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HILLINGDON
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A

External Services Scrutiny Committee

Councillors on the Committee

John Riley (Chairman)
Ian Edwards (Vice-Chairman)
Tony Burles
Brian Crowe
Phoday Jarjussey (Labour Lead)
Allan Kauffman
John Oswell
Michael White

Date: **TUESDAY, 14 JULY 2015**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Terms of Reference

1. To scrutinise local NHS organisations in line with the health powers conferred by the Health and Social Care Act 2001, including:

   (a) scrutiny of local NHS organisations by calling the relevant Chief Executive(s) to account for the work of their organisation(s) and undertaking a review into issues of concern;

   (b) consider NHS service reconfigurations which the Committee agree to be substantial, establishing a joint committee if the proposals affect more than one Overview and Scrutiny Committee area; and to refer contested major service configurations to the Independent Reconfiguration Panel (in accordance with the Health and Social Care Act); and

   (c) respond to any relevant NHS consultations.

2. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

3. To scrutinise the work of non-Hillingdon Council agencies whose actions affect residents of the London Borough of Hillingdon.

4. To identify areas of concern to the community within their remit and instigate an appropriate review process.

Agenda

PART I - MEMBERS, PUBLIC AND PRESS

Chairman's Announcements

1 Apologies for absence and to report the presence of any substitute Members

2 Declarations of Interest in matters coming before this meeting

3 Exclusion of Press and Public

To confirm that all items marked Part I will be considered in public and that any items marked Part II will be considered in private

PART II - PRIVATE, MEMBERS ONLY

8 Any Business transferred from Part I

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

17 June 2015

Meeting held at Committee Room 5 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Tony Burles, Brian Crowe, Phoday Jarjussey (Labour Lead), Allan Kauffman, John Oswell and Michael White **Also Present**: **LBH Officers Present**:
3.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
4.	**MINUTES OF THE MEETING ON 28 APRIL 2015** *(Agenda Item 4)* Consideration was given to the minutes of the meeting held on 28 April 2015. It was agreed that the Committee would request further information from The Hillingdon Hospitals NHS Foundation Trust to be presented at a future meeting in relation to the schools outreach work that had been undertaken by the Paediatric Diabetes team. It was noted that this work had clear links to the work undertaken by other bodies such as Public Health in relation to obesity, healthy eating, sport engagement and Members would be able to enquire about how this work was joined up. It was agreed that Healthwatch Hillingdon would be asked to provide the Committee with an update at a future meeting in relation to its review of the CAMHS service in the Borough. **RESOLVED: That:** **1. THH be asked to provide the Committee with an update on the schools outreach work undertaken by the Paediatric Diabetes team;** **2. Healthwatch Hillingdon be asked to provide an update on its CAMHS review; and** **3. the minutes of the meeting held 28 April 2015 be agreed as a correct record.**
5.	**MINUTES OF THE MEETING ON 12 MAY 2015** *(Agenda Item 5)* The Chairman noted that this had been a useful meeting and that the Committee would look forward to the update that would be forthcoming as a result. **RESOLVED: That the minutes of the meeting held on 12 May 2015 be agreed as a correct record.**

6.	**MINUTES OF THE MEETING ON 14 MAY 2015** *(Agenda Item 6)* **RESOLVED: That the minutes of the meeting held on 14 May 2015 be agreed as a correct record.**
7.	**ANNUAL QUALITY ACCOUNT 2014/2015 AND UPDATE - THE LONDON AMBULANCE SERVICE NHS TRUST (LAS)** *(Agenda Item 7)* The Chairman welcomed those present to the meeting. Ms Zoe Packman, Director of Nursing and Quality at the London Ambulance Service, apologised for not having attended a previous Committee meeting to discuss the Trust's draft quality report but thanked Members for the feedback that they had provided. She advised that a copy of the final version of the report would be forwarded to Members for their information. Members were advised that the report had been produced in a standard format and, as such, the LAS was somewhat constrained on the content that it could include. Ms Packman noted that the report had set out the Trust's quality priorities for the forthcoming year which had included the appointment of a consultant midwife (three days per week) to provide training, support and expert advice. Work had also been planned in relation to the extensive number of frequent callers which put addition pressure on the limited resources of the Trust. To this end, a Darzi fellow had been appointed to review this issue from September 2015. Members were advised that the LAS worked closely with the Metropolitan Police Service, Urgent Care Centres and clinics to triangulate information and share intelligence about common frequent callers. In addition, the LAS had an information sharing agreement in place with social services - although these agreements needed to be in place before information could be shared, Members were assured that this was not an onerous process. Concern was expressed that information sharing in relation to persistent callers was not as joined up as it could be. Ms Packman advised that, once the Darzi fellow was in post, consideration could be given to attending a future meeting to discuss the matter further with Members As mental health continued to feature prominently in the work of the LAS, six mental health nurses had been appointed to support the teams from the clinical hub. The review of the mental health pathway was a continuing area of work and, to this end, mental health focus groups were being organised to better understand how the service could be improved. In addition, work had been undertaken to ensure that the staff voice was considered (for example, there were a large number of individuals training to become paramedics and, as possible future members of staff, it was thought important to listen to their feedback). It was acknowledged that staffing had been a big issue for the LAS and that this was likely to continue, given the current shortage of paramedics. Members were advised that the LAS had put together a robust recruitment and retention plan and that, reassuringly, the Trust now had more joiners than leavers. The LAS worked closely with the Open University and four other universities (Hertfordshire, Greenwich, St Georges and Anglia Ruskin) that offered the Paramedic Science degree, as well as offering placements for these students. There had been an increase in the 2014/2015 university cohort but it was acknowledged that this would take time to come to fruition.

Members suggested that more information about this recruitment work needed to be included in the quality account report.

The opportunities available to paramedics had increased, enabling them to work for GP surgeries, the police, acute hospitals, etc, as well as for other ambulance trusts which meant that the LAS had significant competition for new staff. Although it could be said that the LAS had not been cognisant quickly enough to see this competition coming, it had anticipated there being a potential significant cohort of retirees in the near future and was planning accordingly. The £18.9m CCGs funding had enabled an extensive transformation programme where the LAS had worked extensively with the CCGs in Harrow, Brent and Ealing (these were the CCGs that hosted the LAS on behalf of the whole of London).

Ms Packman advised that the Care Quality Commission (CQC) had undertaken an inspection of the LAS from 1 June 2015 to 6 June 2015 but that unannounced inspections were still being undertaken. It was anticipated that the LAS would receive the CQC final report in September 2015 and that representatives from the External Services Scrutiny Committee would be invited to attend the quality summit meeting.

Members were advised that patient and public engagement had featured high in the LAS priorities and that the organisation had participated in more than 600 events across London in the last year. These events had been wide ranging and included engagement with the Brownies and other clubs. As this work was mostly undertaken in their own time, Members commended LAS staff for attending these community events and for the valued service that they provided. However, it was noted that people's good experience of the front line service was not necessarily reflected in their view of the whole organisation.

It was noted that the Shockingly Easy campaign had resulted in more defibrillators being available in high footfall areas (for example, shops and gyms) and more people trained to use them. This campaign had saved many lives and the LAS was grateful to the community responders that had been involved. It was noted that Hillingdon had installed defibrillators in all primary and secondary schools within the Borough but it was not clear whether or not these units were included within the LAS total. Members were advised that work was underway to map out the location of all defibrillators in London to provide the LAS with a broader picture to enable identification of the closest equipment at the time it was required.

Although Members understood that the quality report was required to follow a specific format and include certain information, concern was expressed that it was difficult to read and understand. It was suggested that the LAS provide information relating to Hillingdon in an appendix to ensure that the organisation continued to comply with Monitor's requirements - this information would then enable the Members to see the impact of the Trust's quality priorities on the Borough. Ms Pauline Cranmer, Assistant Director of Operations - North West Sector for the London Ambulance Service, advised that she would ensure that this information was forwarded to the Committee.

Insofar as the information provided within the table of National Clinical Performance Indicators, Members advised that they were unable to glean anything from the data provided as there were no comparators and no information about survival rates and how these compared with other boroughs. It was noted that the LAS was driven to include this information as it was a national requirement and was in relation to clinical indicators that had to be reported. However, the LAS did collect data to enable a monthly comparison with other ambulance trusts and provided quarterly reports on this

to the CCG to demonstrate the safety of the service. Ms Cranmer advised that, as her role covered Hillingdon, Harrow and Brent, she would be able to provide Members with this comparative data. For example, Hillingdon had achieved 40% ROSC (the return of spontaneous circulation) compared to the London average of 30%. Members noted that this level of detailed information would help them to build a clearer picture of the effectiveness of the services provided by the LAS which would enable more accurate reporting to the Health and Wellbeing Board and Cabinet.

Members noted that the LAS was responsible for providing the South East London 111 service. This service was based in Beckenham and had been very successful with well developed paths between the 111 service and the 999 service. The service covering Hillingdon was provided by Harmoni.

Ms Packman advised that interviews had been undertaken for the appointment of a substantive Chief Executive. Although the post had been offered, the Department of Health notification was awaited to enable the appointment to be shared publicly. Members were assured that the LAS' leadership had been instilled locally and that it had been mapped to that of organisations such as the CCGs to enable the development of local issues.

Members were advised that calls to the LAS were triaged to determine the level of response that they required. For example, a cardiac arrest or a major road traffic accident would result in an auto dispatch of a single responder and an ambulance. Fast response cars were not required for all calls as they tended to only be used to deal with critical issues. There were times when a call may have been deemed to be critical and a fast response car dispatched but that, as the call progressed, more detail about the situation came to light and it transpired that the car was not required. However, as the cars were not always recalled in these situations, work was now underway to rectify this use of resources.

In the quality report, the information in relation to arrival at hospital against appointment time table showed a marked decrease between December and February/March 2015 which then quickly returned to a more 'normal' level. Ms Packman advised that she would look into this and report back to Members.

Ms Packman advised that patient transport was a small part of the work undertaken by the LAS. She noted that consideration would need to be given over the next year as to whether the Trust should concentrate on the emergency part of the business. Members noted that the LAS was constrained by national pay scales whereas private businesses were able to pay whatever salary they saw fit.

With regard to serious incidents, information was shared with the patient concerned and their family. This information was then anonymised and included within a report to the Board. The Trust would then work with other services, for example, the hospital, to address any particular issue of concern and then report on the lessons learnt. To ensure that this information was scrutinised by the local authority, it was agreed that future reports would be shared the Committee and that every effort would be made to attend those External Services Scrutiny Committee meetings that they were invited to.

Concern was expressed that the information contained within the report in relation to time spent on vehicle did not actually tell the reader anything. Ms Packman advised that she would look into this and report back.

Members were advised that ambulances were placed at optimum points around the

	Borough to give them the easiest access to major routes through the area to enable a fast response to calls. Although ambulances could sometime be held up at hospital, this tended to be at certain hospital peak points and would affect the availability of turning a vehicle around ready for the next call. To avoid this wait, consideration was given to the queues at hospitals when transporting a patient. Members were advised that there was an adequate number of vehicles available but that there were just not enough staff to man them. Ambulances tended to need replacing every 5-7 years and would each cost approximately £140k fully kitted. Ms Packman advised that she would be happy to organise for the Committee to visit the control room in Waterloo in small groups of 3 or 4 maximum. It was noted that the LAS had paused its application to become a Foundation Trust (FT) to ensure that it met 100% of the FT criteria. Ms Packman advised that there was no longer a fixed deadline for the LAS to become an FT and that alternative options were now available to the Trust (for example, an alternative organisational structure). Consideration would need to be given to the best option for the Trust. If the LAS did continue with its FT application, it would welcome the Committee's support. Ms Packman advised that there were two big drivers for complaints which increased with activity: the time taken for an ambulance to arrive; and callers being referred to another health care provider (as their condition did not require an ambulance). In addition, there had been complaints about staff attitude which was not acceptable and was dealt with on a local level. Ms Cranmer advised that she reviewed all local complaints for Hillingdon and, although there had been a 24% increase in complaints, this had been for the whole of London. She would provide the Committee with the local figures. Members expressed concern about the challenged posed by Heathrow airport. Ms Cranmer advised that patients at the airport were transient and, as such, often staff spent more time convincing them to go to hospital when appropriate than those patients outside of the airport. LAS staff at Heathrow comprised a regular cohort who travelled around the site on bikes. It was noted that the demographic composition of the driving population had changed significantly and had possibly contributed to the number of vehicles who did not get out of the way for ambulances when they were travelling with lights and sirens on. It was suggested that the work undertaken by the LAS in schools include some form of education about how important it was for vehicles to clear the way for ambulances so that this would could be fed back to parents as well as being instilled in the young people before they learnt to drive. Furthermore, consideration would be given to using Council facilities to promote this message. **RESOLVED: That the report be noted.**
8.	**WORK PROGRAMME 2014/2015** *(Agenda Item 8)* Consideration was given to the Committee's Work Programme for 2015/2016. It was agreed that the Committee's first review would be in relation to alcohol and that consideration would need to be given to whether the review should look at alcohol related admissions (inpatient) or presentations to hospital. Focusing on underage drinkers would enable to Committee to look at what work was undertaken to prevent longer term alcohol abuse and the associated impact on the health service. It was agreed that the Working Group would comprise two Conservative Members and two

	Labour Members. Other possible reviews that could be undertaken by the Committee or update reports that could be requested included: • Female genital mutilation (FGM); • Child Sexual Exploitations (CSE); • Probation Service; • frequent callers (links between the police, health services and council services); and • Drug treatment and substance misuse update. It was agreed that the updates on previous reviews would be included on the agenda fro the meeting on 16 February 2016 rather than 15 March 2016. Members were advised that the Democratic Services Manager had submitted evidence on behalf of the Committee in relation to the CQC inspection of the LAS. **RESOLVED: That:** **1. The scoping report be agreed; and** **2. Subject to the changes agreed at the meeting, the report be noted.**
	The meeting, which commenced at 6.00 pm, closed at 7.55 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

EXTERNAL SERVICES SCRUTINY COMMITTEE - UPDATE ON THE PROVISION OF HEALTH SERVICES IN THE BOROUGH

Contact Officer: Nikki O'Halloran
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Appendix A: Central and North West London NHS Foundation Trust - CQC Report
Appendix B: London Ambulance Service Complaints Information
Appendix C: Healthwatch Hillingdon Annual Report 2014/2015

REASON FOR ITEM

To enable the Committee to receive updates and review the work being undertaken with regard to the provision of health services within the Borough.

OPTIONS AVAILABLE TO THE COMMITTEE

Members are able to question the witnesses and make recommendations to address issues arising from discussions at the meeting.

INFORMATION

Central and North West London NHS Foundation Trust (CNWL)

CNWL is a large and diverse organisation, providing health care services for people with a wide range of physical and mental health needs. The Trust employs approximately 7,000 staff to provide more than 300 different health services across 150 sites. CNWL services in Hillingdon cover a broad range of both mental health and physical health community services as follows:

a) Mental health - Adult mental health both inpatient services and community based services, older adult mental health services including inpatient services, community based provision and specialist memory service, psychiatric liaison services with in-reach to Hillingdon Hospital A&E and wards, IAPT, mental health rehabilitation, addiction services, (drugs and alcohol), and child and adolescent mental health services (CAMHS).
b) Community physical health - including Rapid Response service to prevent unnecessary hospital admission, both adult and paediatric speech and language therapy, specialist community dentistry, home-based children's nursing service, adult district nursing, specialist community paediatricians as part of the Child Development services, school nursing service, specialist wound care services, adult home-on and rehabilitation services, wheelchair service, health visiting, Hillingdon Centre For Independent Living (HCIL), Looked After Children specialist team, community based palliative care team, inpatient intermediate care ward (Hawthorn Intermediate Care Unit), Podiatry and musculo-skeletal physiotherapy services.

CNWL services are delivered in a variety of settings; predominantly in patient's homes but also in hospital settings, GP practices, health centres, schools and children's centres. Approximately 1,000 CNWL staff work across the London Borough of Hillingdon with 600 of these living in the Borough.

Child & Adolescent Mental Health Services (CAMHS)

Hillingdon CAMHS provides community mental health services to children and young people up to the age of 18 with complex mental health difficulties and their families in a range of different ways depending on their needs. The types of difficulties dealt with by CNWL are predominantly what would be described as Tier 3 (complex and severe) CAMHS services. Due to resourcing issues, there is a limited service provided at Tier 2 (mild/moderate):

- Complex emotional and behavioural problems
- Deliberate self-harm
- Anxiety and depression and serious mental illness such as psychosis and eating disorders
- Family relationship issues and parenting
- Hyperactivity or poor concentration (ADHD, ASD)
- School refusal
- Children with mental health needs related to learning difficulties, physical illness or disability
- Challenging behaviour

Psychologists, psychiatrists and therapists provide assessment and treatment packages for children, young people and their families. Treatment may include cognitive behaviour therapy (CBT), family therapy, play therapy and individual/group psychotherapy. Medication is also used when appropriate and carefully monitored by the doctors.

Tier 4 inpatient services for children with the most serious problems, are not provided by CNWL for Hillingdon children. This service is commissioned from a variety of providers via NHS England.

At the External Services Scrutiny Committee meeting on 15 July 2014, it was noted that the types of difficulties dealt with by CNWL were predominantly what would be described as Tier 3 (complex and severe) CAMHS services, with a limited service provided at Tier 2 (mild/moderate) due to resourcing issues. Tier 4 services were provided by a number of providers that were commissioned by NHS England (NHSE).

It was recognised that there had been a number of commissioning gaps in the CAMHS service provided in the Borough and Ms Maria O'Brien had advised that work was underway with the CCG and local authority to address these issues.

The CQC undertook an inspection of CNWL in February 2015. The resultant CQC report has been attached at Appendix A.

NHS Hillingdon Clinical Commissioning Group (CCG)

The proposal for new clinical commissioning groups was first made in the 2010 White Paper, 'Equity and Excellence: Liberating the NHS' as part of the Government's long-term vision for the future of the NHS. In order to shift decision-making as close as possible to patients, power and responsibility for commissioning services was devolved to local groups of clinicians. The role of CCGs is set out in the Health and Social Care Act 2012 and specifies that CCGs will:

- Put patients at the heart of everything the NHS does
- Focus on continually improving those things that really matter to patients – the outcome of their healthcare

- Empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

The CCG is a group of all local GPs and health professionals that is responsible for planning and designing local health services for Hillingdon residents. It is responsible for buying/commissioning health services (including community health and hospital services) for people in Hillingdon. These services include:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services

The organisation covers the same geographical area as the London Borough of Hillingdon and is made up of all 48 GP practices in the Borough. It works with patients and health and social care partners (e.g., local hospitals, local authorities and local community groups) to ensure services meet local needs.

The CCG has a governing body which meets in public each month and the agendas and papers for these meetings can be found on the CCG website. The governing body is made up of GPs from the Hillingdon area and at least one registered nurse and one secondary care specialist doctor.

Hillingdon CCG is overseen by NHS England at a national level. NHS England is the body that ensures that clinical commissioning groups have the capacity and capability to successfully commission services for their local population. As well as overseeing clinical commissioning groups, NHS England commissions the following services itself:

- General Practice
- Pharmacy
- Dentists
- Specialist services (i.e. those required by a limited number of people)

Better Care Fund

The CCG is working with the Council and key voluntary and community sector organisations to provide more services that cover both health and social care. Government funding has been made available through the Better Care Fund to support specific services that are provided to patients using health and social care, in the first instances, targeted at services for the over 65s.

Royal Brompton and Harefield NHS Foundation Trust (RB&H)

Royal Brompton & Harefield NHS Foundation Trust is the largest specialist heart and lung centre in the UK, and among the largest in Europe. The Trust works from two sites: Royal Brompton Hospital in Chelsea, West London; and Harefield Hospital near Uxbridge.

RB&H is a partnership of two specialist hospitals which are known throughout the world for their expertise, standard of care and research success. As a specialist Trust, it only provides treatment for people with heart and lung disease. This means that its doctors, nurses and other healthcare staff are experts in their chosen field, and many move to the RB&H hospitals from throughout the UK, Europe and beyond, so they can develop their particular skills even further. The Trust carries out some of the most complicated surgery, offers some of the most

sophisticated treatment that is available anywhere in the world and treats patients from all over the UK and around the globe.

The organisation has a worldwide reputation for heart and lung research. It works on numerous research projects that bring benefits to patients in the form of new, more effective and efficient treatments for heart and lung disease. The Trust is also responsible for medical advances taken up across the NHS and beyond. Each year, between 500 and 600 papers by researchers associated with the Trust are published in peer-reviewed scientific journals, such as *The Lancet* and *New England Journal of Medicine*.

The service at Harefield Hospital has developed rapidly into a busy 24/7/365 acute cardiac centre. To ensure that RBH is able to meet the increasing demand, it had put investment plans in place to expand capacity at Harefield Hospital as a precursor to larger scale redevelopment on the site. It is anticipated that the three phases to the redevelopment will result in a 20% increase in capacity at Harefield Hospital:

- Phase 1 - to provide an additional 6 critical care beds, a new purpose built scanning centre and a new 18 bed inpatient ward (Holly Ward). It was anticipated that this would be completed by March 2015.
- Phase 2 - to provide an endoscopy / minor procedures facility and more day case / short stay beds and a daycare lounge. In addition, Oak Ward will be rebuilt as a 2 storey ward (providing an additional 30 beds), the hospital entrance will be reconfigured and the lodge house will be converted for use by up to 4 patients who are medically but not socially fit for discharge.
- Phase 3 - will see the creation of a new purpose built 3 storey graduated care unit, an imaging centre and bring together 48 critical care and high dependency beds. It is anticipated that this will be completed in the next 3-4 years.

The Hillingdon Hospitals NHS Foundation Trust (THH)

The Hillingdon Hospitals NHS Foundation Trust (THH) provides services from both Hillingdon Hospital and Mount Vernon Hospital. THH delivers high quality healthcare to the residents of the London Borough of Hillingdon and, increasingly, to those living in the surrounding areas of Ealing, Harrow, Buckinghamshire and Hertfordshire, giving a total catchment population of over 350,000 people. Providing the majority of services from the Trust, Hillingdon Hospital is the only acute hospital in Hillingdon with a busy Accident and Emergency department, inpatients, day surgery and outpatient clinics.

THH provides some services at the Mount Vernon Hospital, in co-operation with the East & North Hertfordshire NHS Trust. Mount Vernon Hospital has a modern Diagnostic and Treatment Centre and new buildings house four state-of-the-art operating theatres to carry out elective surgery, plus outpatient services, a spacious waiting area and coffee shop.

The Trust has been awarded £12.4 million from the Department of Health to re-engineer its Emergency Care Department at Hillingdon Hospital. This was the second largest successful bid awarded to London Trusts, as part of a wider £330 million allocation for England. The aim of the project is to redesign emergency care pathways to reflect best practice for increasing primary care and reducing admission and length of stay in hospital. Alongside this, a new Urgent Care Centre has been developed offering quick treatment to patients who do not need the full A&E service. This is an extremely large and very exciting project for the Trust, it is the biggest development on the Hillingdon site for 40 years and will make a huge difference to the emergency department and for local people.

It is anticipated that the redevelopment will see improvements made to the hospital's A&E department, paediatric emergency department, acute medical admissions unit and endoscopy unit. The design of the building and changes in the clinical pathways were developed in conjunction with patient groups, the clinical staff and local GPs. Dr Richard Grocott-Mason, the Trust's Joint Medical Director, says: "The guiding principle behind our plans is to ensure that patients can access the right service at the right time. This redevelopment will improve the care we can offer to patients and help to shorten the time that they spend in hospital. It will also strengthen the Trust's position as a 'fixed point' for acute care as identified by the North West London 'Shaping a healthier future' programme."

Shaping a healthier future (SAHF)

At the External Services Scrutiny Committee meeting on 15 July 2014, Mr Shane DeGaris, Chief Executive of THH, advised that the Trust's outline business case (OBC) in relation to *Shaping a healthier future* review was expected to be signed off by the THH Board in July 2014. The OBCs for North West London (NWL) would be considered as part of an overall plan for NWL. It was anticipated that the Trust would received £17m as part of this review to help with the backlog of maintenance and building improvements. A further £23m was expected for work in relation to Theatre upgrade and the expansion of A&E, maternity and critical care services.

