Review of compliance

West London Mental Health NHS Trust St Bernards and Ealing Community Services	
Region:	London
Location address:	Trust Headquarters Uxbridge Road Southall Middlesex UB1 3EU
Type of service:	Acute services with overnight beds Prison Healthcare Services Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Community based services for people with mental health needs Doctors consultation service Doctors treatment service
Date of Publication:	November 2011

Overview of the service:	The St Bernard's and Ealing Community Services location of West London Mental Health Trust is registered to provide the regulated activities assessment or medical treatment for people detained under the Mental Health Act 1983, treatment of disease, disorder or injury and diagnostic and screening procedures.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

St Bernards and Ealing Community Services was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

Patients supported by community services were interviewed by Ealing LINk representatives to gain their views of the treatment and care provided. The information provided contributed to the overall findings of our inspection.

Patients said they were usually involved in making decisions about their treatment and care and had opportunities to give feedback on their experiences. The majority said they had seen and agreed their care plan and some said they had signed the plan and had been given a copy of it. Patients told us there were activities on offer in the hospital such as using the gym, arts and crafts and watching TV. They said they felt safe in the wards and would talk to staff, advocates or relatives if they had a concern.

Patients told us there were usually sufficient numbers of staff on duty to meet their needs. However, they also told us they did not get their escorted leave as there wasn't always a member of staff available. One ward was described as "chaotic at times" by patients due to staffing issues. They said "staff do their best, there isn't enough of them" and "there is an over reliance on bank and agency staff".

Patient comments across the services included "the nurses and doctors are really very good", "staff are generally lovely" and "the nurses are ok".

What we found about the standards we reviewed and how well St Bernards and Ealing Community Services was meeting them

Outcome 01: People should be treated with respect, involved in discussions about

their care and treatment and able to influence how the service is run

The majority of patients using services were usually involved in making decisions about their treatment and care. Patient views were sought and taken into account about the way in which services were provided. Patients privacy was usually respected but we found viewing panels to rooms were left open after use on one ward.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health Trust was meeting this essential standard but to maintain this we have suggested improvements.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Patients using services at the St Bernard's and Ealing Community Services location received treatment and care in accordance with their identified needs. Although most care plans identified individual needs, some did not and psychological assessment was not always included. Patients were not always aware of the content of their care plan and had not received a copy themselves.

Overall we found that improvements were needed for this essential standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

Patients using services were protected from the risk of abuse. The hospital had implemented robust policies and procedures and staff were trained to recognise the signs of abuse.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health Trust was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

Patients using the service were safe and received appropriate care. The trust had processes in place to ensure sufficient staff were on duty to meet the needs of patients. However, escorted leave could not always be accommodated within the numbers of staff available, and bank and agency staff did not always have the necessary skills and knowledge available to support patient needs.

Overall, we found that improvements were needed for this essential standard

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The trust has systems in place to ensure staff are supported to maintain and develop their knowledge and skills to keep patients safe and to competently meet their health and welfare needs.

Overall we found that the St Bernard's and Ealing Community Services location of West

London Mental Health NHS Trust was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The trust had effective risk and quality monitoring systems in place to ensure patients had access to safe, quality care.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health NHS Trust was meeting this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Patients using the inpatient and community services told us they were usually involved in making decisions about their treatment and care but not always. They said they had access to a primary nurse, key worker or case manager and had opportunities to discuss their individual treatment and care.

Patients said they were asked about their views on the service and attended community meetings where they could voice their opinions. Some patients told us that community meetings didn't always take place as scheduled or didn't start on time which meant that they didn't have sufficient opportunity to raise all of their questions. Overall patients said they felt listened to but on occasions they did not feel able to speak up at ward meetings especially when a lot of professionals attended.

The majority of patients asked said they had been told of their rights whilst being detained under the Mental Health Act (MHA) and they knew to speak with staff or their advocates if they had a question about their stay in hospital. We found that three patients on Mary Seacole ward could not remember being reminded of their rights.

Other evidence
The trust has systems in place for patients to give feedback on their experiences of

treatment and care. They told us patients were able to provide feedback at community meetings, patient forum meetings and through the use of the electronic patient experience tracker (PET).

The weekly results of the PET were used to identify immediate issues and enabled the trust to take action to address them. The results of feedback were reviewed at ward, directorate and trust board meetings.
Patient privacy and dignity and respect questions were included in the PET, and the tracker reports seen for Mary Seacole ward showed an improving rating in these areas.

Staff told us that patients were allocated key workers or primary nurses and that they had one to one meetings but the frequency was variable across wards due to workload issues. We observed patients participating in a daily group meeting and they were encouraged to share their views and experience.

Posters and leaflets were displayed advertising the advocacy services available in the trust for patients, relatives and carers. Detained patients access to statutory Independent Mental Health Advocacy services is constrained by the level of staffing within the current provision.

