register. For example, the lack of permanent consultant psychiatrist on Kershaw Ward, and lack of dietetics input on Kershaw Ward and Redwood Ward.
- Ward managers were aware of trust contingency plans for emergencies. For example, adverse weather or a flu outbreak.

Information management

- The service used systems to collect data from wards that were not over-burdensome for frontline staff.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.
- The trust migrated to a new electronic patient record system during the inspection, and not all patient care records could be easily located by staff new to the system. However, support was available to help staff become familiar with the system.
- Patient records could only be accessed by staff who had been authorised to do so.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing, training and patient care. However, not all managers had access to information to assure themselves that staff were up-to-date and have received their supervision.
- Wards had processes in place to ensure that notifications were made to external bodies as required, for example, to the Care Quality Commission and local authority.

Engagement

- Staff, patients and carers had access to timely and relevant information about the trust. For example, staff received a monthly trust bulletin and had access to the trust intranet.
- Patients had opportunities to feedback on the service they received through community meetings, surveys, one to one sessions and ward rounds.
- The trust had identified there was room for improvement with engaging carers at Kershaw and Redwood wards, and the service user and engagement lead planned to roll out a carers forum in March 2019, to give carers an opportunity to feedback on the service their relative or friend received.
- Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. Feedback was displayed on 'you said, we did' notices within the service.
- Leaders engaged with external stakeholders, such as service commissioners and Healthwatch.

Learning, continuous improvement and innovation

- NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
- On Ellington Ward, staff were proud to have obtained the accreditation for inpatient mental health services (AIMS). The other wards were engaged with applying for accreditation, but had not yet achieved it.
- Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, leaders on Kershaw Ward and Redwood Ward attended a monthly quality improvement (QI) group.
- Staff used QI methods and knew how to apply them. On Redwood Ward, staff were involved in a number of QI projects. Staff had completed a QI project with the aim of improving handover efficiency. Staff now used a simplified handover sheet, which concisely captured patient information. Staff were also involved in a QI project looking at the recruitment of volunteers to support staff and patients on the ward.
- The manager on Ellington Ward attended quarterly trust falls meetings to discuss research around falls and planned to develop this in a QI project.