Shaping a healthier future is aimed at improving healthcare by investing in local, community-based services in North West London (NWL) and concentrating specialist care, including services available in A&Es, in major centres of excellence. Clinicians leading the programme believe the proposals have the potential to save hundreds of lives each year by improving both primary care[1] and emergency care[2].

With regard to the SAHF proposals, it has generally been thought that, in theory, there will be no impact on the waiting times in Hillingdon Hospital's Accident and Emergency if patients are transferred following the closure of A&E at Ealing Hospital. This would be achieved by increasing the staffing and using the embedded funding.

In 2012/2013, 4,205 babies were delivered at Hillingdon Hospital (3,200 in 2004/2005). It is anticipated that the developments resultant from SAHF proposals would increase this total by around 2,000. THH has successfully bid for £741k of Government funding which is being used to refurbish and modernise the ten delivery rooms on the ground floor delivery suite. This funding is completely separate from any funding that might be forthcoming as part of the SAHF proposals to increase maternity capacity at Hillingdon.

The London Ambulance Service NHS Trust (LAS)

The London Ambulance Service NHS Trust (LAS) is the busiest emergency ambulance service in the UK to provide healthcare that is free to patients at the time they receive it. The Trust works closely with hospitals and other healthcare professionals, as well as with the other emergency services and is the only NHS Trust that covers the whole of London. It is also central to the emergency response to major and terrorist threats in the capital.

[1] Primary Care - Services which are the main or first point of contact for the patient, provided by GPs community providers and so on.

[2] Emergency Care - Treatment for medical and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.

The 999 service LAS provides to Londoners is purchased by Clinical Commissioning Groups and its performance is monitored by NHS England but, ultimately, LAS is responsible to the Department of Health. LAS has over 5,000 staff, based at ambulance stations and support offices across London and its accident and emergency service is split into three operational areas: west, east and south. Each of these areas is managed by an assistant director of operations, and each ambulance station complex has its own ambulance operations manager.

Information in relation to complaints made to the LAS have been attached at Appendix B.

The CQC undertook an inspection of the LAS in June 2015. The resultant CQC report will be published later in the year.

Healthwatch Hillingdon

Healthwatch Hillingdon is a new health watchdog run by and for local people. It is independent of the NHS and the local Council. Healthwatch Hillingdon aims to help residents get the best out of their health and care services and give them a voice so that they can influence and challenge how health and care services are provided throughout Hillingdon. Healthwatch Hillingdon can also provide residents with information about local health and care services, and support individuals if they need help to resolve a complaint about their NHS treatment or social care.

From April 2013, Healthwatch Hillingdon replaced the Hillingdon Local Involvement Network (LINk) and became the new local champion for health and social care services. It aims to give residents a stronger voice to influence how these services are provided. Healthwatch Hillingdon is an independent organisation that is able to employ its own staff and volunteers.

Healthwatch aims to listen to what people say and use this information to help shape health and social care services. It will help residents to share their views about local health and social care services and build a picture of where services are doing well and where they can be improved. It will use this information to work for improvements in local services. Healthwatch Hillingdon will also provide residents with information about local health and care services including how to access them and what to do when things go wrong. It will help refer people to an independent person who can support them in making a complaint about NHS services.

Healthwatch Hillingdon has recruited eight Board Members to join the Chairman, Jeff Maslen, on the Board. This Board contains a balance of strong strategic leadership, governance, organisational and financial skills required to lead the new organisation. The Board will be able to represent the communities which it serves and ensure there is a good understanding of the broad areas of health and social care.

Healthwatch Hillingdon's 2014/2015 Annual Report has been attached as Appendix C.

Local Medical Committee (LMC)

Londonwide LMCs supports and acts on behalf of 27 Local Medical Committees (LMCs) across London. LMCs represent GPs and practice teams in their negotiations with decision makers and stakeholders from health and local government to get the best services for patients. They are elected committees of GPs enshrined in statute. Londonwide LMCs and LMCs also provide a broad range of support and advice to individuals and practices on a variety of professional issues.

A local medical committee is a statutory body in the UK. LMCs are recognised by successive NHS Acts as the professional organisation representing individual GPs and GP practices as a whole to the Primary Care Organisation. The NHS Act 1999 extended the LMC role to include representation of all GPs whatever their contractual status. This includes sessional GP and GP speciality registrars. The LMC represents the views of GPs to any other appropriate organisation or agency.

In the United Kingdom, LMCs have been the local GP committees since 1911. They represent all General Practitioners in their geographical area which is historically coterminous with the successive Primary Care Organisations or other healthcare administrative areas. As the organisation and complexity of primary care has increased and along with the call for increased professionalism and specialisation of for instance negotiators, LMCs' administrative structures have developed from a pile of papers on the kitchen table of the LMC medical secretary to permanent staff and offices with substantial assets. This has allowed the LMCs to develop relationships ranging over time, topic and space between mutual suspicion and antagonism to useful cooperation for common benefit with NHS administrative organisations.

Care Quality Commission

The role of the Care Quality Commission (CQC) is to make sure that hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and encourage these organisations to make improvements. The CQC does this by inspecting services and publishing the results on its website to help individuals make better decisions about the care they receive.

Inspecting all health and social care services in England is not the only role the CQC undertakes. To make sure people receive safe and effective care, the CQC also takes enforcement action, registers services and works with other organisations. The CQC believes that everyone deserves to receive care that is safe, effective, compassionate and high-quality. For this to happen, the CQC inspects hospitals, care homes, GPs, dental and general practices and other care services all over England.

Witnesses

Representatives from the following organisations have been invited to attend the meeting:

- Central & North West London NHS Foundation Trust (CNWL)
- Hillingdon Clinical Commissioning Group (CCG)
- Royal Brompton & Harefield NHS Foundation Trust (RB&H)
- The Hillingdon Hospitals NHS Foundation Trust (THH)
- London Ambulance Service (LAS)
- Healthwatch Hillingdon
- Local Medical Committee (LMC)
- Care Quality Commission (CQC)

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Central and North West London NHS Foundation Trust

Quality Report

Trust Headquarters
Stephenson House
75 Hampstead Road
London NW1 2PL
Tel: 020 3214 5700
Website: www.cnwl.nhs.uk

Date of inspection visit: 23 - 27 February 2015
Date of publication: This is auto-populated when the report is published

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Campbell Centre Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre Park Royal Centre for Mental Health St Charles Mental Health Centre The Gordon Hospital	 RV3Y1 RV383 RV312 RV320 RV346
Long stay rehabilitation mental health wards for working age adults	Fairlight Avenue Hillingdon Hospital Mental Health Centre (Colham Green Road) Horton Haven Kingswood Centre Roxbourne Complex	 RV314 RV3AN RV351 RV3CA RV355
Forensic inpatient wards	Park Royal Centre for Mental Health	RV312
Child and adolescent mental health wards	Collingham Child and Family Centre	RV3CX
Wards for older people with mental health problems	Beatrice Place Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre	RV329 RV3AN RV383 RV320

Summary of findings

	St Charles Mental Health Centre TOPAS Waterhall Care Centre The Butterworth Centre	RV3Y2 RV391
Wards for people with learning disabilities	Kingswood Centre Seacole Centre	RV3CA RV3CV
Community based mental health services for adults of working age	Stephenson House	RV3EE
Mental health crisis services and health based places of safety	Campbell Centre Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre Park Royal Centre for Mental Health St Charles Mental Health Centre The Gordon Hospital Stephenson House	RV3Y1 RV3AN RV383 RV312 RV320 RV346 RV3EE
Specialist community mental health services for children and young people	Stephenson House	RV3EE
Community based mental health services for older people	Stephenson House	RV3EE
Community mental health services for people with learning disabilities	Stephenson House	RV3EE
Community substance misuse services	Stephenson House	RV3EE
Community health inpatient services	Windsor Intermediate Care Unit Hillingdon Hospital Mental Health Centre (Hawthorne Unit) South Wing St Pancras Hospital	RV3X8 RV3AN RV3X1
Community health services for children, young people and families	Stephenson House	RV3EE
Community health services for adults	Stephenson House	RV3EE
Community end of life care	Stephenson House	RV3EE
Community dental services	Stephenson House	RV3EE
Community sexual health services	Stephenson House	RV3EE

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We found that Central North West London NHS Foundation Trust was performing at a level which led to a judgement of **requires improvement**.

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

The inspection of the trust was one of great contrast. The community health services were rated as good with the sexual health services rated as outstanding. The overall rating for caring was outstanding reflecting the individualised care provided in the community dental and sexual health services. The mental health services had three core services that required improvement. These were the acute wards for adults of working age, wards for older people with mental health problems and the community based mental health services for adults of working age.

The area of greatest concern related to safety and responsiveness on the acute wards for adults of working age which were rated as inadequate. There were however significant challenges being faced by the trust at the time of the inspection with pressures across the mental health acute care pathway.

We also found geographical differences, especially in London between the inner and outer London boroughs. The inner London boroughs were facing the greatest bed pressures for people needing acute mental health services. The outer London boroughs were facing challenges of demands for community services and difficulties in staff recruitment resulting in waiting lists. This was particularly notable in the London Borough of Hillingdon for mental health and community services.

There was much for the trust to be proud of. Most notably we found staff were very positive about the work of the trust and in most places care was delivered by hard working, caring and compassionate staff.

Two areas stood out as being very positive. The first were the opportunities given to staff for their personal development through strong support and access to training. We heard of many examples where staff had been able to extend their skills and develop their career within the trust and as a result provide better care to patients. Secondly we heard many examples of where the trust embraced innovation and change. Staff told us how new ideas were welcomed and we saw many examples of service improvements taking place.

We found the trust was well led. There was a strong leadership team who had developed an open culture where the vision and values were known and were being put into practice. At the time of the inspection the trust was implementing a new divisional structure with a greater focus on local contact. Running through this will be a new accountability structure to ensure effective communication and learning. This will hopefully lead to more robust governance processes and to staff working at ward and team level receiving the information they need to know.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** for the following reasons.

In the acute wards for adults of working age we found that:

- Some of the ward environments at the St Charles MHC, Park Royal MHC and the Gordon Hospital did not have clear lines of sight. There was a lack of planning of how risks in the environment would be managed on a daily basis.
- The failure to increase staffing to support increased numbers of patients on some wards put patients at risk of not having their needs met appropriately.
- The training of staff in new restraint techniques had not yet been fully implemented. This meant that staff working together on wards were not all trained in the same techniques and in line with current best practice on the use of prone restraint. At the end of the last quarter there were about 75 incidents of prone restraint a month across the trust. Until this training is complete staff were using out of date interventions that could present a risk of injury to staff and patients.
- Although the trust had a plan to reduce the number of ligature points on the wards, the work would take some time to complete. Until this was done, patients on the ward who were at high risk of suicide would be at increased risk. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature risks on the wards in terms of the support given to individual patients who were at high risk of suicide to keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions.
- In the event of the use of rapid tranquilisation, monitoring of physical vital signs was not always maintained until the patient was alert.
- The records relating to the seclusion of patients at St Charles MHC did not provide a clear record of medical and nursing reviews, to ensure that these kept people safe and were carried out in accordance with the code of practice.
- There were a significant number of detained patients absconding from acute wards especially from St Charles, Park Royal and the Gordon Hospital. In the 6 months prior to the inspection 82 detained patients absconded whilst receiving

inpatient treatment and not when taking leave. In response to a serious incident, steps had been taken to address this at one hospital. Further review and actions were needed to reduce the risk of harm for patients using these services.

In the community based mental health services for working age adults we found that:

- Not all services had properly maintained automated external defibrillators (AED) machines to be used in the event a person had a cardiac arrest.
- The standard of some risk assessments was poor. They were out of date and lacked detail. Important information was not included.
- There were insufficient staff available in the Brent, Hillingdon and Harrow community recovery teams to work as care co-coordinators which meant that duty workers in some services were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk.

On the wards for older people with mental health problems we found that:

- Oak Tree ward and TOPAS did not comply with the guidance on same sex accommodation.
- On Redwood ward the medication trolley was not locked when left at the nurse's station. We saw medication had been left where it could have been picked up by patients which meant that they may not have been protected from avoidable harm.
- On Redwood ward the drugs to be used for emergency resuscitation were not stored together which could make them harder to locate in an emergency.
- At the TOPAS centre there was no record so staff knew about current safeguarding alerts and any actions that needed to take place to keep people safe.

However across the trust staff knew how to report incidents and the trust was implementing a range of measures to share the learning from incidents. Whilst most staff teams knew about incidents that had happened in their services, there were teams that had not benefitted from learning across divisions.

The trust had worked to reduce some areas of risk highlighted in serious incidents such as reducing the numbers of pressure ulcers acquired in services and reducing the risk of falls.

Safeguarding was understood by staff and the trust was actively involved in local multi-agency safeguarding work.

Summary of findings

In most services the trust recognised the importance of maintaining safe staffing levels and had a recruitment strategy in place that was addressing staffing shortfalls.

Medication was managed well across most of the trust and any safety issues were promptly identified and addressed.

Are services effective?

Good

We rated effective as **good** for the following reasons:

Most patients had a comprehensive assessment in place including where needed a physical health assessment. Whilst there was still further work to do, the quality of care planning had improved and the trust was monitoring and improving on the numbers of people being given a copy of their care plan.

The trust had a wide range of measures in place agreed with commissioners, stakeholders, other professional bodies and set internally to monitor and improve the outcomes of people who use their services.

The training provided by the trust was varied and welcomed by staff who felt they had opportunities to develop their knowledge and skills. Inaddition to an induction and mandatory training staff also attended a wide range of other training both internal and external to the trust. Staff felt well supported through supervisions and appraisals.

There were many positive examples of multi-disciplinary and multi-agency working.

The trust was making good progress in the training of staff and appropaite use of the Mental Capacity Act.

There were however a few areas for improvement as follows:

- In community based mental health services the provider must ensure that patients using community services are referred for regular physical health checks.
- In wards for older people with mental health problems the provider must ensure on Redwood ward that patients physical health checks take place regularly to ensure their health is monitored.

Are services caring?

Outstanding

We rated effective as **good** for the following reasons:

Summary of findings

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- In wards for older people with mental health problems the provider must ensure on Redwood ward that patients physical health checks take place regularly to ensure their health is monitored.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** for the following reasons.

In the acute wards for adults of working age and the PICU we found that:

- Despite work to mitigate this, the pressure on acute beds meant that wards were often over-occupied. There was not always a bed for patients and they slept on sofas or a temporary bed was used. Patients returning from leave did not always have an identified bed and a bed was not always available in the PICU.

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

In the mental health crisis services and health based places of safety we found that:

- People who were in a place of safety and were assessed as requiring inpatient beds experienced long delays before being admitted. The delays in accessing inpatient beds meant that some people received care that did not meet their needs.
- The places of safety at the Gordon hospital and Park Royal had no separate access.This meant that people had their privacy compromised as they arrived at the places of safety.
- In the North Kensington home treatment team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

On the wards for older people with mental health problems we found that:

- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. Some of these patients were not clinically appropriate for the ward environment.
- Most wards admitted patients into the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

On the long stay rehabilitation mental health wards we found that:

- In some areas information on how to complain was not clearly displayed and sometimes verbal complaints were not addressed using the complaints process where the patient would have liked to access this procedure.

Summary of findings

Whilst for patients needing an acute mental health service the service was not responsive at the time of the inspection, we did find that in other services patient access and discharge arrangements were working well and in line with local targets. We did however note that there were a number of services with long waiting lists in the London Borough of Hillingdon. The services were very aware of the need to offer appointments that met the needs of the patients and the importance of being reliable and punctual.

Most of the care was delivered in facilties that promoted recovery, comfort, dignity and confidentiality. Where this has not been achieved this will need to be addressed.

The trust served a very diverse population across each of the areas it covered. The trust demonstrated a real commitment in terms of meeting people's equality, diversity and human rights.

In some areas information on how to complain was not available. We also heard from patients who said they would have preferred their verbal complaint to be addressed in a more formal manner. The trust is introducing a centralised patient support service which will aim to make it easier for patients to provide feedback and raise concerns. It also aims to improve how they acknowledge and respond to concerns received about their services.

Are services well-led?

Good

We rated well led as **good** for the following reasons:

The trust had a clearly developed vision with values and strategic objectives. The staff knew what these were and felt part of the organisation.

The trust was led by a stable board and executive team. There was a programme of visits to services and leaders were felt to be visible and accessible. The trust were following through the recommendations from a governance review undertaken by Deloitte last year which should further develop their leadership.

The trust had undertaken work to meet the 'fit and proper persons requirement' which ensures that directors of health service bodies are fit and proper persons to carry out the role. This included undertaking a number of checks and this process needed to be completed.

The trust used a range of indicators and other measures such as surveys to monitor the performance of services. In many cases this accurately reflected when improvements needed to take place. Managers in teams and wards were using this information to varying degrees to highlight when work was needed. The trust did

acknowledge that there were still too many variations in standards between services. The new divisions with a new accountability framework appears to offer an opportunity to improve information and reduce variations.

The inspection took place at a time when the trust was being asked to save nearly 20% of its income over 3 years resulting in the consolidation and redesign of a number of services. All the savings plans included senior clinical input and feedback from people who use the services. However some staff felt they could be better informed and involved in the changes.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, recently retired Director of Mental Health and Disability, Department of Health

Team Leader: Jane Ray, Head of inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team of 118 people included:

Ten allied health professionals

Four analysts

One dentist

Thirteen experts by experience who have personal experience of using or caring for someone who uses the type of services we were inspecting

Twenty nine inspectors

Five junior doctors

Ten Mental Health Act Reviewers

Twenty two nurses from a wide range of professional backgrounds

Two planners

Two pharmacists

Seven senior doctors

Four social workers

Nine people from a range of other backgrounds such as governance, safeguarding, policy, communications etc.

Why we carried out this inspection

We inspected this core service as part of our on going comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, overview and scrutiny committees, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Sought feedback from patients and carers through attending fourteen focus groups and meetings
- Received information from patients, carers and other groups through our website
- Carried out two short notice inspections in Epsom and Milton Keynes
- Visited the main sites for the community services with the Divisional Leads

During the announced inspection visit from the 23 – 27 February 2015 the inspection team:

- Visited 137 wards, teams and clinics
- Spoke with 285 patients and their relatives and carers who were using the service
- Spoke with the managers or acting managers for each of the wards and teams
- Spoke with 913 other staff members; including doctors, nurses and social workers

Summary of findings

- Attended and observed 87 hand-over meetings and multi-disciplinary meetings
- Joined care professionals for 31 home visits
- Attended 22 focus groups attended by around 200 staff
- Interviewed 9 senior executive and board members

We also:

- Collected feedback from 177 patients using comment cards
- Looked at 413 treatment records of patients
- Carried out a specific check of the medication management on 10 wards
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Requested and analysed further information from the trust to clarify what was found during the site visits

After the main inspection week the inspection team:

- Carried out eight more short term announced or unannounced inspections of wards and teams including community based mental health services, community CAMHS teams, community learning disability teams and wards for older people.

The team inspecting the mental health services at the trust inspected the following services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay rehabilitation wards
- Forensic inpatient wards
- Wards for older people with mental health problems
- Wards for people with learning disabilities
- Wards for children and adolescents with mental health problems
- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people
- Community mental health services for people with learning disabilities
- Specialist community mental health services for children and young people

The community based substance misuse services provided by the trust were also inspected but not rated.

The team inspecting the community services at the trust inspected the following services:

- Community health services for adults
- Community health services for children, young people and families
- Community inpatient services
- Community end of life care
- Community dental services
- Community sexual health services

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the trust.

Information about the provider

Central and North West London NHS Foundation Trust (CNWL) provides integrated health and social care services to a population of around three million people living in the South-East of England including London, Milton Keynes and Buckinghamshire. The trust has an annual income of £439 million, employs just under 6500 staff who provide about 300 services from more than100 locations.

Sixty per cent of the trusts services are provided in the community, in people's homes, clinics and schools. The trust also has specialist inpatient services for people needing intensive treatment. Services are provided to children and young people, adults of working age and to older people.

CNWL was formed in 2002, following the merger of three mental health trusts. It became a foundation trust in 2007. Over the years additional contracts were awarded to the trust so it now provides mental health and community health services.

The mental health services provided by the trust are located mainly in the five London boroughs of Westminster, Kensington & Chelsea, Brent, Harrow and

Summary of findings

Hillingdon as well as Milton Keynes. The community services provided by the trust are located mainly in Camden, Hillingdon and Milton Keynes. Other services are provided outside these areas. In addition the trust also provides health services in 17 prisons, young offenders institutions and immigration removal centres. These services were not inspected during this inspection but will be inspected jointly with HMI of prisons. The trust works in a complex commissioning environment, with services commissioned on a local and national level.

The trust has 28 locations registered with CQC. CNWL locations have been inspected on 33 occassions at 18 of the locations. Four locations were non-compliant at the time of this inspection as follows:

- Beatrice Place – Regulation 9 care and welfare of people who use services
- The Campbell Centre – Regulation 20 records
- HMP Woodhill – Regulation 19 complaints
- St Charles Mental Health Centre – Regulation 18 consent to care and treatment, Regulation 9 care and welfare of people who use services and Regulation 10 assessing and monitoring the quality of service provision

With the exception of HMP Woodhill this non-compliance was followed up as part of the inspection.

What people who use the provider's services say

Before the inspection took place we met with 13 different groups of patients, carers and other user representative groups as follows:

- Loud and clear advocacy service (Brent, Harrow and Hillingdon)
- Mind in Harrow
- Older adult user group (Kensington & Chelsea and Westminster)
- Westminster Mind
- Rethink (Milton Keynes)
- Westminster carers network
- Milton Keynes carers network
- Mortimer Market user group
- Wheelchair user group – Hillingdon
- Brent user group
- Healthwatch user group (Hammersmith & Fulham, Kensington& Chelsea and Westminster)
- Meeting with representatives from Healthwatch (Camden, Milton Keynes, Kensington & Chelsea and Hillingdon)
- Different Voices advocacy group – at St Charles

During the inspection the teams spoke to 465 people using services or their relatives and carers, either in person or by phone. We received 177 completed comment cards. We also received 32 individual comments from people through our website.

Much of the feedback we received was very positive as follows:

- Most staff were kind, supportive, tried to meet peoples needs, professional and helpful. This was particularly positive when people had named individuals who were involved in their care.
- The trust promoted user engagement through user groups.
- The trust offered opportunities for user involvement for example in staff recruitment, policy development, patient forums etc.
- The trust was promoting and making increased use of advocacy services.
- Some services received particular mention such as the memory clinics.

Some of the challenges that we were told about were as follows:

- The greatest number of concerns were from people who told us their experiences of accessing acute mental health services and included – length of time waiting in A&E for a bed, patients sleeping on couches in wards as a bed was not available, patients moving between wards and sites and carers not always told.
- Carers not always feeling well informed, listened too or involved such as attending ward rounds. Carers also expressed particular concerns about staff not responding when they reported that the person they were supporting was experiencing a deterioration in their health.
- Some negative comments about staff attitudes – especially at the Gordon Hospital

Summary of findings

- Access to psychological therapies in a timely manner from staff with the correct skills and experience.
- People not having access to their care plan.
- People not having access to lockable space when they were an inpatient.
- Difficulties in using the complaints process.
- Reductions in services, especially day centres in areas such as Brent.
- Whilst receiving a new wheelchair went well, getting the wheelchair repaired in a timely manner was hard, especially in Hillingdon.
- Whilst the trust welcomed user involvement, it did not always provide feedback when issues were raised.

Good practice

Trust wide:

- The positive attitude of staff was very evident throughout the inspection. This was reflected in their pride in working for the trust and their service and in their wish to provide the highest standards of care to people using the service.
- The pharmacy team not only ensured that the arrangements for the supply of medicines was good, but also provided considerable guidance and support to staff and patients throughout the services.
- Patients carers and staff all valued the courses provided by the recovery college and the opportunities for personal development. The recovery college was very well organised and responsive to local need.
- The trust serves very diverse communities and throughout the inspection we saw many examples of how the trust is supporting people who use the services, their families and carers in terms of their individual needs.