Our judgement
The majority of patients using services were usually involved in making decisions about their treatment and care. Patient views were sought and taken into account about the way in which services were provided. Patients privacy was usually respected but we found viewing panels to rooms were left open after use on one ward.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health Trust was meeting this essential standard but to maintain this we have suggested improvements.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
The majority of patients said they had seen and agreed their care plan; some said they had signed the plan and had been given a copy of it. Patients said they sometimes felt pressured into signing the care plan as they did not want to question or challenge what had been written.

Most patients being supported in the community also told us they had care plans and had been given a copy of it, but not all. The majority of patients said that they knew who their primary nurse/key worker/case worker was and how they could contact them. Staff told us they met monthly with their named patients to review the care plan and discuss individual needs and we saw that patients were involved in Care Programme Approach (CPA) meetings with the multidisciplinary team at the time of the inspection.

Patients told us there were activities on offer in the hospital such as using the gym, arts and crafts and watching TV. We saw patients participating in an activities session which corresponded to that advertised on the programme. Patients also told us that they could refuse to take part in group activities if they did not feel able to engage in them.

Other evidence
The trust audited the electronic patient care plans regularly, the results were reported to the directorate clinical governance group and then to the trust clinical governance group. We saw ward based action plans that were in progress to address where shortfalls had been identified. The action plans had identified the lead people and dates by which key actions had to be achieved. The plans were monitored by the

directorate managers.

The majority of care plans we looked at were detailed and personalised to reflect each person's individual needs. Detailed risk management plans were in place and had been reviewed. However, we also saw several care plans that did not reflect the patient's own views or individual self-assessed needs.

We were told by staff that there was no involvement of a psychologist in the assessment and development of patient care plans. This issue has been raised in previous MHA commissioners reports and is an expectation within the Mental Health Act Code of Practice and Royal College of Psychiatrist guidance.

Information on the services patients could access and details of patient's rights were displayed in the communal areas of the wards.

Our judgement
Patients using services at the St Bernard's and Ealing Community Services location received treatment and care in accordance with their identified needs. Although most care plans identified individual needs, some did not and psychological assessment was not always included. Patients were not always aware of the content of their care plan and had not received a copy themselves.

Overall we found that improvements were needed for this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Patients told us they felt safe in the wards and would talk to staff, advocates or relatives if they had a concern.

Other evidence
The trust had implemented robust safeguarding policies and procedures and had identified lead staff for safeguarding children and vulnerable adults across the organisation.

Staff we spoke with confirmed that they had received training in safeguarding adults and children. They were aware of the trust's policy and procedure on safeguarding and whistle blowing. Staff were aware of the different types of abuse that patients could experience and were clear about the reporting systems if an allegation of abuse was made. We have received safeguarding notifications following alleged incidents of abuse which were investigated in accordance with the local authority safeguarding processes.

Some wards visited had a seclusion room. The staff told us the decision to put a patient into seclusion was made jointly with the responsible doctor. It was only used as a last resort when the patient or others were at risk of harm through their behaviour. Staff confirmed that records would be kept detailing the frequency of observation and the condition of the patient during the period of seclusion.

Patient's human rights were usually upheld, although Mental Health Act (MHA) commissioner colleagues have noted occasions at their visits where patient access to

smoking areas had not been equally applied across the services at this location.

Our judgement
Patients using services were protected from the risk of abuse. The hospital had implemented robust policies and procedures and staff were trained to recognise the signs of abuse.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health Trust was meeting this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Patients told us there were usually sufficient numbers of staff on duty to meet their needs. However, they also told us they did not get their escorted leave as there wasn't always a member of staff available and on one ward patients described the ward as chaotic at times. They said "staff do their best, there isn't enough of them" and "there is an over reliance on bank and agency staff".

Patients told us that "on Mary Seacole you have some very good HCA's; just out of this world", "there are some very good members of the home treatment team who will take you out to a cafe or post office, and help to integrate you back into society", "staff are very helpful", "I trust staff here, can't praise them enough", "nurses and doctors are really very good", "staff generally lovely" and "nurses are ok".

Staff reported they felt that the shortages of staff left the patients and themselves in a vulnerable position. They told us that episodes of violence and aggression had occurred because there was a delay or not enough staff to escort patients off the ward and on visits as detailed in their individual care plans.

Other evidence
Staff confirmed that they had the expected numbers of staff on duty to meet the needs of patients. Staff confirmed and we saw that bank and agency staff were used to fill vacant shifts. It was reported that agency and some bank staff did not know the patients, did not have access to the electronic care planning system or have swipe cards to open doors.

The trust had commenced recruitment for vacant posts following a review and reorganisation of services across the trust. Trust managers have provided an undertaking to use regular bank staff with the necessary skills to fill available shifts. An action plan was in place to manage the changes and issues on Mary Seacole Ward.