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

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

Community based mental health services for working age adults:

- A consultant pharmacist attended the North Kensington and Chelsea community recovery team every week. Patients could book appointments with them to discuss their medicines.
- The North Westminster assessment and brief treatment and community recovery teams provided

very good care. They were particularly sensitive to the cultural background of patients. Patients received care and treatment specifically tailored to their own diverse needs.

- Almost all services had employed peer support workers, people who had used or were using mental health services, who were a positive addition to the teams.
- Several community services involved patients in interviewing prospective new staff members as part of the recruitment process.
- Most teams held regular forums for patients and carers to give feedback about the service.

Rehabilitation wards for working age adults

- Staff across the services had a very good understanding of the Mental Capacity Act and were able to demonstrate good documentary evidence of using the Act in practice.

Inpatient wards for people with a learning disability

- A wide variety of information had been made available in accessible formats for people using the service.

Children and adolescent inpatient wards

- Each child was offered an individualised programme of assessment and treatment. Upon admission a range of assessments were completed including psychiatric and psychological assessments. The team worked together to formulate detailed care plans.
- Collingham was a member of the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS (QNIC) accreditation network. The service was recently accredited 'as excellent'.
- NICE guidance was followed when prescribing medication.Trust guidelines for unlicensed medicines were followed.
- Behavioural therapy and systemic family therapy were amongst the NICE recommended treatments available for children at Collingham.
- The service's last routine outcome measurement report completed from the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS (QNIC) for the period of April 2013 – 2014 showed positive results. Outcome measures were used in the service to monitor a person's progress in a systematic way.
- Children's feedback was sought and used to inform service development.
- Children had participated in the interview process for a new member of staff and for student placements by developing interview questions for the panel on areas that were important to them.

Specialist community mental health services for children and young people

- The Brent CAMHS service ran the targeted mental health in schools (TaMHS) programme. They worked to support school staff to recognise young people with emotional wellbeing and mental health needs. They provided access to advice and consultation from a professional in mental health.
- Young people had been used on interview panels for new staff in the trust and had been involved in developing questions for candidates.

Wards for older people with mental health problems

- At Beatrice Place the team was pioneering a new sensory activity programme designed for adults in the advanced stages of dementia called Namaste. This evidence based programme focused on meeting the physical and emotional needs pf patients through meaningful activity which in turn decreases distress and resulting behavioural problems. The activity used music, fragrance, plants, sensory stimulation, massage and food treats to improve the comfort and pleasure of the patient's experience. It had just started running but Beatrice Place was the first NHS service to pilot the programme. Staff reported that a couple of their higher risk patients had improved communication and demonstrated less agitation and distress since they started attending the programme.

Community based mental health services for older people

- Brent and Kensington & Chelsea and Westminster memory clinics are accredited by the Royal College of Psychiatrists as 'excellent' as part of their memory service national accreditation programme.

Summary of findings

- The Brent memory service have introduced five primary care dementia nurses (PCDN). The PCDN was developed from the Admiral Nurse model which is patient and carer focused and described as having 'one foot in the memory service and one foot in GP surgeries'.The role is intended to support GPs to better manage patient care and reduce referrals to the service as well as enabling people who use the service to stay in their own home with support for longer.

Community dental services

- The commitment of staff to provide the best care they could. Staff spoke with passion about their work, felt proud and understood the values of the organisation.
- The positive feedback received from patients regarding the quality of care they received. The care provided was person centred, individualised and based on evidence based guidelines.

Community health inpatient services

- South Wing St Pancras had introduced weekly observations of staff practice. Ward managers visited and observed the practice of staff on other wards. The ward managers relayed their findings to the clinical lead at the St Pancras community in patient weekly clinical indicator team meetings.

Sexual health services

- The sexual health services participated in a wide range of research and innovation both nationally and internationally. This means that the patients who use these services had access to some of the latest approaches to meet their individual needs.

Community health services adult teams

- Good partnership working between Hillingdon hospital and the community rehabilitation team had highlighted to commissioners bed days could be reduced by providing intensive seven day a week therapy through evidenced based practice. As a result commissioners had invested significantly in the rehabilitation team.
- Camden respiratory and neuro-therapy teams had a range of positive initiatives to ensure vulnerable people had access to good quality and effective care. For example taxis were provided for the patient and carer to attend the pulmonary rehabilitation class. The class included group and individual exercises, education sessions and a question and answer session with the consultant. Sessions with nurse, clinical psychologist, dietitian, occupational and physiotherapists were available. British Lung Foundation packs were given to patients and leaflets were available in different languages with access to interpreters if required. Patient feedback had informed the timing of sessions.
- The district nurse bag in Milton Keynes had been designed to ensure all the necessary equipment was available to use during each appointment.

Community health end of life care

- In response to concerns from a group of people with a learning disability the Islington ELiPSe team and the Camden palliative care team worked with the group giving them advice, information and support about the decisions they could make regarding their care at end of life.
- The Hillingdon palliative care team worked closely with nursing homes to improve the end of life care for people in the home which had resulted in an increase in people dying in the homes rather than in hospitals.
- The 'transform end of life project' will run for five years to educate, mentor and train clinical and medical staff in end of life care. New documentation was being piloted which incorporated five key tools to improve communication between patients, families and clinical staff that will also roll out across the community Camden, Islington ELiPSe palliative care services.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

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

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

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

- The trust must ensure information is available to inform patients how to make a complaint. They must ensure verbal complaints are addressed and, if needed, patients and carers have access to the formal complaints process.

Action the provider MUST take to improve mental health crisis services and health based places of safety:

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

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

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

Action the provider MUST take to improve the long stay / rehabilitation mental health wards for working age adults

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

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

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

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve trust wide services

- The trust should complete its work to fully embed the work on the fit and proper person requirement.
- The trust should fully implement the new accountability framework to ensure there is effective ward to board sharing of information and learning.
- The trust should complete it's work on complaints to ensure they are addressed in a more consistently high standard.

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

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

Summary of findings

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

Action the provider SHOULD take to improve mental health crisis services and health based places of safety:

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

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

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

Action the provider SHOULD take to improve forensic wards

- The trust should consider how learning from incidents across different divisions is embedded in practice

especially where there are wards with similaries either in geography or function such as other wards on the Park Royal site and other rehabilitation wards in the trust.

- The trust should consider if a seclusion room can be provided on the same floor as the wards.
- The trust should ensure areas for work identified in infection control audits are carried through.
- The trust should provide ongoing training and support to ensure all staff had a good understanding of the Mental Capacity Act and how this would be used in practice with the patients using these services.
- The trust should ensure that repairs to equipment in the wards are reported and fixed in a timely manner.

Action the provider SHOULD take to improve community mental health services for people with learning disabilities:

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

Action the provider SHOULD take to improve the long stay / rehabilitation mental health wards for working age adults:

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

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

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

Summary of findings

Action the provider SHOULD take to improve children and adolescent inpatient wards

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

Action the provider SHOULD take to improve specialist community mental health services for children and young people

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

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

- The trust should ensure staff working on wards for older people can clearly articulate how they are supporting patients to keep safe in terms of the ligature risks on the ward.
- At St Charles chairs with split covers should be repaired or replaced and enough chairs should be available so people can eat together.
- Here actions are needed following environmental risk assessments, these should be followed through.
- The trust should review the layout at Beatrice Place to try and provide gender separation in terms of bathroom facilities.
- On Redwood ward risk assessments should be updated following incidents.
- The trust should ensure staff have opportunities to discuss and learn from incidents across the trust and not just their site.
- The trust should ensure that Mental Health Act documentation is completed correctly for patients on TOPAS, Redwood ward and the Butterworth Centre to ensure people are being supported to understand their rights, their medication is authorized and their leave is approved.
- The trust should ensure that staff have been supported to have the training needed to support patients with their physical healthcare in line with the training provided at Beatrice Place.
- The trust should ensure that where patients are subject to a deprivation of liberty safeguard that the authorisations are kept under review and updated as needed.

Action the provider SHOULD take to improve the community-based mental health services for older people

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

Action the provider SHOULD take to improve community substance misuse services

- The provider should ensure that each person receiving treatment has potential risks associated with the treatment assessed, and that where potential risks are identified an appropriate plan to manage or mitigate these risks is put in place. This work had been identified by the trust and needs to be completed.
- The provider should ensure that a robust system to monitor and dispose of medical equipment that has passed its expiry date is in place at each site.

Summary of findings

- The provider should ensure that staff record information relating to physical health checks in a standardised format to ensure that this information is readily accessible to all staff who may need to access it.
- The provider should ensure that all patients with identified health risks, such as at QT prolongation, are referred at regular intervals for electrocardiograms (ECG), in line with trust policy and procedure.
- The provider should ensure that recovery care plans across all sites are holistic and contain all information relating to care and treatment including the views of the patient.
- The provider should ensure that a clear policy and procedure is available at all sites that provides guidance on the frequency with which patients prescribed controlled medicines should be reviewed by the prescribing doctor.
- The provider should ensure that premises promote the dignity of people needing to access facilities at each geographical site.

Action the provider SHOULD take to improve community dental services

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

Action the provider SHOULD take to improve community health inpatient services

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

Action the provider SHOULD take to improve in community health adult teams

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

The district nursing teams in Hillingdon should all maintain high standards of infection control practice.

Central and North West London NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust's systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. Administrative support and legal advice was available from the Mental Health Act lead in a centralised team within the trust, as well as Mental Health Act law managers and Mental Health Act administrators based at each hospital site.

The staff carried out regular audits to ensure the Mental Health Act was being implemented correctly and produce a quarterly Mental Health Act Performance Report. A Mental Health Law group met every two months to review Mental Health Act performance and trends and provided a governance structure.

Training was provided to staff centrally and within local teams. Role specific training was given where required. Overall staff appeared to have a good understanding of the Mental Health Act and code of practice.

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

There was a good adherence to consent to treatment and capacity requirements and copies of consent to treatment forms were mostly attached to medication charts where applicable.

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

Within all of the wards visited apart from the learning disability services we found that people had access to Independent Mental Health Advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.

Where there are some individual areas for improvement these are identified in the core service reports.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust provides a statutory mental health law training course all staff working in clinical settings. This includes training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

Requires improvement

Are services safe?

The trust has an up to date policy on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

We found variations in the use of the MCA in terms of the completion of MCA assessments and recording this appropriately and the use of best interest meetings. The long stay rehabilitation mental health wards for working age adults showed good practice in terms of the Mental Capacity Act. Where there are some individual areas for improvement these are identified in the core service reports including the forensic inpatient wards and learning disability wards.

There is a trust wide MCA lead and also leads in different services to support staff as needed.

Between the 1 May 2014 and the 31 October 2014 there had been 102 DoLS applications. Some were still waiting to be assessed and several had not been authorized. In the wards for older people with mental health problems we found some DoLs where the authorisations had expired and new applications needed to be made. This reflects the on-going learning process that trusts are experiencing about this process.

Adherence to the MCA is monitored through the Mental Health Law group which provided a governance process. This looked at the results of audits and considered new methodology.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as **requires improvement** for the following reasons.

In the acute wards for adults of working age we found that:

- Some of the ward environments at the St Charles MHC, Park Royal MHC and the Gordon Hospital did not have clear lines of sight. There was a lack of planning of how risks in the environment would be managed on a daily basis.
- The failure to increase staffing to support increased numbers of patients on some wards put patients at risk of not having their needs met appropriately.
- The training of staff in new restraint techniques had not yet been fully implemented. This meant that staff working together on wards were not all trained in the same techniques and in line with current best practice on the use of prone restraint. At the end of the last quarter there were about 75 incidents of prone restraint a month across the trust. Until this training is complete staff were using out of date interventions that could present a risk of injury to staff and patients.
- Although the trust had a plan to reduce the number of ligature points on the wards, the work would take some time to complete. Until this was done, patients on the ward who were at high risk of suicide would be at increased risk. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature risks on the wards in terms of the support given to individual patients who were at high risk of suicide to

Requires improvement

Are services safe?

keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions.
- In the event of the use of rapid tranquilisation, monitoring of physical vital signs was not always maintained until the patient was alert.
- The records relating to the seclusion of patients at St Charles MHC did not provide a clear record of medical and nursing reviews, to ensure that these kept people safe and were carried out in accordance with the code of practice.
- There were a significant number of detained patients absconding from acute wards especially from St Charles, Park Royal and the Gordon Hospital. In the 6 months prior to the inspection 82 detained patients absconded whilst receiving inpatient treatment and not when taking leave. In response to a serious incident, steps had been taken to address this at one hospital. Further review and actions were needed to reduce the risk of harm for patients using these services.

In the community based mental health services for working age adults we found that:

- Not all services had properly maintained automated external defibrillators (AED) machines to be used in the event a person had a cardiac arrest.
- The standard of some risk assessments was poor. They were out of date and lacked detail. Important information was not included.
- There were insufficient staff available in the Brent, Hillingdon and Harrow community recovery teams to work as care co-coordinators which meant that duty workers in some services were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk.

On the wards for older people with mental health problems we found that:

- Oak Tree ward and TOPAS did not comply with the guidance on same sex accommodation.
- On Redwood ward the medication trolley was not locked when left at the nurse's station. We saw medication had been left where it could have been picked up by patients which meant that they may not have been protected from avoidable harm.
- On Redwood ward the drugs to be used for emergency resuscitation were not stored together which could make them harder to locate in an emergency.
- At the TOPAS centre there was no record so staff knew about current safeguarding alerts and any actions that needed to take place to keep people safe.

However across the trust staff knew how to report incidents and the trust was implementing a range of measures to share the learning from incidents. Whilst most staff teams knew about incidents that had happened in their services, there were teams that had not benefitted from learning across divisions.

The trust had worked to reduce some areas of risk highlighted in serious incidents such as reducing the numbers of pressure ulcers acquired in services and reducing the risk of falls.

Safeguarding was understood by staff and the trust was actively involved in local multi-agency safeguarding work.

In most services the trust recognised the importance of maintaining safe staffing levels and had a recruitment strategy in place that was addressing staffing shortfalls.

Medication was managed well across most of the trust and any safety issues were promptly identified and addressed.

Our findings

Track record on safety

- The CQC Intelligent Monitoring system was used to give an indication of potential risks for the trust in preparation for the comprehensive inspection. There was a risk identified in relation to an indicator which

measures the number of deaths of patients detained under the Mental Health Act. This showed that there were two deaths from December 2012 till November 2013.

- NHS Trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS). In total 7680 incidents were reported to NRLS between the 1 December 2013 and 30 November 2014. These figures showed that two-thirds of the incidents reported occurred in a mental health setting. Of these 80% were classified as "no harm" incidents.
- For the purposes of the inspection there was a focus on never events and serious incidents. Between the 1 December 2013 and 30 November 2014 there were 0 never events, 144 serious incidents and 39 deaths.
- Most of the serious incidents related to community services and were grade 3 or 4 pressure ulcers. Most of these occurred in the patients' own home. It was not possible to tell from the data if the pressure ulcers were found by community staff when they started providing a service, or if they occurred during the course of providing a service.
- The trust provided a more detailed breakdown of the serious incidents between September 2013 and January 2015. For mental health services there had been three inpatient deaths during this time two in the Milton Keynes services and one in Hillingdon. There had also been 14 suicides of patients receiving services from the trust, 2 in Brent, 6 in Milton Keynes and 6 in Hillingdon. There had also been one homicide in Hillingdon. Just prior to the inspection there was another suicide in Westminster. An independent review is taking place of the cluster of suicides in Hillingdon.
- From the 2 September 2013 till 30 September 2014 there were 3 admissions of patients under 18 to an adult ward, although they were offered support to meet their needs until an appropriate placement was identified. This is reported as a serious incident due to the potential risks for the young person of being in an adult environment.
- The NHS Safety Thermometer measures a monthly snapshot of four areas of harm including falls. From November 2013 for the next 13 months the numbers of pressure ulcers had continued to fluctuate. This is largely outside of the trusts' control as they report pressure ulcers for community patients when they start to provide them with a service. The number of patient falls resulting in harm had reduced in the second six months to 96 cases.
- The trust provided a more detailed breakdown of the serious incidents between September 2013 and January 2015. This showed that for community patients receiving an inpatient service 7 had developed pressure ulcers, 4 at the Windsor unit in Milton Keynes, 2 at the Hawthorne unit in Hillingdon and 1 at St Pancras in Camden. Also at the Windsor unit in Milton Keynes 4 patients had experienced fractures as a result of falls. Last years quality account had made reducing avoidable pressure ulcers a target in the Milton Keynes services and this was achieved. Training is mandatory on reducing falls and pressure ulcers for all staff working in services for older people.
- Every six months the Ministry of Justice publishes a summary of schedule 5 recommendations which have been made by coroners with the intention of learning lessons from the causes of deaths. In the most recent report (October 12 – March 2013) there were two recommendations about patients being cared for by the trust. Only one of these was directly related to the trust's services and was about the use of medications for patients with a bi-polar disorder and the need to provide contact details for when further psychiatric care is needed on discharge letters sent to GPs.

Learning from incidents

- The feedback from external stakeholders was that the trust was open and transparent and shared information on incidents and the action taken. This meant it was fulfilling its duty of candour.
- The trust monitored whether it was completing the investigation of serious incidents within the expected timescales. Between the 1 December 2013 and 30 November 2014 there had been 144 serious incidents. At the time this information was collected 26 had exceeded the expected timescales for completing the investigation and one had been open for over 10 months. We were told by staff that delays in investigations can be very difficult for staff especially where they are suspended from duty.
- The five Central and West London clinical commissioning groups fed back that in 2013 / 2014 there were concerns raised about the quality of serious

incident report root cause analyses being received in relation to suicides. This led to the trust developing a team to ensure this work was completed to an appropriate standard and this has led to an improvement in the quality of this work in line with the national serious incident framework for reporting. Four root cause analyses were randomly chosen by the inspection team and these had been completed comprehensively.

- In the 2013 NHS Staff Survey the trust performed better than the national average for staff witnessing and reporting potentially harmful incidents and near-misses. This reflected our inspection findings that staff were confident in the use of the incident recording system and the application of the incidents and serious incidents policy.
- The trust monitored the numbers of incidents reported as part of its monthly service line dashboard. The trust had an incident group that reviewed recent incidents, identified themes and scope for organisational learning.
- The trust had a number of means of sharing learning from incidents and complaints. This included an email bulletin called 'Listen. Learn. Act' . There were also learning events, for example the assessment and brief treatment teams had quarterly learning from incident events. There were also lots of meetings across the trust, peer reviews and some opportunities for reflective practice.
- The trust also produced an annual organisational learning report looking at themes coming out of incidents and complaints. This had highlighted four main areas for work for 2014-15. These were communication and information sharing during clinical handover, discharge or transfers of care. The second area was risk assessments, risk management and mitigation through care planning. There was also a theme about understanding and managing expectations. The final area was workforce and leadership issues which included areas such as adequate staffing and staff behaviour and attitude.
- At the time of the inspection the trust had just implemented a new divisional structure in December 2014 strengthening its links with local geographical areas. Alongside this was the introduction of a new accountability framework which included the executive board reviewing the incidents in each division. There is also an exception reporting process to ensure significant incidents were escalated quickly to the Chief Operating Officer.
- As part of the new divisional structure there were defined governance structures through divisional management boards and divisional quality boards. They will take responsibility for ensuring the learning from incidents reaches individual services through monthly service level team meetings.
- The inspection of the trust took place at a time when these changes were relatively new and still being embedded. This meant that whilst staff generally knew about incidents and the associated learning that had taken place within their immediate teams, there was less knowledge and learning across different geographical areas or between divisions. This was particularly noted in the community based mental health services for adults of working age, forensic wards, rehabilitation services and wards for older people with mental health problems.
- Staff were positive about the process of de-briefing after a serious incident. This ensured that support was provided to the patient and the staff involved in the incident. Where needed staff were supported to seek medical assistance, have input from occupational health and counselling services. It also provided an opportunity for the team to reflect on learning from the incident.

Safeguarding

- The trust had systems in place to safeguard people from abuse. Most staff we spoke to understood the importance of safeguarding vulnerable adults and children.
- Due to the size of the trust, services had safeguarding leads who could support staff with raising an alert and knew the detailed arrangements in the geographical area in which the service was located. Staff in most services said that they felt able to raise issues of potential abuse and seek advice from local safeguarding teams on whether an alert was appropriate.
- Local authorities fed back that the trust was actively engaged in local multi-agency safeguarding boards and associated work.
- The trust had a central safeguarding committee that reviewed recent safeguarding cases, identified themes

and organisational learning. Overall the numbers of alerts was increasing reflecting increased staff awareness. In addition services kept a record of local safeguarding issues so that they could ensure that where follow up action or learning was needed that this could place. At the TOPAS centre in Milton Keynes we found this information was not available and staff were not clear on the actions they needed to take.

- Safeguarding training was delivered at three levels for vulnerable adults and children. Staff attended the appropriate level of training based on their role. The trust monitored the completion of this mandatory training and in most areas of the trust over 90% of staff had completed the required training.
- The trust carried out an internal audit of its safeguarding work in 2014. This found the need for safeguarding information on the intranet to be improved, to ensure safeguarding is discussed at supervisions and to look at opportunities for shared learning.

Assessing and monitoring safety and risk

- The trust was aware that work was needed to improve assessing and managing risk to patients. There was a target in place for the mental health services that risk assessments should be completed and reflected in care plans in 95% of patient records. At the end of the last quarter at the end of December 2014 an internal audit showed this had only been achieved in 80% of records.
- The inspection looked at the availability and content of risk assessments across the core services and found a very mixed picture. In some services the risk assessments had improved such as the psychiatric intensive care units. In others the picture was very mixed. For example in some of the teams providing community based mental health services for adults the risk assessments were excellent. But in the Harrow team there were risk assessments that needed to be reviewed or where current potential risks were not reflected in the risk assessment.

Potential risks

Safe staffing

- The trust had carried out a review of staffing levels across the services and agreed the levels that should be in place although it was reviewing the skill mix of staff in inpatient settings. The trust had an e-roistering system in place which enabled them to monitor staffing levels.
- At the end of the last quarter December 2014 the trust had 721 vacant posts out of 6542 budgeted posts. At the time of the inspection there were staff vacancies of around 10% which had reduced from 16% a year ago. There were particular hotspots for vacancies including offender care and band 5 nurses in community services in Milton Keynes and Hillingdon and band 5/6 mental health nurses in Milton Keynes, Brent and Harrow. There were higher vacancies in outer London boroughs, for example 23% vacancies in Brent. Nurse recruitment was the greatest challenge. The executive team received a monthly update on recruitment and the specific challenges were noted on risk registers where appropriate.
- The trust had an active recruitment and retention strategy. This included improving how it attracted potential staff through targeted recruitment schemes. Ideas being put into practice were working with the universities to attract nursing students, engaging with local communities to attract staff and national & international recruitment. They also attracted staff through offering opportunities for learning and development. The courses provided through the recovery college were attractive to staff. There was a career pathway for health care assistants and they supported unqualified staff who wanted to do nurse training. Work was on-going to reduce the time taken to recruit staff and to address hotspots with targeted recruitment.
- There was a strong commitment to only recruiting staff with the appropriate skills through the use of assessment centres. Less than 40% of prospective nurses received a job offer following verbal and numerical skills testing. Staff commented on the improved quality of new staff who were being recruited.
- The trust was trying to increase the number of bank staff they can call on and reduce the use of agency staff. Bank staff received the same training as substantive staff in terms of statutory and mandatory training.
- The NHS staff survey results in 2014 reflected some of these challenges as one of the bottom five ranked

scores was the percentage of staff working extra hours. Staff experience had improved in the percentage of staff pressure in the last 3 months to attend work when feeling unwell but had deteriorated in terms of the percentage of staff suffering work related stress.

- Levels of staff sickness were generally within reasonable levels at 3.5%. Higher levels of staff sickness were noted in the Milton Keynes services at 5.7% and acute mental health services at 4.5%. Staff turnover was running at 18.2%.
- We did find that whilst staffing was very challenging in a number of areas, that the trust was working to keep staffing safe. The main area of concern was on the acute wards for adults of working age where there due to bed pressures there were extra patients spending the day on a few wards and where day time staffing levels had not been adjusted to reflect these increased numbers.
- The week of the inspection we found the number of people using the community based mental health services who were waiting to be allocated a care co-ordinator varied between the community recovery teams. In Kensington & Chelsea and Westminster there were 2 or 3 people. Whereas in Harrow there were 16, Brent 35 and Hillingdon 40. Whilst these people were reviewed weekly and there were plans to allocate them to senior staff, and help being received from other teams, their lack of a named care co-ordinator could impact on their care as they had complex needs and needed close support.
- Where patients needed higher levels of observation and support managers were able to increase the staffing levels. Also we heard of arrangements that had been made to meet the needs of patients with specific needs. For example in the community team for people with a learning disabilities in Brent and Harrow the speech and language therapy post was vacant and so the trust had made an arrangement with another provider to ensure patients with swallowing difficulties could receive timely treatment while the post was being filled. We also found many examples of teams working together to prioritise work and ensuring that patients needs were met.

Safe and clean ward environments and community care

- The trust provided services from a very variable range of physical environments. The trusts estate comprised of 124 buildings within 100 separate sites. Some buildings were new and purpose built such as the mental health unit at Northwick Park Hospital and the Hawthorne intermediate care unit in Hillingdon. Others such as the Gordon Hospital in Westminster were older and provided very challenging environments for the delivery of care.
- During the inspection we heard from staff that there could be challenges in the timely completion of building repairs that were impacting on the quality of the service available to the patients. This was raised in particular by staff working in some of the London mental health rehabilitation services and the Park Royal mental health unit. From the 1 April 2014 the estate maintenance services were provided by single outsourced service provider.
- We did found that facilities were generally clean. Infection control and health & safety is monitored across the trust through audits and this is overseen by trust wide committees. The inpatient services had patient led assessments of the care environment (PLACE). Overall the PLACE assessments gave high cleanliness scores with St Pancras having the lowest score at 95.4%. Staff working in community services had a good understanding of infection control.
- Standards of infection control were generally high across the trust although it was noted that some district nurses in Hillingdon were not removing outer clothing before carrying out patient care.
- The health and safety group is supported by an estates led fire safety group. In November 2014 the London Fire Brigade served an enforcement notice in respect of Pall Mall a community mental health site. The trust confirmed that the improvements required in terms of information available on site, staff training and work on fire doors had taken place and the enforcement notice had been lifted.
- The trust had undertaken risk assessments of ligature risks in the mental health inpatient areas during the last year. These were prioritising where physical changes to the environment to reduce ligature points would take place first. The previous inspection at St Charles had identified that ligature risk needed to be managed more effectively and this was an area of non-compliance. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature risks on the wards in terms of the support given

to individual patients who were at high risk of suicide to keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions. For example all the bathroom doors had been removed and replaced with curtains in the bathrooms used by the shared bays at the Campbell Centre in Milton Keynes.

- At the Gordon Hospital the two place of safety rooms both contained ligature points. The toilet for use of people was also not ligature free. Although staff could manage risk through observation, the environment meant people could not be supported safely without compromising their privacy. The trust had agreed to the refurbishment of the place of safety and work was starting in April 2015.
- We looked at whether patients using mixed gender inpatient services were provided with 'same sex accommodation' to promote their privacy and dignity. We found that in most wards this separation was provided with male and female patients having separate bedrooms and bathroom areas. However at Oak Tree ward in Hillingdon and TOPAS in Milton Keynes these arrangements were not completely in place which compromised peoples safety, privacy and dignity. In a couple of community rehabilitation services (Fairlight and Colham Green) and one continuing care service for older people (Beatrice Place) bathrooms were used by people of both genders or involved people passing the bedrooms of other patients to reach the bathrooms. These were smaller community based services and the staffing and risk assessments in place meant that these arrangements did not compromise the privacy and dignity of people currently using the services, however where possible providing separate bathrooms for people of each gender should be promoted.

Physical interventions

- The trust had a policy on the prevention and therapeutic management of violence and aggression. This had been updated in 2014 after the publication of the Department of Health guidance "Positive and Pro-active Care".
- Between 1 May 2014 and 31 Oct 2014 restraint was used on 773 occasions. Restraint was being used mostly on the mental health psychiatric intensive care units, acute and forensic inpatient wards. In 284 (36.7%) of these 773 incidents, patients were restrained in the prone position. In 319 (41.3%) of the 773 incidents of restraint rapid tranquilisation was administered. The number of prone restraints was being closely monitored by the trust through a restrictive interventions group. However at the end of the last quarter (December 2014) the numbers of prone restraints remained at around 75 a month which is a high figure. The trust had a strategic action plan on restrictive interventions and had set a target to reduce the use of all forms of restraint by 50% in 18 months. Physical intervention training was delivered by an in-house tutor team and the model used was the general services association . The training focused on verbal de-escalation techniques but also teaches techniques to safely restrain patients. Since October 2014, all staff attending this training had been taught in a new technique to safely restrain patients in the supine position. At the time of the inspection over 200 staff had been trained in the new technique however these were staff from across the wards. They were not able to always use this revised training as they could be working with people who had not had been taught the new technique. Immediately after the inspection the trust said they had developed a plan to accelerate the delivery of restraint in the supine position to the remaining staff that required this update. The trust had secured an external training venue and had brought in additional trainers to deliver this. This additional training would be commencing in April 2015 and was scheduled for completion in June 2015. Whilst this new technique is expected to support a reduction in prone restraint wider work was also being undertaken via the trust's strategic action plan to support a reduction in all restrictive interventions. Areas know to be high users of all forms of restrictive practices would be prioritised with a particular emphasis on de-escalation and alternatives to physical interventions and enforced medication. The trust said that as part of this training package, all staff will receive an introduction to positive behaviour support planning and advanced directives.
- There were in total 276 incidents of use of seclusion across 14 wards at the trust (1 May- 31 Oct 2014). Eighty (29.9%) of incidents recorded were in Caspian Ward (Park Royal), this was followed by Shore Ward with sixty (21.7%) incidents. There were no incidents of long term segregation recorded. The trust was aware of variations in the use of seclusion across the sites and the Restrictive Interventions group were monitoring the

seclusion incidents. The seclusion rooms across the trust were generally in a reasonable state. One seclusion room at Park Royal Mental Health Centre had a 'blind spot', where staff could not safely view the patient at all times. At Northwick Park the seclusion room had no clock. There had previously been a clock but it was removed as the fixture it hung from was considered a ligature risk. The clock was reinstalled and was ligature risk free by the end of our visit. The medical and nursing reviews were checked for people in seclusion and at St Charles these were not clear or contemporaneous. This meant that patients were at risk of not having their needs reviewed in a timely manner whilst in seclusion.

- Between the 1 September 2014 and the 28 February 2015 there were 247 incidents of patients detained under the Mental Health Act who were absent without leave. These were mostly from acute inpatient wards and the numbers were St Charles 57, Hillingdon 43, Park Royal 40 and the Gordon Hospital 30. Thirty three percent (82) of these incidents were patients who had absconded whilst residing on the ward. The three sites with the most incidents of patients absconding from the ward were St Charles 21, Gordon Hospital 17 and Park Royal 12 incidents. The trust was monitoring numbers of patients absconding and this was reported on the trust performance dashboard. In addition at the Gordon Hospital additional staff had been deployed to observe the entrances to the wards following a serious incident that took place just prior to the inspection.
- A few examples of blanket restrictions were identified in the rehabilitation mental health wards. This included set levels of observation for everyone in one service, restricting access to making hot drinks and one service where the front door could only be unlocked from within the staff office. These needed review to ensure the least restrictive measures were in place that reflected peoples individual needs.

Safe equipment

- Medical devices across the trust were mostly regularly maintained and checked regularly to ensure they were fit for purpose. They were also appropriately located to ensure they could be accessed when needed. The exception to this was at the Pembroke Centre in Hillingdon where the equipment needed a maintenance check. Also on Redwood ward at St Charles the medication used for emergency resuscitation had been separated into two storage places which could make it hard to locate in an emergency.

Medication management

- There were safe and effective arrangements in place for medicines. The trust was actively and continuously seeking ways to improve medicines management, medicines optimisation and patient safety related to medicines.
- Medicines governance arrangements were good. The trust held regular medicines management meetings and safe medication practice group meetings. We looked at the minutes of these meetings and saw that action was taken promptly when any issues were identified. Medicines errors and incidents were reported quarterly. There was a good culture of reporting of medicines incidents to encourage learning, and we saw that there were local learning events following on from any medicines incidents. We saw that there had been only 5 service user incidents related to medicines in 2014, none of which had resulted in serious harm.
- The trust carried out a wide range of medicines related audits to assess how they were performing, and to identify areas for improvement, such as audits of controlled drugs, missed doses, medicines reconciliation, safe and secure handling of medicines, medicines dispensing times, antibiotic prescribing and rapid tranquilisation. The audits for 2014 demonstrated that the trust was performing well. Where improvements were needed, we saw that action was taken promptly. For example, although medicines were stored securely in all of the areas we inspected, the trust's own safe and secure handling of medicines audit 2014, carried out in 226 areas where medicines were handled, had identified that some improvements were needed, such as disposal of pharmaceutical waste and medicines refrigerator monitoring. The trust already had an action plan in place to address this.
- The trusts medicines reconciliation audit 2014 showed that 98% of patients admitted to the trust had a medicines reconciliation completed during their stay, 86% within 24 hours of admission. The purpose of a medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission and therefore minimising medication errors. The trust's audit showed

that further work was needed to meet the standards set in the trusts medicines reconciliation procedure, such as the number of sources used to identify prescribed medicines and completing of the medicines reconciliation within the agreed timeframe. The trust already had an action plan in place to address this.

- Arrangements for the supply of medicines were good. There was one trust pharmacy department at St Charles Hospital, which supplied medicines to six of the trust sites. There were service level agreements in place with other NHS trusts for the supply of medicines to the other trust sites. There were also arrangements in place for medicines supplies and advice out of hours. Patients and staff in all of the locations we inspected told us that they did not experience any delays in receiving their medicines, both on the wards and on discharge from the trust. Therefore there was good access to medicines and medicines advice.
- Dispensing time audits from 2014 showed that 88% of all out patient prescriptions were dispensed within 60 minutes. The trust's dispensing turnaround times for medicines for discharge showed that 18.8 % took longer than 4 hours to dispense and check, however the chief pharmacist told us that more accurate data is going to be collected for the next audit, as medicines for discharge were ordered in advance, so the long turnaround time did not necessarily mean that this had caused any delays in discharging people from the trust.
- The trust took part in the Prescribing Observatory for Mental Health (POMH-UK), a national audit-based quality improvement programme to improve prescribing practice in mental health. We saw from these audits that some areas for improvement had been identified, such as medicines reviews for people prescribed anti-psychotic medicines, prescribing thiamine for people undergoing alcohol detoxification in substance misuse services and improvements needed to the monitoring for people prescribed lithium therapy. The trust was already taking action to make these improvements.
- When we checked a sample of prescription charts in each of the areas of the trust we inspected, we saw that these were completed fully, providing evidence that people were receiving their medicines safely and as prescribed. When people were detained under the Mental Heath Act, the appropriate legal authorities were in place for medicines to be administered. There was evidence in all of the areas we inspected, apart from at Milton Keynes, of good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. The issues with medicines management at Milton Keynes had already been identified by the trust prior to our inspection. The chief pharmacist told us that there was a lack of senior pharmacy leadership on this site, which had an impact on how medicines were managed; however there was already agreement to recruit a pharmacist in 2015 to oversee medicines management at Milton Keynes.
- We did find on Redwood ward at St Charles that patient safety was compromised with medication being left unattended within the reach of patients.

Good

Are services effective?

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

Summary of findings

We rated effective as **good** for the following reasons:

Most patients had a comprehensive assessment in place including where needed a physical health assessment. Whilst there was still further work to do, the quality of care planning had improved and the trust was monitoring and improving on the numbers of people being given a copy of their care plan.

The trust had a wide range of measures in place agreed with commissioners, stakeholders, other professional bodies and set internally to monitor and improve the outcomes of people who use their services.

The training provided by the trust was varied and welcomed by staff who felt they had opportunities to develop their knowledge and skills. In addition to an induction and mandatory training staff also attended a wide range of other training both internal and external to the trust. Staff felt well supported through supervisions and appraisals.

There were many positive examples of multi-disciplinary and multi-agency working.

The trust was making good progress in the training of staff and appropriate use of the Mental Capacity Act.

There were however a few areas for improvement as follows:

- In community based mental health services the provider must ensure that patients using community services are referred for regular physical health checks.
- In wards for older people with mental health problems the provider must ensure on Redwood ward that patients physical health checks take place regularly to ensure their health is monitored.

Our findings

Assessment and delivery of care and treatment

- The trust used several electronic patient record systems across its various locations. Most of the areas we visited completed comprehensive assessments of the people they were supporting. The assessments varied dependent on the needs of the individuals. For example older people admitted to inpatient services would be assessed for the risk of falls and tissue viability.
- The trust had set a target that all patients would have a recorded medical physical health assessment after admission. In the last quarter this was achieved for 97% of patients. The trust also had a target of all mental health inpatients having a nursing physical assessment after admission. In the last quarter this was achieved for 94% of patients (just below the target of 95%). The inspectors found that these assessments had been completed.
- The National Audit of Schizophrenia found in 2014 that the trust was well below what should be provided in terms of monitoring physical health for patients with this diagnosis. We looked at whether patients were having their physical health monitored and appropriate support with physical health care conditions. The arrangements for this varied throughout the trust. However in most areas this was taking place. On Redwood ward at St Charles, a ward for older people not everyone was having regular physical health checks despite having complex physical health care needs. In the community based mental health services we found that in Hillingdon and Harrow there were patients who had been identified as needing an annual physical health check that had not been referred to the GP.
- The trust acknowledged that the quality of care planning is variable across the trust. This is not aided by the different patient record systems. We found that there was a lot of work taking place to improve care planning and in many of the areas we visited the quality of care planning had improved and they were more personalized. In some teams the care planning was very good such as in the community mental health services

for children and young people. In the specialist dental services the clinical records were well constructed and including treatment plans that showed that different options had been considered.

- The trust knows there is more work to do to ensure patients are offered a copy of their care plan. For community patients the trust had a target of 80% having been offered or received a copy of their care plan. At the end of the last quarter 74% of patients said they had been offered or received a copy of their care plan. We found that patients being offered a care plan varied between services. In the community health services for adults, most people had a copy of their care plan in their home. In the community based mental health services a significant number of patients would just have a copy of a letter from a lead professional clinician to their GP which said that the letter constituted a care plan. These were sometimes written in technical language that the patient would find hard to understand. In the learning disability services most patients had a care plan but more thought was needed to ensure these were accessible and meaningful to the individual.

Outcomes for people using services

- The trust has a wide range of measures in place agreed with commissioners, other stakeholders such as Monitor and in partnerships with social care with the aim of improving the outcomes of people who use their services.
- The Commissioning for Quality and Innovation (CQUIN) framework for 2014/15 has incentivised the trust to deliver improvement. We heard about some of the areas they are working on such as expanding the use of the friends and family test, further reductions in the prevalence of pressure ulcers and developing shared patient records.
- The trust ensured it maintained the care it provided and the associated procedures in line with the latest NICE guidance. A trust wide group oversees this process and shared the work with divisional teams.
- The trust in 2013-14 had participated in all of the national clinical audits that it was eligible to participate in. Those relating to its mental health services included the National Audit of Schizophrenia and the Prescribing Observatory for Mental Health (POHM-UK). They had also participated in national clinical audits relating to its community services including the Sentinel Stroke National Audit Programme, National Audit of Intermediate Care, the Falls and Fragility Fractures Audit Programme, the National Parkinsons Audit and the Epilepsy 12 Audit (in Milton Keynes).The actions that were taking place from these audits were reported in the trusts annual Quality Account.
- In October 2014 the trust identified that there were 106 internal and local clinical audit projects taking place. These had been agreed by the trust or division or service as a priority as part of their quality improvement processes. Examples of trust wide internal audits included infection control hand hygiene audits and a safeguarding adults audit. Local clinical audits covered a wide range of areas including assessments, risk assessments, discharge information, capacity assessments. Some were very specific to the service such as the use of sub-dermal implants in sexual health services or the management of children with asthma in school for the school nursing service in Hillingdon. These audits led to change for example the audit on the management of children with asthma in school had led to more training for teachers and other school staff.
- In terms of measuring outcomes for individuals the trust was using the Health of the Nation Outcome Scales to measure the health and social functioning of people with a severe mental illness and over time the patient outcomes. Services also used a range of other outcome measures to see how patients were progressing. Some specific examples of this were found at the Collingwood child and family centre where the progress of the young people was carefully monitored. In the end of life care services the outcome of care approaches was monitored to see if they supported patients to die in their own homes rather than in hospital. In community health services for children, young people and families the progress of children who were participating in programmes to reduce obesity was monitored.

Staff skill

- The trust provided a corporate induction for all staff. All staff had to attend within one month of starting their employment. We heard that this training was very helpful and also enabled staff to meet colleagues who will work across the trust.
- In addition staff received a local induction that supported them to understand their specific role in the services. For example the learning disability service provided a five day training course providing staff with specific skills.

Good

Are services effective?

- The trust had core mandatory training requirements with attendance defined for qualified and unqualified staff working in different parts of the trust. This included fire safety, moving and handling, health and safety, infection control, safeguarding adults and children, conflict resolution, equality and diversity, information governance and resuscitation & anaphylaxis. At the time of the inspection 86% of staff had completed the mandatory training, although the trust was struggling to ensure this data was collected accurately.
- In addition there were other statutory and essential to role training courses. For example staff working in services for older people received training on falls and pressure ulcers. School nurses and district nurses received training on vaccinations. Some training was specifically provided for managers such as investigations & root cause analysis.
- Staff talked positively about the training opportunities they received. For example the trust is piloting the Care Certificate for healthcare assistants. Starting this year they were going to put all HCAs though the course. Staff also talked about accessing training through the recovery college.
- The trust worked in partnership with a number of higher education institutions and local education training boards. It provided apprenticeships, undergraduate and post-graduate vocational training programmes especially in mental and sexual health, medicine and nursing. They had the quality of some of this work closely monitored by Health Education England. An example of this work was in post-graduate medical education where the trust had developed a programme which had won awards in faculty development and leadership.
- The trust expected all staff to have completed an annual appraisal and at the time of the inspection 85% had this in place and the target in the trust was 95%. This was close to the national average of 86% and had been identified as an area for improvement in the staff survey 2014. The trust said that they were moving their focus from staff completing an appraisal to ensuring this was completed well.
- The trust had an expectation that staff will have access to monthly clinical and managerial supervisions. Most staff we talked to said they were receiving clinical and managerial supervision although the frequency was variable between services. Staff at the Windsor unit in Milton Keynes said their supervision was not happening regularly as there was interim management arrangements in place while a permanent manager was recruited.
- The trust expected staff to have access to regular team meetings and we found that these were usually taking place and in some cases there were also meetings providing opportunities for reflective practice which was well received.
- We found examples of where managers were working to address staff performance issues. Staff said this can sometimes take far too long and the trust acknowledged that the process needed to be streamlined and this work was underway.
- The trust aimed to celebrate the success of staff who lived the trust's values. They had an 'employee of the month' award and an 'annual gem ceremony ' to celebrate exceptional staff contributions.

Multi-disciplinary working and inter-agency work

- Staff spoke favourably about internal multi-disciplinary work. We observed 87 multi-disciplinary meetings and staff handovers. This reflected some good practice and we saw staff working well together in a respectful manner making the most of each others skills and experience.
- We also saw many examples of how different teams in the trust worked together to support patients as they moved between services. This was particularly evident for patients who were moving from inpatient services to receiving support from community teams. We heard about how information was shared and staff from community teams attended meetings on the ward.
- We heard from stakeholders that the trust faced on-going challenges in working with GPs and sending them timely information.
- We found some examples of good inter-agency work and also some challenges. We heard from a number of local authorities about the successful integrated partnerships working across health and social care through section 75 agreements. For example in Harrow and Westminster there were pooled budget arrangements in place. We heard about a number of successful initiatives such as the work with the police and the establishment of the street triage team in Milton Keynes which has seen a reduction in the number of people being taken to a police cell as a place of safety. Another initiative was the trust's work with the homeless

project with housing colleagues in the Royal Borough of Kensington and Chelsea where trust staff were supporting people with their mental health so that housing colleagues could have greater success with addressing their housing needs. We were told by local authorities that they welcomed the change in the trust's structure with its local borough focus and felt that this would make communication with the trust work better. They also valued the trust having a head of social work and a partnerships development manager who work closely with the borough lead social workers through the local partnership boards.

- NHS England commented that the trust actively contributed to both national and regional clinical advisory structures in areas such as HIV, eating disorders and CAMHS. The Trust also contributed to London wide groups for mental health services such as the perinatal network, CAMHS group and eating disorders groups. These groups have reviewed pathways in London services, contributed to quality incentive schemes and implemented national processes as required.

Information and Records Systems

- Staff told the inspection team repeatedly about the difficulties of working with the different patient record systems found throughout the trust.
- This has been acknowledged by the trust and there is an information technology strategy in place. An external IT firm had been appointed to build and deliver a new IT infrastructure. This will include opportunities for mobile technology so staff that can access information when working in the community and patients have access to their information and opportunities to be more involved in planning their care for example through the use of social media. It is hoped this work will improve the trust information and record systems.

Consent to care and treatment

- The trust provided a statuatory mental health law training course for all staff working in clinical settings. This includes training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. In some areas CNWL staff can access local multi-agency training such as in Milton Keynes.
- The trust had an up to date policy on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- We found variations in the use of the MCA in terms of the completion of MCA assessments and recording this appropriately and the use of best interest meetings. The long stay rehabilitation mental health wards for working age adults showed good practice in terms of the Mental Capacity Act. Where there are some individual areas for improvement these are identified in the core service reports including the forensic inpatient wards and learning disability wards.
- There is a trust wide MCA lead and also leads in different services to support staff as needed.
- Between the 1 May 2014 and the 31 October 2014 there had been 102 DoLS applications. Some were still waiting to be assessed and several had not been authorized. In the wards for older people with mental health problems we found some DoLs where the authorisations had expired and new applications needed to be made. This reflected the ongoing learning process that trusts are experiencing about this process.
- Adherance to the MCA is monitored through the Mental Health Law group which provided a governance process. This looked at the results of audits and considered new methodology.

Assessment and treatment in line with Mental Health Act

- The trust's systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. Administrative support and legal advice was available from the Mental Health Act lead in a centralised team within the trust, as well as Mental Health Act law managers and Mental Health Act administrators based at each hospital site.
- The staff carried out regular audits to ensure the Mental Health Act was being implemented correctly and produce a quarterly Mental Health Act Performance Report. A bi-monthly Mental Health Law group met to review Mental Health Act performance and trends and provided a governance structure.
- Training was provided to staff centrally and within local teams. Role specific training was given where required. Overall staff appeared to have a good understanding of the Mental Health Act and code of practice.
- For the most part detention paperwork was filled in correctly, was up to date and was stored appropriately.

Good

Are services effective?

- There was a good adherence to consent to treatment and capacity requirements and copies of consent to treatment forms were attached to medication charts where applicable.
- People had their rights explained to them on admission to hospital. Where people did not understand their rights, the Trust had a policy that a discussion of rights would be repeated daily for the first 14 days following detention and weekly thereafter. We found however that discussions of rights were not always regularly repeated following unsuccessful attempts.
- Within all of the wards visited apart from the learning disability services we found that people had access to independent mental health advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.
- Where there are some individual areas for improvement these are identified in the core service reports.

Outstanding ☆

Are services caring?

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

Summary of findings

We rated caring as **outstanding** for the following reasons:

The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff. In many services we saw great attention being given to providing care that was meeting the individual needs of each patient. This was particularly notable in the community dental and sexual health services where staff were going the extra mile. The trust was aware of a few areas where the attitude of staff had distressed some patients and was taking steps to address this constructively.

The trust undertook regular surveys to obtain feedback from people who used the services to promote the improvement of the care provided. We found many examples of carers being actively involved but the trust has also recognised that there is further work needed in some areas. The trust was working well with advocacy services.