We were told that vacancy information was monitored monthly and reported to the directorate managers and the trust board as part of the integrated performance report. The July 2011 integrated performance report showed the trust actual vacancy rate as 8.8% which is below the trust benchmark of 11%.

Our judgement
Patients using the service were safe and received appropriate care. The trust had processes in place to ensure sufficient staff were on duty to meet the needs of patients. However, escorted leave could not always be accommodated within the numbers of staff available, and bank and agency staff did not always have the necessary skills and knowledge available to support patient needs.

Overall, we found that improvements were needed for this essential standard

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to patients about this outcome.

Other evidence
Staff confirmed there were opportunities to attend training. They told us they had undertaken mandatory training and this was documented in their individual training passport.

Ward managers showed us the monthly training reports they received detailing staff mandatory training status which was rated using a traffic light system. They confirmed they were required to act on the information and ensure staff attended the next available course if the rating was red. The trust integrated performance report July 2011 showed that the key performance indicators for training were rated as amber and green.

The trust had implemented additional reminders to staff and managers to reduce the 'did not attend' (DNA) rate as it had been noted that the numbers had increased and more staff were falling out of date with their mandatory training.

Ward managers told us there was a daily managers meeting with the senior nurse and directorate manager to identify issues and improve communication across the unit. Staff told us that they had monthly supervision meetings with their line manager and an annual appraisal where objectives and training needs were established.

The July 2011 integrated performance report records that 40% of 2010/11 staff

appraisals had been completed on line and 54% of staff had agreed objectives for 2011/12, both targets had significantly improved from the previous month.

The trust has policies and procedures in place for staff to report concerns and incidents of bullying and harassment. Staff that we spoke with said that they were aware of how to raise concerns if they needed to. The telephone number of a staff confidential helpline was displayed in all areas should staff wish to raise concerns regarding bullying and harassment.

Our judgement
The trust has systems in place to ensure staff are supported to maintain and develop their knowledge and skills to keep patients safe and to competently meet their health and welfare needs.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health NHS Trust was meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Patients said they were asked about their views on the service and they could attend the community meetings to voice their opinions. Patients said they could also use the patient tracker to give the service their views in confidence.

Patent feedback via the patient tracker is monitored at ward, directorate and trust board level.

Other evidence
The trust had implemented robust risk management policies and procedures and maintained a risk register comprised of key risk areas throughout the organisation. Managers confirmed they were responsible for maintaining a local register of key risks and had developed action plans to address or minimise the identified risks.

Staff told us they had received training in how to report incidents and the review process. The trust had systems in place to ensure lessons arising from incident investigations were shared across the trust. They also told us that 'red alert emails' were sent out with details of the learning and any changes in practice that were required to be implemented. The trust provided examples of actions taken in response to learning from incidents.

We looked at three completed serious untoward incident (SUI) reports. The reports were completed in accordance with trust guidance and all detailed how and where lessons learnt would be disseminated. Action plans attached had key dates,

responsible persons and reporting mechanisms documented.

The minutes of the directorate and trust clinical risk group meetings documented the discussions about reviews and outcomes of SUI investigations. The Trust Incident Review Group minutes showed the outcome of SUI reviews were considered in that forum and the trust board minutes detailed the reports signed off as completed by the Director of Nursing and Patient Experience.

Our judgement
The trust had effective risk and quality monitoring systems in place to ensure patients had access to safe, quality care.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health NHS Trust was meeting this essential standard.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 01: Respecting and involving people who use services</td></tr>
<tr><td colspan="2">Why we have concerns:
The majority of patients using services were usually involved in making decisions about their treatment and care. Patient views were sought and taken into account about the way in which services were provided. Patient's privacy was usually respected but we found viewing panels to rooms were left open after use.

Overall we found that the St Bernard's and Ealing Community Services location of West London Mental Health Trust was meeting this essential standard but to maintain this we have suggested improvements.</td></tr>
</table>

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
Patients using services at the St Bernard's and Ealing Community Services location received treatment and care in accordance with their identified needs. Although most care plans identified individual needs some did not and psychological assessment was not always included. Patients were not always aware of the content of their care plan and had not received a copy themselves.

Overall we found that improvements were needed with this essential standard.</td></tr>
<tr><td rowspan="2">Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 13: Staffing</td></tr>
<tr><td colspan="2">How the regulation is not being met:
Patients using the service were safe and received appropriate care. The trust had processes in place to ensure sufficient staff were on duty to meet the needs of patients. However, escorted leave could not always be accommodated within the numbers of staff available, and bank and agency staff did not always have the necessary skills and knowledge available to support patient needs.

Overall, we found that improvements were needed for this essential standard</td></tr>
</table>

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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