There were however a few areas for improvement as follows in services for older people with mental health problems:

- On Redwood ward at St Charles we saw that a number of the female patients attend the mealtime in their nightwear with no dressing gown and this did not preserve their dignity.
- Patients were not always involved in their care planning nor did they have a copy of their care plans where appropriate.
- On several wards patients did not have access to a lockable space in their rooms and were not able to lock their own bedroom doors.
- People could not close their observation panel from inside their room to have privacy.

Our findings

Dignity, respect and compassion

- The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff.
- We observed many examples of positive interactions between staff and patients throughout the inspection visit. For example when we inspected the Brent home treatment team we found the consultant and was making links with the GP's of the patients so that he could meet with the GP and patient to discuss any matters about the patients care and discharge arrangements. In the community sexual health services patients told us about how staff really paid attention to the details of their care and recognised their emotional needs. In the specialist dental services we saw staff taking the time to fully explain the treatment and providing the reassurance and empathy during complex treatments. In the end of life services we heard about the support that was provided to the whole family.
- There were a few places where there were a cluster of negative comments about the attitude of staff from people who have used the services. This was particularly noted for the Gordon Hospital and St Charles. It was also noted that an analysis of complaints completed by the trust had also highlighted staff attitude as a recurring theme. We could see that this was being addressed in a variety of ways including through supervision and the use of training to promote positive behaviours. Where needed the trust was also investigating individual concerns.
- We did also find on some of the wards for older people with mental health problems that further steps could be taken to promote people's dignity and privacy. For example on Redwood ward at St Charles female patients were attending mealtimes wearing a nightdress but no dressing gown. In wards for older people with mental health problems we found that some observation panels in bedroom doors could not be closed on the inside by the patient.

Outstanding ☆

Are services caring?

- The trust carried out a number of internal surveys to measure patient satisfaction in the care they were receiving. In quarter three ending December 2014 these surveys showed that 98% (of 2618) reported they were treated with dignity and respect, 91% (out of 104) felt safe during their most recent mental health inpatient stay and 91% (out of 623) thought their care co-ordinator had organised the care that they needed well.

Involvement of people using services

- We found that in most wards there were regular community meetings taking place which enabled patients to have some involvement in the services they were receiving.
- There were eight different advocacy services operating across the geographical areas covered by the trust. People who used the services told us that had information available about the advocacy services and could access these as needed.
- The trust did a survey in quarter 3 ending in December 2014 which received feedback from 2601 patients. The results were that 81% of people using services reported that they were 'definitely' involved as much as they wanted to be in their care and treatment. We did find though, when looking at patient records that there was mixed recording to show that patients, carers or an advocate acting on their behalf had definitely participated in discussions about their care and treatment. This was evident in wards for older people with mental health problems.
- We also heard about local surveys that took place within some services. For example in the community sexual health services quick feedback cards had been devised with tear off tabs and were placed in clinical waiting areas. In some clinics up to 94% of the patients completed the surveys and the cards were read daily to ensure urgent matters were addressed in a timely manner.
- The trust had a target that for mental health patients who have a carer identified that their details are in the person's notes. The target was for this to be in place for 70% of patients and at the end of the last quarter 76% of patients' had this information in place.
- From feedback from carers and from an analysis of the complaints there was still a recurring theme of some carers not feeling involved, not being invited to meetings or being listened to. The trust had recognised the need for further work on this and had an improving involving project. This included a commitment to carers to provide them with better information on who to contact in a crisis, how to complain, medication, recovery college courses amongst others. This is an area for on-going work as not involving carers who know the people receiving a service can lead to risks of that person not having their needs met.
- Most of the inpatient areas we visited had arrangements in place to introduce patients arriving on the ward in a thoughtful manner that enabled them to be shown around. We saw different examples of information being given to patients and their relatives and carers to introduce them to the service.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as **requires improvement** for the following reasons.

In the acute wards for adults of working age and the PICU we found that:

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

In the mental health crisis services and health based places of safety we found that:

- People who were in a place of safety and were assessed as requiring inpatient beds experienced long delays before being admitted. The delays in accessing inpatient beds meant that some people received care that did not meet their needs.
- The places of safety at the Gordon hospital and Park Royal had no separate access.This meant that people had their privacy compromised as they arrived at the places of safety.
- In the North Kensington home treatment team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

On the wards for older people with mental health problems we found that:

- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. Some of these patients were not clinically appropriate for the ward environment.
- Most wards admitted patients into the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

On the long stay rehabilitation mental health wards we found that:

- In some areas information on how to complain was not clearly displayed and sometimes verbal complaints were not addressed using the complaints process where the patient would have liked to access this procedure.

Whilst for patients needing an acute mental health service the service was not responsive at the time of the inspection, we did find that in other services patient access and discharge arrangements were working well and in line with local targets. We did however note that there were a number of services with long waiting lists in the London Borough of Hillingdon. The services were very aware of the need to offer appointments that met the needs of the patients and the importance of being reliable and punctual.

Most of the care was delivered in facilties that promoted recovery, comfort, dignity and confidentiality. Where this has not been achieved this will need to be addressed.

The trust served a very diverse population across each of the areas it covered. The trust demonstrated a real commitment in terms of meeting people's equality, diversity and human rights.

Requires improvement

Are services responsive to people's needs?

In some areas information on how to complain was not available. We also heard from patients who said they would have preferred their verbal complaint to be addressed in a more formal manner. The trust is introducing a centralised patient support service which will aim to make it easier for patients to provide feedback and raise concerns. It also aims to improve how they acknowledge and respond to concerns received about their services.

Our findings

Right care at the right time

The trust worked closely with commissioners, local authorities, people who use services, GPs and other local providers to understand the needs of the people it serves and to plan and design services to meet their needs. This meant that across the trust there were a number of different service configurations in place across the mental health and community services.

Mental health acute care pathway:

- The most significant area of concern from the inspection related to acute care pathway for mental health services. In the six months between the 1 April 2014 and 1 September 2014 the average mean bed occupancy for the acute beds on each site was as follows: St Charles 108%, the Gordon Hospital 103%, Park Royal 113%, Northwich Park 106% and the Riverside Centre in Hillingdon 108%. In December 2014 the trust closed one further acute mental health ward, Mulberry South ward at the South Kensington and Chelsea Mental Health Centre. The trust said they had delayed this closure for several months in response to bed pressures.
- The trust told us that due to these exceptional pressures they were now placing a few patients in the independent sector and buying beds from another trust. This arrangement had started shortly prior to the inspection. The trust also had a very committed bed management team who worked hard to manage the whole process of ensuring people who needed admission had a bed.
- All the acute wards for working age adults we visited were full and the majority of patients on the wards were detained under the Mental Health Act 1983. With the exception of one ward, the wards were operating with over-occupancy. On Thames ward there were 21 patients allocated to the 17 beds. Crane ward had 27 patients (four patients on leave) allocated to 18 beds, plus one extra patient accommodated in a quiet lounge. Frays ward had 23 patients allocated to 18 beds. An extra bedroom had been created on Amazon, Ganges and Crane wards, by converting a quiet lounge into a bedroom. In some cases these were a long way from toilet/ bathroom facilities, which patients had to ask to use, due to these being kept locked.
- As a result of the over-occupancy of wards, beds were not always available for patients on their return from leave. For the first two months of 2015 there were 68 occasions across the acute and PICU wards when a bed was not available to patients in need of these, or there were delays to a patient receiving a bed. The highest number of these occurred on Thames ward, where there were 18 occasions, and on Danube ward there were 10 occasions when a bed was not available.
- Overall, between November 2014 and January 2015 there were a total of 57 occasions where patients did not have a bed to sleep in and slept on the sofa or in the quiet room on a temporary bed. Some incident reports showed that a patient was kept in the 'Place of Safety' (136 suite) for two nights. One person had also spent 32 hours in the assessment area at St Charles MHC when no bed was available on Danube ward.
- There were frequent moves between wards for some people for non-clinical reasons. Between November 2014 and January 2015 there were 85 occasions across the acute wards where patients slept on a ward other that the one they were admitted onto. The highest number of these occurred at St Charles MHC where during this period there were 38 occasions when patients slept on another ward. Other data submitted by the trust showed that for the month of February 2015, there were 167 occasions when patients slept out on another ward.
- Some patients were transferred during the night and went to wards where they did not know, or were not known by, the multidisciplinary team. We were informed they were always escorted by a qualified nurse. Patients told us that sometimes they were moved very late at night, for example at around midnight, and had to return to the ward by 6:30am the following morning.

This was confirmed to us by staff, although they said they attempted to move patients after they had received their evening medicines, between 9:00pm and 10:00pm. Patients told us that when they refused to move they were accommodated on sofas on the wards.

- The wards that patients transferred to was a substance misuse ward, older people's ward or rehabilitation facility. However, a patient from Frays ward slept overnight in a psychiatric intensive care unit (PICU) despite there being no clinical need requiring this. This meant there would not always be a bed available in the PICU when a person required more intensive care. The moving of patients between wards impacted on the continuity of care they received and patients reported this as being disruptive to their care and well-being.
- On Danube ward a patient had spent eight consecutive nights on a different ward, followed by a further thirteen on another ward. The patient had spent the majority of their admission sleeping on a different ward from that to which they were admitted. Another patient had spent ten consecutive nights on a different ward, whilst another had spent five consecutive nights away from the ward. On Thames ward a patient admitted on 31 January 2015 had spent every night of their admission on another ward, which was 24 consecutive nights.
- Linked to the pressures on the acute care pathway we found that some people were kept in the places of safety for a long time. From December 2014 till the end of January 2015 the places of safety were used 157 times. Of these, the length of stay was 6-10 hours in 31 cases and over 10 hours in 18 cases. Most of these (26) occurred at the Westminster place of safety. Staff told us that due to pressure in finding a bed within an inpatient ward, some people had to wait a long time prior to admission. We looked at the incident reports relating to the places of safety for January 2015. These showed that people were often having to wait a long time before being admitted. For example, one person had to wait 18 hours before getting a bed, another spent two nights waiting for a bed and a third left the unit to sleep on an older people's ward at 23:10 before returning early in the morning. The delays in accessing inpatient beds meant that some people received care for extended periods of time in an environment that did not meet their needs.
- In Milton Keynes the trust had developed a pilot street triage service to try and reduce the usage of section 136

In this scheme, which had been in operation since beginning of January, a nurse was based with the police for four nights a week, Thursday to Sunday. Initial results have shown a reduction in admissions to the health based place of safety. For the first three weeks of January there were 20 contacts, only one of these lead to usage of the place of safety.

- The psychiatric liaison teams worked 24 hours a day in accident and emergency departments. In Harrow the team provide staff for a 'transit' lounge. This room had armchairs and tea making facilities. It was designed to provide a quieter area for people to be assessed and supported in rather than the A&E. Staff we spoke with told us they found this facility useful as it enabled them to support people in a comfortable environment with more confidentiality. The trust opened a second 'transit' lounge in Hillingdon during the week of the inspection.
- At the time of the inspection the trust was trying to mitigate the pressures for patients needing to access acute services. We saw very active bed managers across all the sites trying to support discharge arrangements and access beds within the trust. The trust had also just agreed arrangements to place some patients in services provided by another London NHS Trust and some beds in the independent sector.

Other mental health inpatient services:

- Some patients were experiencing a delay in their discharge. For example in the long stay rehabilitation mental health wards there were patients waiting for discharge. Despite the support of bed managers and the pro-active work of staff the delays were usually caused by the difficulties of finding alternative suitable placements to meet peoples needs. This was also the case for some patients using the learning disability services.

Community mental health services:

- The home treatment teams had a target that all urgent referrals were assessed within an hour. This was generally achieved. Most of the teams were not 24 hour. During the hours the teams worked they would receive referrals directly. Out of hours, people would be referred to the psychiatric liaison teams. The home treatment

teams were responsible for 'gatekeeping' all admissions to inpatient beds. Most teams were achieving, or close to achieving, 100% for this indictor that all referrals that may need admission to hospital were seen by the team.

- The trust had an urgent advice line that is available out of hours. This provided advice, support and signposting to other services. Some people raised concerns with us that this was called a crisis line, as the team could only signpost and support, rather than provide full crisis team support.
- For the assessment and brief treatment teams and the assessment and short term intervention team in Milton Keynes people were usually seen and assessed within locally agreed target times.
- For the community recovery teams whilst most referrals were accepted the Brent and Hillingdon teams had waiting lists for patients who needed a care co-ordinator.
- We did hear about the challenges of discharging some patients due to a lack of shared care arrangements with GPs about the administration of antipsychotic medication.
- For the substance misuse teams there were no waiting lists operating in any service and patients referred to the services would be assessed and receive treatment within 3 weeks. In Hillingdon we did hear that due to high demand they were thinking that they may need to introduce a waiting list. The Ealing and North Westminster services offered a 'one stop shop' where patients could access support with social issues which was really valued by the patients.
- The community mental health teams for older people had a 10 days working target from referral to assessment, for non-urgent cases. This target was being met except in Hillingdon where the waiting time was 15-20 working days.
- The memory clinics had a target waiting time of 30 days from referral to assessment. In Hillingdon this target was being missed and people were waiting 90 days. A temporary doctor had been employed to help with the backlog of referrals.
- The learning disability teams did have a waiting list for speech and language therapy whilst posts were being filled. The trust had arranged input with another provider for patients with swallowing difficulties so their urgent needs could be addressed. The Harrow team did have a waiting list of 56 people for psychology input but they were being reviewed to see if they still needed a service.
- Across the CAMHS teams we were told that they tried assess young people within agreed timeframes. Emergency admissions to A&E were seen by staff on the same day, urgent referrals within 24 hours and routine referrals within four weeks. Referrals were usually screened by senior clinicians and sent on to the appropriate pathway. Waiting times for young people varied depending on the pathway they were allocated to. There were a high number of referrals in Brent and Hillingdon teams and these continued to increase. The number of referrals accepted into teams had outstripped capacity which had had an impact on waiting lists and times for treatment. In Hillingdon there had been an increase in deliberate self-harm cases presenting to A&E who were not previously known to CAMHS or previously identified by other agencies. At the time of the Hillingdon inspection there were over 100 people on the treatment waiting list and some had been waiting for 12 months or more for treatment. A clinically driven protocol was in place to manage and reduce the waiting list. This was done through a multi-disciplinary process overseen by a consultant and team manager. A clinical nurse specialist had been brought in to help reduce the waiting list and following the inspection we were informed that further funding had been awarded to the Hillingdon team by the local commissioning group for a further two, fixed term, posts to help reduce the waiting list further. However, a longer tem sustainable plan was not in place. In Brent waiting lists were discussed in team meetings. Risk was monitored and urgent cases were prioritised. For instance if people self-harmed or exhibited psychotic behaviours. The biggest waiting lists were for people with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD).

Community health services:

- Sexual health services operated a direct referral system across all clinics with appointments normally available within 48 hours. Drop in sessions were also available. Clinic hours had extended to make them more accessible for people outside office working hours.

Requires improvement

Are services responsive to people's needs?

- Community health inpatient services had clear care pathways from admission to discharge. Discharge planning started as soon as patients were admitted to the wards.
- For community dental services there was an assessment process to ensure patients met the referral criteria. In the Hillingdon services there had been a sharp increase in referrals into the service for patients who met the criteria. This had heavily impacted on the waiting times for specialist treatment such as endodontic and periodontal treatment. The average waiting times were currently 26 weeks for endodontics (longest wait 39 weeks), 15 weeks for periodontics and 19 weeks for paediatric dental care. In the meantime, Hillingdon dental services had put initiatives in place to try and reduce the waiting lists where possible. This included varying and utilising the skill mix of clinical staff to increase clinic hours and therefore numbers of patients seen.
- For community health services for children, young people and families there were different arrangements in place across different geographical areas and teams in terms of referral, transfer and discharge arrangements. At the time of the inspection some teams or specialisms were experiencing waiting lists. For example the referrals for speech and language therapy in Milton Keynes had increased and there was a 17 week waiting list for an assessment. The Mosaic Centre in Camden single point of referral system experienced a backlog of referrals at the end of 2014. This was mainly due to the increase in referrals and the lack of sufficient staff to carry out the assessment. This was addressed once the backlog was found and a new process was now in place to manage the number of referrals. At Hillingdon there were good processes for the handling of referrals through a single point of access and multi-disciplinary triage. For example a child being referred to the Woodlands centre would be assessed and if they were identified as having a social communications disorder the child would be passed on to the rapid autistic spectrum disorder assessment team. In Hillingdon the service had set up a local parents forum called 'transition' which was a meeting for older children with complex needs and their parents to discuss how they would be transferred as their child got older.
- The community end of life services could be accessed through self-referral and from professionals. New referrals were allocated on a daily basis. Urgent referrals were followed up in 24 hours and non-urgent referrals in 48 hours. These targets were being met. Patients also had access to advice out of hours although the detailed provision depended on local arrangements.
- The community health services for adults had different arrangements in each borough. For example in Milton Keynes there was a rapid assessment and intervention team who triaged referrals to ensure the service provision was prioritised. In Camden referrals including self-referrals went to a central access point where they were triaged and the allocated to the appropriate team.

Accessibility of appointments:

- Generally we found that services were aware of the need to follow up patients who missed appointments especially where they might find it difficult to engage.
- Most services tried to offer flexible appointments and were aware of the need not to cancel urgent appointments and to be on time for appointments.

The facilties promote recovery, comfort, dignity and confidentiality

- Most of the services where care was provided were clean, well decorated and comfortable. Most inpatient services had access to quiet lounges, rooms for therapeutic activities and outside space.
- Some services, where people were staying for a longer period of time encouraged people to bring with some personal possessions and personalise their rooms. An example of this was at the Butterworth centre which was a service for older people with mental health problems.
- On the acute mental health wards we found that patients could not always make phone calls in private, some quiet lounges were being used as bedrooms. At the Gordon Hospital there was a lack of outside space and at the Campbell Centre at Milton Keynes bathroom doors off shared bedrooms had been replaced by curtains due to ligature concerns which compromised the privacy of patients.

Requires improvement

Are services responsive to people's needs?

- On some acute wards and wards for older people with mental health problems we heard that patients were not able to lock their rooms and store possessions without them being put in a ward safe. This meant that items had gone missing which caused distress.
- The feedback about meals in inpatient services was mixed. At the Riverside centre in Hillingdon patients were positive about food but at St Charles people were less positive which corresponded with recent findings from surveys. Most services used a system of chilled meals being heated up although others cooked meals on the site. Access to snacks and drinks was generally good although patients being able to make their own drinks varied without there always being a clear reason.
- Access to therapeutic activities were generally very good for people using inpatient services. In the community people spoke positively about the courses available at the recovery college. In some services we did hear there were not enough activities in the evening and in the learning disability services we found that the activities that took place were sometimes less than the ones on their individual activity plan.
- In the Hillingdon community recovery team (Mead House) some areas that patients used were neglected with paint flaking off walls and chairs that appeared dirty as they were worn.
- At the North Kensington home treatment team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.
- The places of safety at the Gordon hospital and Park Royal had no separate access. Park Royal had its place of safety unit on the first floor and the toilet was reached by going through the nurses' office. The Gordon hospital place of safety was accessed through the front door for the hospital. This meant that people had their privacy compromised as they arrived at the places of safety. The trust had plans to redevelop both of these places of safety.The other places of safety had their own entrances and privacy could be maintained within the suites.
- The building where Westminster CAMHS was based was not considered fit for purpose. Options were being considered in the trust for a new base. Similarly the building where Brent CAMHS was based was considered not fit for purpose. The estates team within the trust had been tasked with finding appropriate premises.
- The clinic environment for sexual health services were very pleasant and these had been designed with input from patients and staff working with the architects.

Meeting the needs of all people who use the services

- The trust served a very diverse population across each of the areas it covered. The trust demonstrated a real commitment in terms of meeting people's equality, diversity and human rights.
- The trust was part of the Stonewall Diversity Champions programme. For the past two years the trust had made it into the Stonewall top 100 employers at numbers 23 and 70. In 2014 they came top of the Stonewall healthcare equality index receiving particular praise for training on LGBT equality and the Mortimer Street outreach services within the sexual health services.
- The trust had five equality objectives 2012-16 which included: increasing diversity awareness raising opportunities available to staff, developing community engagement events with minority communities relevant to each service, improving recording rates for sexual orientation, disability staus and religion of patients on the patient administration systems, reducing the proportion of staff members reporting discrimination and harassment from patients, carers and the public and improving the proportion of staff who thinks the organisation acts fairly with regard to career progression regardless of ethnic background, religion, sexual orientation or age.
- Equality and diversity training was mandatory and 81% of staff were up to date with this training.
- The trust's excellent Equality Act compliance report 2014 gave examples of some of the work done by the trust. This included a strengthened equality and diversity leads network, an extended faith visitor programme, a trust faith and spirituality conference, an in house interpreting service providing over 9500 face to face interpreting sessions in the past year, a quarterly newsletter 'inclusion news', community development workers, expanded numbers of peer recovery trainers in

the recovery college and peer support workers in clinical settings. We saw many examples of this work in our visits to services where people were being provided with support that reflected their individual needs.

- There were several networks for staff including BME network. These were led by staff. The BME network looked at policies and was working with managers on diversity issues. There was a leadership programme for BME staff and a women in management course.
- The trust was using values to drive culture and encourage constructive challenge of poor behaviours eg not speaking in a foreign language in front of other staff and patients.
- The trust was aware of areas where staff do not reflect the diversity of the client group and there had been some targeted recruitment to try to address this.
- The focus this year was on staff with disabilities. This has not been given the same level of focus as other minority groups.

Learning from concerns and complaints

- Information on how to complain was provided in most inpatient wards and in community services. In the rehabilitation services at Horton and in the psychiatric intensive care units the information was not available. Staff tried to resolve concerns at the time they were raised and these were recorded in patients notes. Several patients told us that they would have preferred their concerns to be dealt with more formally as they did not feel they had been thoroughly addressed.
- Some information had been developed in individual services to gain feedback and support people using services to raise concerns. For example, an easy read and pictorial complaints leaflet was available for patients and relatives at the Kingswood Centre. Sexual health service staff had all been trained to ask for feedback about the service and had developed tear offer comments cards for people using the service to record complaints and feedback. The trust website also had information on how to make a complaint but senior managers acknowledged this was not easy to follow. It was hoped that a new system for managing concerns and complaints, that was being introduced, would address this and make it easier for people to make a complaint.
- Approximately 72% of complaints received by the trust between October and December 2014 related to a mental health service. Complainants were offered an opportunity to meet with staff and discuss and resolve their complaints locally. They could bring an advocate or relative or friend with them to the meeting for support.
- The trust responded to most complaints promptly. However, they were not meeting their own target of responding to 95% of complaints within 25 days. The trust had responded to 84% of complaints within the specified time in the third quarter of 2014-15 and to 79% of complaints in the first half of quarter four. Fourteen complaints had been open for more than six months. Several of these were awaiting the conclusion of investigations or were where the complainant had changed their mind about making a complaint and the complaint had been reopened. Five responses had been delayed because investigating staff had left or changed or the reasons for delay were unclear.
- The trust looked at variations in response times between teams and services and followed up with local directors where teams were failing to reach the agreed trust target times.
- We reviewed 13 complaint files and responses provided to complainants by the trust. There were no statements from staff or investigation notes in any of the files. As a result it was difficult to see how the conclusions in the responses had been reached by the investigator.
- The final response letters were not structured consistently and were not signed by the chief executive, or in her absence, by a director.
- The quality of responses varied. For example, one final response failed to explain how the complaint could be escalated to the Parliamentary and Health Service Ombudsman. Another final response letter breached confidentiality as the letter provided employee identifiable data about actions taken against them by the trust. The responses were often very long and detailed but were difficult to understand and not always written in plain English. Most letters failed to identify any learning points arising from the complaint However, one response letter from the psychotherapy service told the complainant there has been a change in the operational policy of the service as a result of their complaint.

Requires improvement

Are services responsive to people's needs?

- The quality of complaint responses was not routinely checked by the associate director for quality or director of nursing, who had overall responsibility for complaints, before letters were sent to complainants. Specific standards had not been set in terms of the quality of responses expected. Senior managers sometimes carried out spot checks on responses to ensure they were of good quality. However, senior managers acknowledged there was a need to provide training to staff in order to set standards and improve the quality and consistency of responses.
- The trust had carried out two complainant satisfaction surveys between September 2013 and May 2014. The number of respondents to the surveys was small but complainants who took part were generally happy with the response to their complaint although several people remained dissatisfied with the process and outcome.
- Reports about complaints and issues taken up with the patient advice and liaison service (PALS) were provided to the trust board every quarter. The report to the board in January showed that specific learning from complaints had been identified. A newsletter had been developed to inform staff about learning from complaints. This was called 'Listen.Learn.Act'. The first newsletter had been sent to staff in December 2014. It highlighted themes from complaints including staff attitude, communication, risk assessment and the importance of following up patients who did not attend appointments.
- The trust did not systematically look at complaints in terms of the ethnicity or other personal characteristics of complainants in order to see whether there were more or less complaints from any particular group of people using the services. In addition the trust did not specifically look at whether complainants were reflective of the population using trust services. A senior manager told us this had been done in the past and that service commissioners had recently requested a breakdown of complainants to include an analysis of ethnicity. However, there was no overall strategy in place to ensure that all patients and people using services were well informed about the trust complaints procedure, could access the system or were confident to raise concerns.
- The trust board had agreed a new centralised patient support service which would incorporate the management of complaints about trust services. The new complaints management process was due to start on 1 April 2015 alongside the implementation of a new incident reporting system.
- This new process aimed to ensure that patients would find it easier to provide feedback about their experiences and that concerns including those raised verbally would be dealt with promptly by local services. Where concerns progressed to being formal complaints about services, the individual service would ensure it was dealt with appropriately and within agreed timescales. Under the new system divisional directors would be responsible for the quality of the complaint responses and sign off all responses for their division. Training was planned for staff including a workshop for senior managers and divisional directors. This was due to commence in May 2015.

Good

Are services well-led?

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

Summary of findings

We rated well led as **good** for the following reasons:

The trust had a clearly developed vision with values and strategic objectives. The staff knew what these were and felt part of the organisation.

The trust was led by a stable board and executive team. There was a programme of visits to services and leaders were felt to be visible and accessible. The trust were following through the recommendations from a governance review undertaken by Deloitte last year which should further develop their leadership.

The trust had undertaken work to meet the 'fit and proper persons requirement' which ensures that directors of health service bodies are fit and proper persons to carry out the role. This included undertaking a number of checks and this process needed to be completed.

The trust used a range of indicators and other measures such as surveys to monitor the performance of services. In many cases this accurately reflected when improvements needed to take place. Managers in teams and wards were using this information to varying degrees to highlight when work was needed. The trust did acknowledge that there were still too many variations in standards between services. The new divisions with a new accountability framework appears to offer an opportunity to improve information and reduce variations.

The inspection took place at a time when the trust was being asked to save nearly 20% of its income over 3 years resulting in the consolidation and redesign of a number of services. All the savings plans included senior clinical input and feedback from people who use the services. However some staff felt they could be better informed and involved in the changes.

Our findings

Vision values and strategy

- The trust had developed its own vision and values in consultation with people who use services, staff, carers and other stakeholders. These were displayed across the trust and people we spoke with were familiar with the four values of compassion, respect, empowerment and partnership.
- The trust had two plans that set out how it would provide high quality and safe care. The first was the trust's strategic plan 2014–19. This highlighted six strategic priorities. These were to put patients first, providing high quality care and best outcomes. The next was a partnership for change looking at system wide transformational change. The others were developing a workforce for the future, achieving financial stability, information technology for the future and having consolidation and growth.
- The second was the trust's operational plan 2014–16 which looked at immediate challenges. The operational plan identified five main challenges. These were to maintain quality and innovation, affordability, working with commissioners to review contacts, improve the use of technologies especially IT and managing increased demand from population increases and an aging population. There were priority programmes refreshed on an annual basis to meet these challenges which included redesigning services, addressing key staffing challenges such as recruitment, modernising information technology systems, maintaining financial control, estate management, opportunities for growth and strengthening the current portfolio of services. The operational plan also set quality priorities for 2015-16 which were to involve patients in decisions about their care, support carers and to have a competent and compassionate workforce.
- The trust appeared to clearly understand the key internal and external challenges and these recognised the financial situation. They had involved internal and external stakeholders in the development of the priorities. These programmes had executive led work

streams. An internal programme management office supported this work through helping staff to implement change programmes to respond to the challenge of achieving savings targets and where possible improving the quality of services. It also worked with senior managers to ensure the progress of projects were monitored.

Governance

- At the start of the inspection, there was a presentation from the trust to the inspection team. This highlighted a major challenge as being variations in standards, practice and environments between services. The inspection found these variations existed and meant that some patients did not always receive services of an acceptable standard.
- The trust did use a range of indicators and other measures such as surveys to monitor the performance of services. It was positive to note that these indicators did reflect areas for improvement. These included ensuring community patients had a copy of their care plan and ensuring mental health patients had a completed risk assessment and that progress was being monitored. The trust also collected information to monitor other priorities such as staff data, complaints data and incident data. The inspectors found that at a ward or team level the use of this information to monitor the service or make improvements was very variable. For example team managers used information about which staff had completed mandatory training to ensure those that needed the training had the time to attend.
- In addition to the use of information the monitoring of the performance of services was achieved through line management arrangements. The chief executive and executive directors met every week and discussed significant concerns. It was apparent from interviews that despite the size and complexity of the trust this team had a very good knowledge of the services provided by the trust, especially the chief operating officer. The executive directors and non-executive directors all talked about how they regularly visited services as a way of finding out what was happening. We heard from wards and teams about these visits and how much they were valued.
- At the time of the inspection a new divisional structure was being implemented to be operational from the 1 April 2015. Alongside this was a new accountability framework. This clearly set out corporate, divisional and service level responsibilities. This also included standardized agendas to be used at monthly meetings to ensure information was shared at all levels of the organisation. It clearly specified the information that the divisions needed to provide to the board and committees to ensure a structured sharing of information and assurance. In addition the executive board will be reviewing the progress of each division on a quarterly basis. Whilst previous divisional structures and monitoring had been in place these new arrangements should result in a more consistent and robust approach. Whilst in an organisation the size of CNWL there will always be some variations in services a measure of success will be if the variations that are having a detrimental impact on patient care are identified and addressed in a timely manner.
- The trust has clear risk management processes in place with risks discussed at different levels of the organisation. Risk registers were collated at a divisional and trust wide level. The most significant risk identified during the inspection, the care of patients needing access to an acute inpatient mental health service, was identified as a high risk on the risk registers for January 2015. The Deloitte final report published in February 2015 had identified that risk registers were in place but some needed to be updated. This had been completed by the trust. We did find in the Harrow and Hillingdon community recovery teams that the risk registers did not reflect the risks being managed by the team. The trust accountability framework going forward linked to the new divisional structures made the consideration of risk management an area of work for all levels of the organisation.
- Commissioners, local authorities and other partners were largely very positive about their working relationships with the trust. Where there were problems they often related to difficulties in addressing local issues with local managers although when the issues were escalated to executive directors they were then resolved promptly. The London clinical commissioning groups also talked about the lack of consistency in terms of the quality of care at a borough level and outcomes being often determined by individual

borough culture. The feedback was that they all felt very positive about the new divisional structure and the improvements this would bring to local knowledge, working relationships, management and decision making.

Leadership and culture

- The executive board consisted of eight executive directors who were the most senior managers responsible for the day to day running of the trust. Most of the executive directors had been with the trust for many years. The chief executive had been in this post since 2007 and prior to this was director of nursing and quality. The chief operating officer joined the trust in 1988 and was appointed to the current role in 2013. The medical director was appointed in 2003 and the executive director of nursing in 2010. The stability and organisational knowledge which came from this consistency was recognised by the inspection team. The Deloitte report recommended the trust to consider succession planning, which seemed very sensible and this had gone to the trust nominations committee for formal consideration.
- The trust also had a very stable group of non-executive directors. The chair had been a non-executive director since 2000 and became trust chair in January 2014. A board development programme was in place and regular away days took place. At the time of the inspection there was no board member with a clinical background which the inspectors felt was needed. The chair recognised the need to have someone with these skills and said that they intended to recruit a clinician later this year when two non-executive positions become available.
- The council of governors consisted of appointed governors representing organisations including local authorities and voluntary services, elected governors representing people who use the services, staff, carers and members of the public. They undertook roles such as appointing the chair and non-executive directors, consulted on service changes and represented the views of members. In addition to quarterly meetings where a range of items relating to the operation of the trust were discussed, there were also sub-groups looking at specific topics and governor breakfasts / teas with the chair where the governors set the agenda. Governors found the chair accessible and felt that the trust listened to their feedback. Individually governors played roles on committees and for example they had significantly influenced the strategic objectives. They also had over-ruled the board on the choice of a non-executive director. From speaking to governors there was clearly a variation in how individuals recognised the need to support and also challenge the board. The Deloitte report recommended a review of the size of the council of governors which was being considered, but there should also be consideration given to whether the governors can further develop their role of constructive challenge.
- The executive directors, non-executive directors and governors had a programme of visits to services and staff were able to tell us about when visits had taken place. Leaders were felt to be visible and accessible especially the chief executive and chief operating officer. Staff also said that they felt they did have opportunities within their services, divisions and trust wide to be involved in the discussions around changes and the development of their services.
- The trust recognised that there was still more work to do to create a healthy culture in the organisation that promoted the safety and well being of staff. Very positively the NHS staff survey 2014 had in the five top ranking scores (and better than the national average) the fact that staff reported good communication between senior management and staff and staff recommended the trust as a place to work or receive treatment. However their bottom five ranking scores included the percentage of staff working extra hours, the percentage of staff experiencing discrimination at work and the percentage of staff experiencing bullying, harassment or abuse from other staff.
- The inspection team did hear many examples of how people felt well led at a team or divisional level and about their positive experiences of team working. Many people described how they felt there was an open door policy and that managers were approachable, supportive and visible.
- The acute wards for working age adults were not well managed overall. There were bed managers in place and staff were working very hard to manage daily bed pressures safely. Contingency measures had not been in place to prevent the impact on patients from the high bed occupancy. Whilst the trust had taken steps just

prior to the inspection to access beds outside the trust, this response had been planned after the problems had developed and patients' safety and dignity had been compromised.

- The trust had a variety of leadership development opportunities in place. A number of staff were undertaking NHS leadership academy courses. Consultant medical staff had access to 'management fundamentals' a bespoke programme co-designed with Imperial College providing 8 training days over a 4 month period. In Camden there was a 'management essentials' training course. In Hillingdon there have been several leadership courses for band 6 and 7 staff. There was also an in-house management development programme for London staff working in the mental health services accredited with the Chartered Management Institute. In Milton Keynes there was a clinical leadership programme for bands 6/7 staff. Staff also had access to a wide range of external courses.
- The trust recognised the pressure placed on staff from working in changing services. There was a programme in place to manage staff sickness and support staff to return to work. There was also a wellbeing strategy developed by the occupational health team and this had extended the employee support scheme to incorporate physiotherapy as well as additional counselling support.
- Most staff we spoke to said they would feel able to raise any concerns with their line manager or other senior staff in the trust. Staff raised eight whistle-blowing concerns from July 2014 – January 2015. Four of these had been referred on by the Care Quality Commission. The trust had publicized the whistle-blowing process and most staff knew that this was available. The whistle-blowing policy was also in the process of being reviewed and the results were being considered at the March 2015 Audit Committee.
- As part of the inspection we looked at whether the trust was fulfilling the regulation relating to the duty of candour. This means they operate with openness, transparency and candour which means that if a patient is harmed they are informed of the fact and an appropriate remedy offered. We heard from a number of patients, staff and external stakeholders that the trust was open and transparent in sharing details of safety incidents. We also saw the trust was taking steps to ensure incidents, complaints and other concerns were fully investigated. Most people felt satisfied with how this is happening, but a few remained unhappy with how their individual concerns had been addressed. The Care Quality Commission will continue to look at the duty of candour as part of future inspections.

Fit and Proper Person Requirement

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of health service bodies are fit and proper persons to carry out the role.
- A new fit and proper persons policy was approved by the trust board on 4 March 2015, the week after our inspection. The policy outlined the checks required for directors on appointment and on-going annual checks of fitness. These included checks of criminal record, insolvency and bankruptcy, identity, right to work, employment history, professional registration and qualifications. The policy required the chair to confirm annually to the council of governors that all directors fulfilled the FPPR.
- The new fit and proper persons policy stated that "DBS checks (criminal record checks) are undertaken only for those posts which fall within the definition of a "regulated activity" or which are otherwise eligible for such a check to be undertaken." However, without a DBS check for all directors, the trust will not fully comply with Schedule 4 part 2 of the Regulation to ensure appointees are of good character.
- The policy described the action to be taken if a director was found to be in breach of the FPPR, which included advising the relevant professional regulator if the individual was a registered health or social care professional.
- A number of actions had been taken in the period between the regulation coming into force in November 2014 and the trust board agreeing the new policy March 2015. For example, the trust had carried out checks of the insolvency register and register of disqualified directors for each director.
- The trust was in the process of applying for a disclosure and barring service (DBS) check for all executive and

non-executive directors. At the time of the inspection disclosures had been received for ten directors. Results were awaited for three people and three applications had yet to be completed.

- All the contracts of current directors had been amended to reflect the requirement for them to be compliant with the FPPR. Directors were required to make an annual declaration of their fitness in respect of the regulation. The trust's constitution had been amended to include a requirement for all directors to fulfil the FPPR. Assessment of the continued fitness of directors was to be undertaken each year as part of the annual appraisal process. All directors had received an appraisal in 2014. The Chair was undergoing an annual appraisal which involved receiving feedback from all directors and governors of the trust.
- We reviewed the personnel files of six directors on the trust board. Three of these were executive directors and three were non-executive directors. All had been appointed prior to the FPPR coming into force in November 2014. There had been no new appointments to the board since then. Most of the checks on current directors required by the policy had already been carried out or were in process. However, one director's file had only one employment reference rather than the required two and in another file there was no evidence that the director's professional qualification had been checked and verified. DBS checks had not yet been completed for two of the six directors we checked.

Engagement with people and staff

- The trust worked with patients and carers in a number of ways to improve the quality of their services. Examples of this included patients helping with telephone surveys to get patient feedback on services (over 2500 calls made a quarter), patients and carers helping with staff recruitment and training, patients and carers involved in setting the annual quality standards, helping on steering groups responding to feedback from surveys and helping to update information materials or reviewing policies. Also patients attended board meetings to share their story. The trust had a carers council that included carers and staff representatives. Carers groups had been established in some services.
- Throughout the geographical area covered by the trust there were a wide network of user and carers groups. Some of these were directly supported by the trust and others are more independent. The feedback from these groups was that whilst the trust was very supportive of the groups and welcomed their feedback, there was also a concern that this did not translate into changes or that they were not aware of the changes that had taken place.
- The new friends and family test was rolled out by the trust in October 2014 and was available online on the trusts website. This included campaigns to encourage patients and staff to complete the test. The test was available in different formats for people with dementia, children and people with a learning disability. It was translated into the organisations top10 languages and was available in a large font.
- The trust had a number of peer support workers employed throughout their services offering practical assistance to help people regain control over their lives and support their recovery. We found that this had enhanced the quality of engagement across the services concerned.
- In June 2014 a staff engagement strategy was launched. The five keys areas of work were as follows: safe staffing (review staffing levels, recruitment, use of e-roistering), personal development for staff (ensure training and appraisals done well), promote staff health and well-being (focus on stress management including a new policy), hand-washing (ensure the facilities are available), reduce staff experiencing discrimination (raise the profile of the equality and diversity network, monitoring themes and addressing issues)
- Staff engagement occurred through a number of other means including a weekly newsletter, use of social media, staff magazine, holding focus groups with staff called "the conversation" and a programme of listening events.
- Staff felt generally very involved in their services and able to raise issues and discuss areas for improvement. The staff working in Milton Keynes and the dental services in Buckinghamshire recognised that they were still adjusting to being part of the trust. In services that were going through a process of change staff did not always feel listened to or sufficiently involved. This was raised by staff in the sexual health services, the Westminster CAMHS service and the home treatment teams in Kensington & Chelsea and Westminster.

Quality improvement, innovation and sustainability

Good

Are services well-led?

- We heard about many areas of innovation across the trust. One of these was the work the trust was doing with GPs to strengthen primary care. This is known as primary care plus and aimed to help people stay well and reduce their need to access secondary services. We were told that in terms of long term development the focus was very much on patients being able to access their physical and mental health services together through fully integrated services.
- The trust also participated in external peer review and service accreditation. This included the Quality Network for Perinatal Mental Health Services at Coombe Wood, the Psychiatric Liaison Accreditation Network where the service at the Chelsea and Westminster Hospital was accredited as excellent and the Quality Network for Inpatient CAMHS where the service at the Collingham Child and Family Centre was also accredited as excellent. Other accreditations included the Quality Network for Inpatient Learning Disability Units, the Memory Services National Accreditation Programme where the Brent, Kensington & Chelsea and Westminster services were accredited as excellent and the Electroconvulsive Therapy Accreditation Service where the St Charles service was accredited as excellent.
- The trust has a clinical ethics committee. It is made up of clinicians, managers, a lay member, a service user as well as a philosopher and an ethics and law lecturer. This committee has been running for 10 years and had reviewed over 95 cases.
- At the time of the inspection CNWL was having to save £84m over the next 3 years, £32.7m in 2014-15, £23m in 2015-16 and £28m in 2016-17. This represented nearly 20% of its income. Monitor expressed concerns about whether these savings would be achieved. A number of people we spoke to throughout the organisation shared this concern. In order to achieve this the trust was consolidating and redesigning services. A number of services that were inspected had taken part in the DRIVE programme (delivering realistic improvements, value and efficiencies). The aim with the support of an external partner was to try and streamline processes such as referrals and documentation and create more time for clinical care as well as saving money. The trust had a programme management office to oversee all the projects. All the savings plans had a quality impact assessment. They always included senior clinical input and where relevant input from people who use the service, carers and wider stakeholders. We looked at the quality impact assessments and found evidence of clinical involvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although numerous ligature risks had been identified on the acute and PICU wards staff were not able to articulate the measures being taken to manage these risks for the patients using the service. There were a number of blind spots in the wards that did not have a clear line of sight. Measures were not always in place to reduce risks to patients and staff. Significant numbers of detained patients were absconding whilst receiving inpatient care. This needed to be reviewed so that measures could be put into place to reduce the risk to patients. This is a breach of Regulation 10 (1)(b)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

This section is primarily information for the provider

Requirement notices

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The trust had not ensured that patients were appropriately assessed and that the welfare and safety of patients was maintained.

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Patients were not being protected against the risks of unsafe or unsuitable care.

The records relating to the seclusion of patients did not provide a clear record of medical and nursing reviews, to demonstrate that these were carried out in accordance with the code of practice: Mental Health Act 1983.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The trust did not take appropriate steps to ensure there were sufficient numbers of staff. The failure to increase staffing numbers in response to increased numbers of patients on the acute admission wards put patients at risk of not having their needs met appropriately. There were insufficient staff available to work as care co-ordinators which meant that duty workers in the Brent, Hillingdon and Harrow CRT's were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The trust had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The wards were over-occupied. On admission to the ward, patients did not have a designated bed and often slept on other wards. Patients returning from leave did not have a bed on their return to the ward.

This section is primarily information for the provider

Requirement notices

Some people in the acute wards experienced several moves between wards for non-clinical reasons during one admission. Of these, some people were transferred during the night or went to wards where they did not know, or were not known by, the multidisciplinary team.

At the Harrow community recovery team patients' risk assessments were not thorough or detailed. They were not updated after risk incidents.

The planning and delivery of care did not always protect the welfare and safety of patients. Several patients using Harrow and Hillingdon CRTs had not been referred for regular physical health checks.

On Redwood ward patients were not having ongoing physical health checks.

On Redwood ward female patients were wearing clothing that did not preserve their dignity.

Patients from adult wards were receiving care and treatment on the older people's wards when this was not always clinically appropriate.

Patients were admitted to the beds of patients on wards for older people with mental health problems who were on leave but not discharged. This meant they may not be able to return to the ward if they needed to.

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Requirement notices

The trust did not have suitable arrangements to ensure the dignity and privacy of people.

Patients were not able to make telephone calls in private.

At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity.

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

This is a breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

The provider had not protected service users from the risk of the use of unsafe equipment by ensuring the equipment is properly maintained and suitable for purpose.

At the Hillingdon community recovery team (Pembroke Centre), the automated external defibrillator (AED) had not been properly maintained. As a result there was a risk to people from the use of unsafe equipment in an emergency situation.

This is a breach of regulation 16(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust did not have an effective system to inform people of how to make a complaint. There was a lack of information in some rehabilitation services and the PICU's to inform people how to make a complaint. There was not a central register of verbal complaints and it was possible that where patients wanted a formal response to their complaint this was not happening. This is a breach of Regulation 19(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout. Oak Tree ward and TOPAS did not comply with guidance on same sex accommodation and compromised patients safety, privacy and dignity. On several wards patients did not have access to a lockable space to safely store their personal possessions which should ideally have been provided through a key to their bedroom door. Patients could not close their observation panel from inside their room to have privacy. Interview rooms at St Charles hospital did not maintain the confidentiality of people using the service. This was in breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider did not protect patients against the risks assosciated with the unsafe handling of medicines. On Redwood ward medication was left in an unlocked medication trolley where patients could have picked it up. On Redwood ward the drugs used for emergency resuscitation were not stored together which could make them harder to locate in an emergency. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider had not made suitable arrangements to ensure that patients are safeguarded from the risk of abuse by responding appropriately to an allegation of abuse. At the TOPAS centre there was no record so that staff would know about current safeguarding alerts and any actions that needed to take place to keep people safe. This was a breach of regulation 11(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Requirement notices

The trust did not have suitable arrangements in place to protect patients against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems to reflect information that it is reasonable to expect the trust to be aware and make changes to the care provided.

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

This was a breach of regulation 10(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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London Ambulance Service NHS Trust

Hillingdon Oversight and Scrutiny Committee Update on LAS Complaints

Background

The following information provides a breakdown of the total complaints received for the Hillingdon CCG area, and a like for like comparison against neighbouring (Brent and Harrow) CCG areas for the 2014/15 year.

The Brent, Harrow and Hillingdon CCG area accounted for 9.60% of the total LAS complaints (1403) received for this period:

Harrow = 2.1%
Brent = 3%
Hillingdon = 4.5%

Nature of complaint

Table 1 – Subject complaints by CCG area 2014/15

Borough	Conduct	conveyance	Delay	Non-conveyance	damage to property	Road handling	Treatment	Safeguarding	totals
Harrow	5	1	15	4	1	3	0	0	29
Hillingdon	11	4	45	0	0	1	1	1	63
Brent	7	0	30	1	0	1	3	0	42
Totals	**23**	**5**	**90**	**5**	**1**	**5**	**4**	**1**	**134**

Resolution of complaints

Table 2 – Complaints awaiting conclusion

	Number awaiting conclusion	Reason
Brent	9	
Harrow	2	
Hillingdon	6	3 awaiting QA report, 1 awaiting clinical opinion, 2 x draft response with PED

Table 3 – Complaint outcomes

Outcome	Hillingdon	Brent	Harrow
Explanation provided	51	26	24
Staff reflective practice and/or training	6	4	3
Complaint withdrawn	0	2	0
No further action	0	1	0

Learning from Complaints – Changes to Service Provision

999 Call Management

- We have implemented an initiative whereby an upgrade is made to the priority level in relation to any patient who is considered to be vulnerable where there is a delay exceeding 60 minutes in an ambulance being sent, irrespective of whether the patient's condition has changed (the usual criteria for an upgrade to be made) or not. This is typically pertinent to elderly patients who have experienced a fall and remain on the floor.

- Since the above, we have introduced a systematic way of ensuring that an automatic upgrade is made to the priority level at the scheduled 60 minute interval.

- Patients who have taken an overdose and now routinely determined at a C1 priority which attracts a target an ambulance response within 20 minutes.

- We have withdrawn the taped message that was historically used to explain what was happening and what a caller should do before an ambulance arrived. This was introduced as a means or releasing call handers to more quickly answer incoming 999 calls. However, complainants found it impersonal and said they wanted to speak to a human being. The initiative also proved counter-productive in that it prompted an increased number of calls seeking the estimated time of arrival, as callers did not necessarily take on board the information in the tape message given the duress that callers can experience at the time of making a 999 call. Callers are now given advice by a call hander.

- Callers to the 999 service complained that we could not offer an estimated time of arrival so that they could make an informed decision about whether to wait for an ambulance patient to or to take the patient to hospital or another care pathway by other means. We have therefore introduced a new facility so that at times of high demand, call handlers are advised of the likely duration before an ambulance is sent so they can pass this on to the caller.

Changes to clinical protocols

- We identified that the triage of seizures did not successfully isolate those 999 calls where the patient was known to have epilepsy but was experiencing a seizure that was atypical for them. Changes have been made to the clinical protocol, including the identification of incidents where the patient has been given benzodiazepine which could impact on their level of consciousness or breathing.

- It was identified that not all maternity units do not have dedicated facility to receive a pre-alert call; this has historically mainly been used to alert A&E departments that patient is being brought there as a high priority emergency, so that a doctor and medical team can be prepared for the patient's arrival. An audit was undertaken in collaboration with Maternity-Unit s pan-London towards improving provision and practice.

- Following several instance where a testicular torsion, presenting as abdominal pain, has resulted in a slow response and culminated in a life-changing event for the patient, we have agreed with the National Academy of International Dispatch to change the triage outcome of patients presenting with this condition. If mention is made of groin pain, call handers now record that so that our Clinical Hub clinicians can undertake an enhanced clinical assessment and re-grade the call, if appropriate.

- The triage of patients with known potentially life-threatening conditions such as Arteriovenous Malformation (AVM), in whom early and subtle symptoms could suggest impending rapid deterioration, has been improved.

- Following several case involving the care provided to patients who had used cocaine, a reminder was issued in a Clinical Update (disseminated across the Trust) that an ECG should be routinely taken as part of the assessment as cocaine can induce a heart attack.

Case Studies

1. Concerns were raised on behalf of the patient by his GP that the attending staff believed that the patient did not need to attend hospital.

   Outcome: Our clinical review concluded that the patient may have benefited from stronger analgesia and although the patient was taken to an appropriate facility, feedback was given to the crew about identification of cardiac chest pains in patients presenting with atypical symptoms and non-diagnostic ECG

2. Concerns were raised by a police officer who believed that she had incurred a needle-stick injury whilst assisting LAS staff with a patient in custody. It was ascertained that a lancet had been used and that it was highly unlikely that a needle-stick injury had occurred.

   Outcome: A full explanation was provided that the lancet has been tested, reviewed and used in trials in accordance with governance practice and that it is a safe system.

3. The relative of a patient who had suffered a fatal heart attack raised a number of issues including why medical apparatus and packaging were left at the scene.

   Outcome: We explained that in the context of an unexpected death it is a requirement that medical devices, such as airway devices and intravenous catheters, are left *in situ*. This is because the scene is regarded as a potential crime scene until the police decide otherwise. Matters were made more complicated in this case because of the property being suspected of being used as a cannabis farm.

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healthwatch Hillingdon

Healthwatch Hillingdon

Annual Report 2014/2015

Contents

Note from the Chair

Welcome to the second Annual Report from Healthwatch Hillingdon. We made real progress in 2014/15. There is no doubt that the people of Hillingdon now have a stronger voice to influence the health and social care services that matter to them.

One of the most pleasing things about the past year is the extent to which we made a difference to the quality of care services in the borough. Thanks to our intervention, healthcare agencies have improved the way they work in the treatment of individual cases, and also more generally by improving standards in some services. Details of some of the changes we have helped to bring about with the help of local feedback are set out in this report, but there is still much to be done. Healthwatch Hillingdon must use its limited resources carefully to achieve maximum impact.

Much of our work is carried out behind the scenes by engaging with local health and social care agencies on issues where improvement is needed. Working in this cooperative, partnership-based way has worked well in most cases. But there were exceptions that demanded a different approach – for example, we publicly highlighted the serious deficiencies in mental health services for children and adolescents. Some of the issues raised for these services called for immediate improvements and concerted action by all relevant partners.

Our achievements this past year have only been possible as a result of the tireless work and effort of our Chief Executive Officer, Graham Hawkes, his staff, our hard working volunteers and helpers and the Members of our Board. I would like to express my appreciation here for all those who have contributed.

Significant challenges lie ahead of us. We need to be even more proactive in seeking out the opinions and experiences of people using care services in the borough, particularly from seldom-heard groups. Young people with mental health and similar problems will certainly continue to be one of our priorities. We will also look at the problems faced by older people living in care homes or receiving care in their own homes.

A big issue for all residents of the borough is the reconfiguration of health services across the whole of North West London. This could have significant implications for patients, in terms of both how and where services can be accessed and their quality and effectiveness. These changes have had a relatively low public profile so far, but we will monitor them closely, gather local views and raise public awareness as appropriate.

The activities of Healthwatch can only be successful if local agencies listen to us and act upon our concerns. This report sets

out some of the successes we have had in this respect, and we aim to build on this in the coming year. Above all else, our job is to give people more opportunity to shape services to meet local needs. The Board, Healthwatch Hillingdon's staff and volunteers will put this at the heart of everything we do.

Jeff Maslen
Chairman
Healthwatch Hillingdon

Note from Councillor Philip Corthorne, Hillingdon Council

I congratulate Healthwatch Hillingdon for the work it has undertaken on behalf of residents and as set out in this annual report.

Healthwatch has developed into a key partner on the borough's Health and Wellbeing Board and as a critical friend in the development of more integrated health and social care in the borough.

As we move towards further pressure on services and budgets, it will be as important as ever that the "voice of the customer" is heard loud and clear in the changes ahead and as we seek further improvement with our health partners.

I'm also delighted that we were able to secure ongoing support for Healthwatch for 2015/16 and 2016/17 to enable it to continue its good work. My thanks go to the staff, the voluntary Board of Trustees and the extensive support network and volunteers who have supported Healthwatch to thrive in Hillingdon.

Cllr Philip Corthorne MCIPD
Cabinet Member for Social Services, Health and Housing
London Borough of Hillingdon

HILLINGDON
LONDON

About Healthwatch Hillingdon

Healthwatch Hillingdon is an independent organisation that represents the views of everyone who uses health and social care services in the London Borough of Hillingdon. We make sure that these views are gathered, analysed and acted upon, making services better now and in the future.

We give local people the platform to improve the delivery of their health and social care services. We monitor local services to ensure they reflect the needs of the community, and where necessary, use statutory powers to hold those services to account.

We are completely separate from the NHS and the local authority, from commissioners and providers of services. Healthwatch Hillingdon is part of the Healthwatch network in England, one of 152 community-focused organisations nationally led by Healthwatch England.

Our vision

Our vision is to become the influential and effective voice of the public. We want to give adults, young people, children and communities a greater say in - and the power to challenge - how health and social care services are run in Hillingdon. This vision is founded on the belief that services work best when they are designed around the needs and experiences of the people who use them.

What we do

- We listen to patients, their families and friends and tell health and social care commissioners and providers about their views and experiences of services.
- We ensure that the voices of everybody in Hillingdon are heard and that no person or community is disadvantaged.
- We review, monitor, challenge, influence and shape how health and social care services are commissioned and provided in Hillingdon.
- We recruit, train and develop the skills of volunteers to help with our work.
- We give local people and communities the opportunity to be involved in the planning, development and delivery of local care services.
- We support and empower people to make informed choices and decisions about their care.
- We help people when they want to raise a concern, or a complaint about a service they or their family and friends have experienced.
- We recommend investigations or special reviews of services to Healthwatch England or directly to the Care Quality Commission.
- For everything we do, our Board, staff and volunteers strive to be fully inclusive and reflect the diversity of the community we serve.

Healthwatch Hillingdon Shop

The generosity of the Pavilions Shopping Centre enables us to run the Healthwatch Hillingdon shop in a busy central location in Uxbridge. The shop provides a fantastic opportunity to engage with local people and promote Healthwatch and the wider voluntary sector. We advertise numerous events in our shop and on our notice boards and offer a full range of information on health and social care issues and services.

This local hub is vital to our work and we look forward to continuing our excellent relationship with the Pavilions in the coming year.

Making our presence felt on the high street - the Healthwatch Hillingdon shop

About Hillingdon

The London Borough of Hillingdon is the westernmost borough in Greater London and is the second largest of the 33 London boroughs. The population is 274,000 according to the 2011 Census. This is expected to rise above 300,000 by 2016.

It is home to a diverse population, representing a vast range of cultures and nationalities - 40% are from Black and Minority Ethnic groups, with 25% who are Asian.

The borough is home to Hillingdon, Mount Vernon and Harefield hospitals, Heathrow Airport, RAF Northolt, and both Brunel and Buckinghamshire New Universities.

Engaging with people who use health and social care services

Overview

2014/15 saw Healthwatch Hillingdon building on its success at engaging with the people of Hillingdon by expanding our activity to learn about residents' experiences of health and social care services. We used diverse methods to raise awareness of our role to encourage as many people as possible to share their views with us. Our strong presence in key public places enabled a broad cross-section of the community to express their views, while tailored outreach activity gave seldom-heard and vulnerable groups the chance to share their experiences.

Raising awareness of our role

We can only get local people to share their views and experiences with us by reaching out into the community, gaining trust and raising our profile. Our staff and volunteers threw themselves at this with a passion in 2014/15. We made contact with thousands of Hillingdon residents through attending community events, workshops and fairs, our presence at the borough's three hospitals and by presenting to the public and community organisations.

Examples of our communications activity include:

- a strong web presence – our site had over 68,000 unique visits over the year, with 20,000 documents downloaded
- guest appearances on Hillingdon Hospital Radio and Hayes FM
- a bus advertising campaign run in partnership with Healthwatch Ealing & Hounslow
- building our social media profile; our Facebook friend numbers rose by over 50% to 350, Twitter followers more than doubled to 725 and our interim report on children's mental health received over 1,000 retweets
- the delivery of 55,000 annual report summaries to residents in the south of the borough by the London Borough of Hillingdon Youth Offending Team
- advertising in the local press, hospital radio magazines and the borough care directory
- distributing 10,000 promotional book marks in partnership with Hillingdon's libraries
- extensive local press coverage of our stories and calls for evidence
- promoting our role through our shop in the Pavilions Shopping Centre in Uxbridge.

Although difficult to quantify, we estimate that our media exposure, attendance at

public events and location within the Pavilions shopping centre in Uxbridge allows us to indirectly engage with more than 100,000 Hillingdon residents.

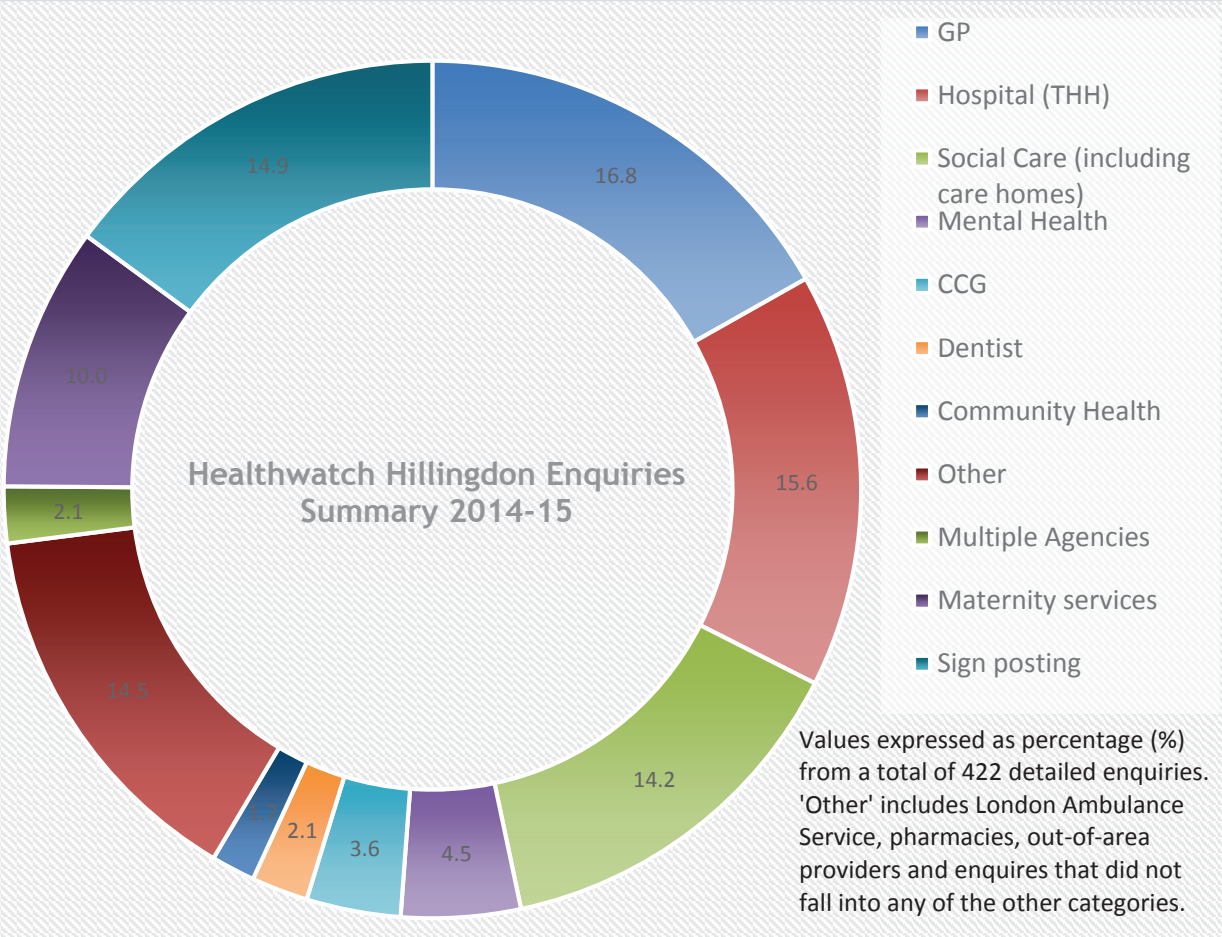
Understanding people's experiences

Healthwatch Hillingdon's staff and volunteers engaged widely across the borough to gather residents' feedback on health and social care. This included targeted work with a number of seldom-heard groups, including young carers, the Gurkha Community, Hillingdon Traveller Forum and the deaf community. The information from this engagement work feeds into our patient experience data, a rich mix of information that helps us monitor service performance and identify where improvements are needed.

During 2015 we:

- actively sought the views of 1,826 people through our outreach activity
- gathered 784 instances of feedback (including complaints, compliments, information requests and patients' views) from all the methods we use to stay in touch with Hillingdon's residents.

Of these 784 enquiries/views, we analysed 422 in detail. The chart below breaks these down by type/subject of enquiry.



Hillingdon hosts three major hospitals and borders on to four counties and three other London boroughs. It is inevitable therefore that we also attract comments from service users, staff and volunteers from outside of the borough. As our contract with the London Borough of Hillingdon stipulates that we support borough residents, we direct these people to their local Healthwatch or NHS Complaints Advocacy provider as appropriate.

Gathering views at Hillingdon's hospitals

Our community outreach programme includes a regular presence in the reception area of all three of the borough's hospitals. All manner of patient experiences are captured at these stalls, and in early 2015 we enhanced this opportunity by introducing comment boards. This enables people to use Post-it Notes to write comments, visible to all, under two headings:

- What I like about the NHS and Social Care Services
- If I could change anything it would be….

Collating these views enabled us to take forward issues with the hospitals. In one case we worked with Mount Vernon Hospital on communication to ease staff concerns about the issue of parking tickets.

The Healthwatch Hillingdon shop

Healthwatch Hillingdon is one of the few local Healthwatch organisations that has a prominent high street presence. Our office and shop is located in the Pavilions shopping centre in Uxbridge near a busy underground tube station. As well as serving as a thriving information hub, it also provides a great opportunity for visitors to tell us about their experiences of care.

Gathering views at Hillingdon's hospitals

We are keen to share our shop facilities with other organisations. This makes the most of a valuable community resource and helps to strengthen our links with vulnerable/seldom-heard groups and other partners. Organisations that have benefitted from this facility include:

- Hillingdon Action Group for Addiction Management
- Refugees In Effective & Active Partnerships
- EACH Counselling & Support's Pukaar Project for women experiencing domestic violence
- the Hillingdon Clinical Commissioning Group.

Listening to young people

Partnering with the National Citizens Service (NCS) was an excellent way of engaging with young people. Our work with a group of 15-16 year olds culminated

in them volunteering for Healthwatch Hillingdon as part of an NCS 'Challenge Day'. After a morning spent befriending and organising activities at the Young Carers Club in Harlington, our volunteers took to the streets of Hayes to carry out peer-to-peer wellbeing surveys with young people aged 12-24. The 32 completed surveys formed a vital part of our work on children and adolescent mental health.

Listening to people with poor mental health

We identified a number of issues in our investigation of unsafe hospital discharge for mental health patients, conducted via interviews and workshops. The patient experiences we obtained were passed to Central and North West London NHS Foundation Trust, who decided that they warranted an internal investigation.

Anonymised data was also passed to the Care Quality Commission and Healthwatch England as part of a wider Special Enquiry into unsafe discharge. We sent submissions representing the views of 20 individuals to this enquiry, more than most other London-based Healthwatch organisations.

Listening to people over 65

Healthwatch Hillingdon engaged widely with the borough's older generation in 2014/15.

- We worked with local organisations and projects such as the Live at Home Scheme, the Pensioners Alliance, the Older Residents' Forum, Community Voice Health, Residents' Associations and Hillingdon and Mount Vernon Hospitals.
- We arranged/participated in activities such as Older Persons' Assemblies (three events), dementia cafés, coffee mornings and a wellbeing event for housebound older people.

Healthwatch Hillingdon also worked closely with the Hillingdon branches of Age UK, Alzheimer's Trust and Hillingdon Carers. Work is ongoing with these groups to identify better ways of gathering feedback on people's experiences of care.

Listening to the Ghurkha community

Healthwatch Hillingdon was one of a number of organisations invited to participate in a wellbeing event for the elderly among the Nepalese Ghurkha community concentrated in the south of the borough. We discovered that some struggled to access GP services because of language difficulties and problems with obtaining interpreters.

We worked with the CRI London Gurkha Settlement Service to produce a bilingual factsheet explaining how to access an interpreter for medical purposes. Gurkha group HGNC distributed two hundred copies throughout this community.

Listening to the deaf community

We acted when feedback from the deaf community alerted us to the refusal by some GP surgeries to arrange for sign language interpreters to attend

appointments. A 'speed dating' session at a Disability Forum event, organised jointly with Hillingdon Council, gave us further insight into the difficulties this was causing. We informed the Clinical Commissioning Group of the need to raise awareness among GPs of their obligations, and produced a factsheet for deaf residents to present to their GP practice. Reports of this problem continued to surface for GP and hospital appointments; including a case where a ten-year-old child was asked to act as a translator. The feedback we gathered enabled us to submit evidence on this London-wide issue to the North West London Quality Safety Surveillance Group.

We encountered a similar lack of awareness among other primary local care providers. Problems with NHS England's commissioning of interpreting services for dentists and opticians were highlighted when we helped an optician to establish the invoicing process for interpreter services after a request for payment had failed.

Enter & View

As an independent consumer champion, Healthwatch Hillingdon has the power to 'Enter and View' health and social care services. These visits can be used to identify good practice and areas for improvement by talking to service users, relatives, carers and staff.

We prefer wherever possible to work closely with our statutory partners as a means of gaining a comprehensive overview of care quality. This approach worked well last year, and Healthwatch Hillingdon did not need to exercise its formal powers of Enter and View in 2014/15.

We will not hesitate however, to use these powers if necessary, or to direct the Care Quality Commission to further investigate any concerns we uncover. Our Decision Making Policy, published on our website, sets out how Healthwatch Hillingdon can use its formal Enter and View powers.

Other approaches to viewing care quality

Healthwatch Hillingdon leads on PLACE assessments (patient-led assessments of the care environment) in the borough. Seven volunteers helped with PLACE assessments at the Hillingdon Hospitals Foundation Trust and the Central North West London Foundation Trust in May 2014. It was a positive experience for our team and a number of improvements were logged for the Trusts' Improvement Programme action plans.

We also conducted a meal audit at Hillingdon and Mount Vernon Hospitals to assess meal quality. Our comprehensive improvement plan helped the Trust and the Director of Nursing and Patient Engagement take appropriate action.

Providing information and signposting for people who use health and social care services

Helping people get what they need from local health and social care services

Healthwatch Hillingdon provides information and signposting in diverse ways to reach as many residents as possible. We have excellent links to and knowledge of service providers in the borough, enabling us to empower people to make choices about their care.

Key methods used to provide information and signposting include:

- our shop within the Pavilions shopping centre in Uxbridge
- attendance at community events and fairs
- our stalls in the reception areas of the borough's three hospitals
- our user-friendly website
- prompt replies to email and telephone queries

Although Healthwatch Hillingdon has not been commissioned to provide direct support for individual complaints about health and social care services, we strive to inform people about complaint or feedback processes. This can include referring people directly to the independent NHS Complaints Advocacy service (provided by VoiceAbility), to DASH (for social care services) or other agencies. In 2014/15 we made:

- 43 direct referrals to VoiceAbility
- 5 referrals to DASH
- 2 referrals to SEAP (NHS Complaints Advocacy service provider for non-London Borough of Hillingdon residents)
- 1 referral to the General Medical Council.

Pointing the way at the Ruislip Fun Day

Our staff and volunteers try to help individuals resolve local issues wherever possible. This approach has worked well; it helps us connect with our local community and allows us to work co-operatively with providers to improve the quality of care. This approach can only work through strong partnership working, and we thank those organisations, such as Hillingdon Hospital and CNWL, that have embraced and supported this approach.

Signposting and support – our impact

Here are just a few examples from the many residents of Hillingdon who have benefitted from our help to find and access local services.

We succeeded in stopping GP surgeries using expensive 0844 phone numbers in 2013/14 in accordance with NHS England guidelines. The last practice in the borough using such a number was brought to our attention by a patient, understandably frustrated at the cost of making appointments on her mobile and the lack of an online booking system. After the surgery repeatedly failed to act on our request to stop using their 0844 number, we escalated the issue to NHS England. The surgery finally agreed to change their number after NHS England's intervention. This has benefitted the practice as well as patients, as fewer people now walk in to make an appointment.

A carer contacted us after her elderly, frail mother was discharged from hospital, twice in quick succession, without an assessment of her care needs. With the family struggling to provide adequate care at home, we contacted the London Borough of Hillingdon Adult Social Services to request a proper assessment. The family subsequently got the help they needed – an outcome they feel was impossible without our intervention.

We supported a family at a Best Interest Meeting to discuss the discharge process for the mother who had been hospitalised for several months following a stroke. Our presence helped the family, social services and the hospital address the complex set of needs, and the patient was discharged to the appropriate setting with the right package of care in place.

A carer contacted us after struggling to arrange a home visit by a community dentist for her mother with dementia. We discovered that the community dentist contract had been awarded to a private dental provider, and after attempts to contact the new provider failed, the issue was escalated to NHS England. The home visit was subsequently arranged.

A Chinese engineering student at Brunel University was experiencing severe pain from kidney stones. After unacceptable delays while waiting for an operation, alongside months of absence from his studies, he contacted Healthwatch Hillingdon. Our advice and intervention with the hospital helped him get the treatment he needed.

'I hate to think what would have happened if I hadn't met Healthwatch Hillingdon. Maybe I would still be waiting for the operation.'

Mr L, Chinese student

Helping our partners to improve their information services

As well as constantly trying to improve our own signposting and information services, we use evidence from local people to encourage partners across the health and social care network to do the same.

For example - our analysis of enquiries and feedback to Healthwatch Hillingdon

identified an interest in the right to be referred to a hospital of choice. Further investigation revealed the lack of local information on the public's rights and obligations under the NHS Constitution – even though the NHS Hillingdon Clinical Commissioning Group (HCCG) are duty bound to promote awareness of this.

As a result of Healthwatch Hillingdon's recommendations, the HCCG website now provides clear information on this issue. This information is also available on our own website and that of Hillingdon Council. We will continue to press for more action to raise public awareness of the NHS Constitution.

Influencing decision makers with evidence from local people

Producing reports and recommendations to effect change

Our mission to become the influential and effective voice of the public will only be realised if our work results in tangible improvements to services.

Each year Healthwatch Hillingdon provides a written response with recommendations to feed into the Quality Accounts for the four NHS Foundation Trusts that operate in the borough. Our role in influencing service quality, however, is a year-round responsibility, not just an annual focus. We hold regular meetings with providers, using patient experience data to challenge service quality and recommend improvements on an ongoing basis.

In this section we provide examples of how we used evidence from local people to influence decisions on health and social care in Hillingdon in 2014/15.

Improving children and adolescent mental health services (CAMHS)

CAMHS was a big focus for Healthwatch Hillingdon in 2014/15, demonstrated by our employment of a Children's Engagement Officer. We worked very closely with Hillingdon Mind to gather evidence from young people. In December 2014 we published '*Listen to me!*' an interim report with far reaching recommendations, and presented it to the Hillingdon Health & Wellbeing Board.

This report has been a catalyst for change. A Children and Young People's Mental Health and Wellbeing multi-stake holder group has been formed to oversee improvements to services. A number of our recommendations were incorporated into the *Joint Social, Emotional Wellbeing and Mental Health Strategy 2015-2018* developed by Hillingdon Clinical Commissioning Group and London Borough of Hillingdon commissioning colleagues. These included:

- conducting children's mental health needs assessments
- more involvement of young people, parents and a wider group of

professionals (including the voluntary sector) in the development of services

- closer collaboration with schools
- a clearer focus on prevention and early intervention
- more universal support services for children and their families.

A second phase of in-depth engagement and evidence gathering has been undertaken during 2014/2015 and the findings from this work will be published in our second CAMHS report (due for publication in July 2015).

Improving domiciliary care

When the London Borough of Hillingdon (LBH) wrote to recipients of domiciliary services to advise them of a change in service provider, we persuaded them of the value of adding Healthwatch Hillingdon's details to the letter. This enabled residents to feed back any concerns about the change and their experiences of care in general - valuable insights that we fed back to LBH. Residents continued to contact us about issues they experienced during the transition. Our recommendations helped LBH and the new providers to tackle teething problems and improve services.

Improving access to NHS Continuing Health Care

Feedback gathered by Healthwatch Hillingdon indicated that many residents were not being told about or getting appropriate access to NHS-funded Continuing Health Care (NHS CHC). Not even NHS Hillingdon Clinical Commissioning Group's (HCCG) own website provided relevant information – requiring us to request CHC checklist assessments directly on behalf of individuals.

Our recommendations led directly to HCCG making additional funds available to the Hillingdon Hospital to support assessment for NHS CHC prior to patient discharge. Information on access to this service was also placed on the HCCG website. We feel there is still scope for further improvement, including the training of frontline NHS and social care staff on NHS CHC eligibility and assessment processes.

Improving the equality of access to services

Healthwatch Hillingdon has continued to act as a strong independent advocate for the implementation of National Institute of Clinical Excellence (NICE) clinical guidelines as a way of improving service quality and ensuring equality of access to NHS treatments. Our representations on the unfair provision of knee replacement operations led to the eight Clinical Commissioning Groups (CCGs) across North West London agreeing to remove the clinically unjustified weight criteria in 2015/16.

We also pressed the case for changes to the referral criteria for inguinal hernias, identified by the Royal College of Surgeons (RCS) as clinically unjustified and unsafe. Our intervention led to a recommendation by the North West London Policy Development Group (on which we have a non-voting seat) that the referral policy should be changed to reflect the standpoints of the RCS and NICE. This is a major step forward for the safety and quality of care for hernia patients across North West London.

Not all of our efforts to improve the equality of access to care have been rewarded. Women across North West London continue to face a postcode lottery for access to life-changing in vitro fertilisation (IVF) treatment. Our proposals for the staged implementation of NICE guidelines have not been fully explored by the CCGs. We will continue to highlight the injustice of this situation to commissioners, Healthwatch England and NHS England.

Putting local people at the heart of improving services

Healthwatch Hillingdon continued to champion the full and effective involvement of local people in the commissioning, provision and management of services in 2014/15. We used our seat on the NHS Hillingdon CCG's Patient and Public Involvement Committee to push for robust processes for involving local people in the full commissioning cycle. Examples of local people influencing services with our support in 2014/15 are set out below.

Improving maternity services

The Hillingdon Maternity Services Liaison Committee (MSLC) oversees local maternity services by bringing together midwives, clinicians, commissioners, public health, Children's Centres and local mothers. The Committee's ability to recommend service improvements based on women's experiences is enhanced by having a Healthwatch Hillingdon volunteer, a local mother, as its Chair. We provide the Chair with advice and administrative support to help her play a full and equal role on the Committee. Crucially, the intelligence we gather from new mothers in the area helps to inform the MSLC's work. This input is making a real difference to services. One example is the new perinatal service set up at Hillingdon Hospital – see the impact story on page 24.

Procuring a wheelchair service

As part of the planning for the procurement of a joint wheelchair service, Harrow and Hillingdon Clinical Commissioning Groups held informal workshops to learn about the experiences of wheelchair users. We invited four wheelchair users to attend, along with our Board Member (and wheelchair user), Allen Bergson. These contributors felt their input helped to shape the proposed contract, and a further meeting enabled them to improve the draft contract. The group also has the opportunity to get involved in the procurement process when the specification goes out to tender in 2015.

The mystery shopper

A Hillingdon resident volunteered to act as a 'mystery shopper' and keep a diary throughout her pregnancy journey, from antenatal stages to the birth of her child. She provided valuable insights into the maternity services at Hillingdon Hospital, a mix of positives and areas for improvement. Her experience was presented as a patient story at the Hillingdon Hospitals NHS Trust board meeting, and the Trust agreed to act to improve services.

Membership of the Health & Wellbeing Board

Our Chair, himself a volunteer, represents Healthwatch Hillingdon on the Health and Wellbeing Board. He fulfils his role as an influential and valued Board member by drawing on support from Healthwatch Hillingdon which includes:

- briefings, reports and advice
- training and experience sharing opportunities
- national good practice guidance on the role of the Board.

Working with others to improve local services

2014/15 saw Healthwatch Hillingdon continue to build on its strong operational relationships with organisations within the NHS, Local Authority and the voluntary sector. These relationships see us take the role of "critical friend" and valued partner for Hillingdon's health and social care providers. Our partnership working and stakeholder engagement gives us considerable strategic input into the shaping of services, ensuring that the experiences of patients and the public are not only heard, but are influencing decisions and improving health and social care in the borough.

We represent residents on a number of multi-stakeholder, provider and commissioner groups in the borough, making the most of these opportunities to use local feedback to inform and influence service change. Initiatives covered by these groups include integrated care, Better Care Fund and Access to London Ambulance Service, GPs, Urgent Care Centre and Accident and Emergency.

Turning complaints into action

Our work with VoiceAbility, the NHS Complaints Advocacy service, alerted us to the potential for using complaints data more effectively to influence care quality. We piloted a series of regular meetings with VoiceAbility to identify mutual concerns based on complaints and our own local intelligence. Joint work is ongoing to turn these insights into recommendations for service improvement, and our

relationship with VoiceAbility is stronger as a result.

"Healthwatch Hillingdon remains one of the CCG's key strategic partners"

Ceri Jacob, Chief Operating Officer, NHS Hillingdon CCG

Joint co-commissioning of GP services

We feel one important issue should be highlighted that needed more input from local Healthwatch. The development of joint co-commissioning of GP services was one of biggest changes to NHS commissioning processes during 2014. There are widely accepted benefits to this change, but questions remain about the risks. These arise mainly from actual or perceived conflicts of interest arising because local Clinical Commissioning Groups (led by independent GP contractors) will be able to buy NHS services from themselves as independent, private providers.

We believe that NHS England could do more to address this issue. Although the local Healthwatch network had an opportunity to share their views with NHS England, it was disappointing that these discussions occurred near the end of the implementation process. We will continue to monitor and engage with the development of the new commissioning arrangements, and do our utmost to ensure that the needs and views of local people are reflected in any proposed plans.

Working with the Care Quality Commission and Healthwatch England

Healthwatch Hillingdon did not make any formal recommendations to the Care Quality Commission (CQC) in 2014/15 to undertake special reviews – either via Healthwatch England or directly.

Healthwatch Hillingdon values our growing relationship with the CQC. We have shared the feedback we have gathered with the CQC prior to their inspections of local GP practises, The Hillingdon Hospitals NHS Trust and Central North West London NHS Foundation Trust (CNWL). As well as submitting a large volume of feedback, we also publicised and attended listening events prior to the inspections and took part in Quality Summit meetings when the reports were published (for the NHS Trusts).

We have also passed on intelligence and patient feedback to the CQC on other local health and social care providers in the London Borough of Hillingdon, including identifying potential providers not registered with the CQC. Regular meetings with our local CQC team are also a valuable opportunity to discuss areas of mutual interest. We look forward to strengthening our relationship with the CQC during 2015/16.

We continued to develop our strong relationship with Healthwatch England and regularly shared relevant local information with them, including our contribution to their Unsafe Discharge Special Enquiry. We have a particularly strong relationship with Healthwatch England's London Development and Policy teams, and value the contributions they make to our work. Our regular attendance at the London Healthwatch Network meetings provides a

valuable opportunity to share intelligence and good practice with others in the London Healthwatch network.

Responses to requests for information

The stakeholder statements in this report are testimony to the strength of our relationships with local commissioners and major providers, and the value they place on us as a trusted 'critical friend'. This appreciation of our role helped to facilitate satisfactory responses to our information requests. On occasions where the initial response was inadequate, strong working links helped to resolve any issues quickly. We therefore had no cause to resort to the formal Freedom of Information route. The success of the cooperative approach, however, was no doubt encouraged by making partners aware that we have this tool at our disposal.

Healthwatch Hillingdon has continued to champion full public openness and transparency from all statutory partners as recommended in the Francis Report. This change requires a culture shift in the system, but we are seeing positive signs of this in the NHS. There is still room for improvement and we look forward to working with local health and social care partners to drive this forward.

Impact stories

Case study one

Exposing the need for change when services fail

Angela Kelley was convinced that her mother had been neglected in a Hillingdon nursing home. But her quest to discover the truth would run for three years before she was finally vindicated.

An independent judgement by the Local Government Ombudsman (LGO) and Parliamentary & Health Service Ombudsman finally revealed the failings of the many organisations involved. The findings highlighted the unnecessary delays faced by complainants and the lack of support for individuals when faced with large organisations.

Angela Kelley

Healthwatch Hillingdon supported Angela in the latter stages of her campaign. The case shows the role that local Healthwatch organisations can play in highlighting the lessons to be learned from bad practice. We reported Angela's shocking experience to Healthwatch England. Our work with Healthwatch England saw the story featured in the national and local media. Healthwatch England's CEO, Dr Katherine Rake, also used this case as part of evidence submitted to the Public Administration Select Committee to highlight the need for improvements to the complaints system and the impact on families when it fails.

"As the complainant, the odds are stacked against you. You're up against the professionals."

"I wish I had known of Healthwatch Hillingdon when my complaint was ongoing. I am glad they are there now for other people."

We will continue to work with both the local NHS and social services to ensure that lessons are learnt from the LGO judgement and that complaints about the care people receive meet the key principles set out in Healthwatch England's report "*My expectations for raising concerns and complaints*" (2014).

Case study two

A new perinatal service for Hillingdon

Healthwatch Hillingdon has continued to support the Hillingdon Maternity Services Liaison Committee (MSLC), the group which oversees the quality of maternity services in the borough. Based on the feedback we collected from women using maternity services, we highlighted the lack of a perinatal mental health services for local women.

The future is bright - a new service for mothers and children

We worked with the MSLC to alert commissioners to this service gap. The NHS Hillingdon Clinical Care Commissioning Group (CCG) accepted this need, and agreed to fund an intermediate perinatal service at Hillingdon Hospital. This service went live in December 2014, and we anticipate that this service model will be fully developed on a more permanent basis.

This has been a great achievement for both Healthwatch Hillingdon and NHS Hillingdon CCG. We are among the first regions in London to commission a dedicated perinatal service. The additional support during and following childbirth will be a huge benefit to Hillingdon mothers. We will continue to support the development of this service across North West London so that it meets NICE national guidelines.

Stakeholder statements

Central and North West London NHS Foundation Trust (CNWL)

Maria O'Brien, Divisional Director of Operations

"CNWL continued to build a mature and constructive relationship with Healthwatch Hillingdon in 2014/15. We seek regular feedback from our service users to help shape our services and improve quality. The feedback we receive from Healthwatch Hillingdon is an important component of this.

As a Trust we embrace a model of co-production with our patients and their carers. We look to Healthwatch Hillingdon to help us achieve this, whether this involves informing our Trust-wide quality priorities or helping redesigning services at a local borough level.

There are regular meetings in place between Healthwatch senior officers and the CNWL Borough Director and Divisional Director of Operations. We recognise the valuable contribution of our local Healthwatch as the voice for our service users and as a critical friend to the organisation to drive improvements. We welcome their visits to our sites and value their regular feedback - dialogue between us is open and transparent, enabling early intervention to address any concerns.

Healthwatch Hillingdon has worked with the Trust on a variety of issues. We thank them for their contribution in 2014/15, including informing our model for redesigning our community mental health services and CAMHS commissioning, and their proactive membership of the Hillingdon in-patient PLACE inspection teams.

We look forward to working with Healthwatch Hillingdon in 2015/16 and the continuation of their challenge function that has become such an important part of our drive for continuous improvement."

NHS Hillingdon Clinical Commissioning Group (CCG)

Ceri Jacob, Chief Operating Officer

"Healthwatch Hillingdon remains one of the CCG's key strategic partners. They play a full part on many of our committees and our Governing Body, contributing to discussions on priorities within the CCG and key strategic plans. Healthwatch Hillingdon is also a member of our Conflict of Interest

Panel, working with us to manage potential conflicts of interest arising from Primary Care Co-Commissioning robustly and transparently.

In addition to input at a strategic level, Healthwatch Hillingdon provides a valuable link to our local population. Local concerns and compliments are shared with the CCG on an ongoing basis, supporting service redesign and evaluation. In the past year this has included work with children and young people accessing local Child and Adolescent Mental Health services (CAMHS) and meeting with our emerging GP Networks to raise awareness of patient engagement at a network level.

Hillingdon CCG looks forward to continuing this constructive dialogue in the coming year."

NHS Hillingdon Clinical Commissioning Group

The Hillingdon Hospitals NHS Foundation Trust

Shane Degaris, Chief Executive Officer

"The Trust has continued to work in close partnership with Healthwatch Hillingdon and appreciates the valuable contribution they provide to the organisation. Representatives from Healthwatch Hillingdon have regularly attended focus groups and committees and have attended meetings of the Trust Board, Council of Governors and People in Partnership.

This year the Trust has worked closely with Healthwatch Hillingdon on the consultation for the priorities for the quality report, PLACE inspections and follow up action. Healthwatch Hillingdon and Healthwatch Ealing attend a quarterly quality meeting, to check progress and gain insights into how the Trust is performing against a number of quality indicators. The Trust has benefitted from the involvement of Healthwatch Hillingdon in Executive appointments at the Trust.

The Trust has provided facilities on a regular basis at both Hillingdon and Mount Vernon Hospital to enable Healthwatch Hillingdon to speak to and capture feedback from patients and the public about their experiences.

Healthwatch Hillingdon has direct access to the Chief Executive and meets bi-monthly with the Chief Executive and Director of Nursing to provide feedback from patients and local residents who are in receipt of services provided by the Trust."

Our plans for 2015/16

Our plans for 2015/16 will reflect Healthwatch Hillingdon's aims and values.

Our aim

Our aim is to become the influential and effective voice of the public. We want to give adults, young people, children and communities a greater say in - and the power to challenge - how health and social care services are experienced in Hillingdon.

Our values - we are:

Inclusive - we work for everyone in the community including the seldom heard and those not able to speak up for themselves.

Influential - we listen to residents and set our agenda on what we hear and use innovation and creativity to secure change.

Independent - we are independent and act only on the behalf of consumers, we challenge those in power to improve services and will speak loudly to highlight failures if necessary.

Credible - we rely on and value evidence and objective data so that we can challenge effectively.

Collaborative - we learn from people's experiences and work positively and in partnership with people, the health and social care sector and the voluntary and community sector in order to get things done.

Opportunities and challenges for the future

Healthwatch Hillingdon is currently finalising a two-year work plan which will provide the framework for our priorities up to March 2017. There are a number of work streams that were not fully completed in 2014/15 which form our early priorities for 2015. These include:

- the oversight and challenge of the Shaping a Healthier Future Programme (especially maternity)
- access to GP surgeries
- the Better Care Fund
- The Care Act
- Primary Care Co-commissioning
- the quality and safety of Health & Social Care Services.

We will also gather the views and experiences of Hillingdon residents on:

- home care
- care homes
- maternity
- discharge from hospital.

We have identified a group of new work streams that will start in late 2015 or early 2016. These will include:

- accident and emergency
- ‘Like Minded’ - an initiative to transform adult mental health across North West London
- Improvement in Children and Adolescent Mental Health Services – one year on
- primary care services
- the impact of the Prime Minister’s Challenge Fund to increase access to GP surgeries.

Our governance and decision-making

Our board

- Jeff Maslen, Chairman
- Stephen Otter, Vice Chair
- Allen Bergson
- Richard Eason
- Turkay Mahmoud
- Baj Mathur
- Kay Ollivierre
- Rashmi Varma
- Martin McElreavey (resigned 13th February 2015)
- Edlynn Zakers (resigned 31st March 2015)

How we involve lay people and volunteers

Healthwatch Hillingdon is governed by a Board of Trustees that consists entirely of lay people and volunteers. Selection and recruitment to our Board is through an open and transparent recruitment process. Meetings of our governing Board are held in public and agendas, minutes and reports of our meetings are routinely published on our website and additionally are freely available upon request.

We continue to encourage members of the local community to attend our Board meetings and provide opportunities for them to question the Board or bring our attention to any relevant issues. We have published our 'Relevant Decision Making Policy' on our website, setting out how the Healthwatch Hillingdon Board makes relevant decisions. This policy is reviewed annually to ensure that the decisions taken by Healthwatch Hillingdon follow national best practice and reflect any guidance from Healthwatch England.

"Healthwatch Hillingdon gives me the opportunity to make a real contribution towards the standard of care for members of the community, often at a time when they are at their most vulnerable. Working as a Patient Assessor has been both educational and enjoyable. It is particularly rewarding to know that Healthwatch Hillingdon can use the experiences and concerns of patients and the public to suggest improvements to services."

Healthwatch Hillingdon volunteer

Financial information

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	175,000
Additional income	100
Brought forward from 2013/14	14,441
Total income	189,541

EXPENDITURE	
Office costs	8,392
Staffing costs	133,612
Direct delivery costs	31,068
Total expenditure	173,072
Balance brought forward	16,469

Contact us

Get in touch

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Uxbridge
UB8 1LN

Key staff:

Graham Hawkes
Chief Executive Officer

Dr Tarlochan Grewal (Raj)
Operations Co-ordinator

Nina Earl
Community Engagement Officer

Pat Maher
Administration & Support Officer

Victoria Silver
Engagement Officer Children & Young People

Phone number: 01895 272997

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Website URL: www.healthwatchhillingdon.org.uk

Company Number: 8445068 | Registered Charity Number: 1152553

We will be making this annual report publicly available by 30th June 2015 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

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EXTERNAL SERVICES SCRUTINY COMMITTEE - UPDATE ON THE IMPLEMENTATION OF RECOMMENDATIONS FROM THE POLICING AND MENTAL HEALTH REVIEW

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

REASON FOR ITEM

To ensure that the Committee monitors the progress of recommendations made through its reviews as agreed by Cabinet.

OPTIONS OPEN TO THE COMMITTEE

- To note the progress provided.
- To consider the developments and progress to date.
- To make comments and / or request further information.

INFORMATION

The attached paper provides a brief summary of progress with regard to the recommendations agreed by Cabinet at its meeting on 23 April 2015 in relation to the Policing and Mental Health review. This information has been kindly provided by Councillor Philip Corthorne.

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Policing and Mental Health	Recommendations	Updates
	RECOMMENDATION 1a –That the Cabinet utilises the requirement of the Care Act, to improve information to users of health, social care and wellbeing services to better signpost mental health services to residents including those available from partner agencies.	
	RECOMMENDATION 1b – That Cabinet endorses the TeleCareLine Service for use by those with mental ill health and requires further promotion be given to how the service can support those with mental ill health. This builds on the successful promotion of the service to residents with a learning difficulty and will support the ethos of reducing the demand on future social care services.	
	RECOMMENDATION 2 – That Cabinet welcomes that Hillingdon Council is one of the first Local Authorities in the United Kingdom to sign up to the Crisis Care Concordat and requires the London Mental Health Crisis Commissioning Guide to be used by the Council and its partners to ensure services meet the needs of Hillingdon residents.	
	RECOMMENDATION 3 – That Cabinet requests that the Health and Wellbeing Board asks the CCG for an update in relation to how it is responding to the London Mental Health Crisis Commissioning Guide and how existing community services will be utilised to develop clear care pathways for people in, or at risk of, mental health crisis.	There are 11 elements of the London MH Crisis Commissioning Guidance (see below) which require collaboration across all partners to implement improvement. This is overseen by the NWL Mental Health and Wellbeing Board work programme, where engagement is required across London (e.g., Interface with Ministry of Justice , London Transport, Metropolitan Police). Locally, responding to London Mental Health Crisis Commissioning Guidance has been agreed as a key priority for 2015/16 by LBH and HCCG, to build on improvements in 2014/15, and address finding in the refreshed Mental Health needs Assessment (December 2014). This priority was also discussed at Social Services, Housing and Public Health Policy Overview Committee in March 2015. Specific progress to date includes: • Development of a pilot crisis telephone help line by CNWL (on the Trust website and 111

		Directory) for all Hillingdon residents, and development of a draft business case for roll out from July 2015. • Development of crisis cards with information about who to contact for current service users. • Training events for GPs on urgent care MH pathways, and development of a direct access phone line to a consultant psychiatrist for GPs. • Urgent care standards for GP referral agreed by all commissioners and providers. • MH discharge lounge in A&E piloted over the 2014/15 winter period – currently being evaluated to inform a business case for development by July 2015 • On site psychiatric liaison service commissioned and fully operational 24/7 at Hillingdon hospital. • Work commenced by LBH to review MHA assessments and AMPHs. • Section 136 protocols developed. • New out of hours 24/7 CAMHS service commissioned. Planned developments – an urgent care pathway is under development for 2015/16. Key features will include single point of access to CNWL services for people in crisis across NWL, and development of crisis pathways. Two local co-production events have been held which were attended by the Local Authority, CCG, MIND, Healthwatch, Service Users, Carers and Staff. The outcome of these meetings has been agreement to propose implementation of a single point of entry (SPA) into Hillingdon Mental Health Services for all referrals. This service will offer a triage and signposting response to all adult mental health services as well as the urgent advice line 365/24 hours and will be available for GPs, Police, Local Authority and other partners to contact for information, advice or referral. Further work is underway to review needs of under-served communities, the outcome of which will inform urgent care pathways in Hillingdon. Urgent care plans for Hillingdon will also require partners to adopt a holistic approach to address crisis pathways including timely assessment by AMPs, emergency housing and effective care planning **QUESTION:** Is the crisis help line for new or existing residents? **ANSWER:** The crisis line is open to all residents and is on the trust website and 111 Directory.

		QUESTION: What are the urgent care standards for GP referrals and is this the same for practitioners from the local authority and police referring into secondary care? Are they standards or performance targets set in the contract? **ANSWER:** The Trust, with commissioners, has developed standards outlining the definition of urgent, routine and routine plus for GP referral only, and these have been adopted as part of the urgent care concordat. These standards are part of CNWL contract. The response times for assessment are monitored in the 2014/5 contract as: emergency within 4 hours; urgent within 24 hours; and routine within 4 weeks. However, there is no target as it was part of the CQUIN. The Trust has regular meetings with the Police and has met specifically with the Police from Heathrow. **QUESTION:** How successful has the psychiatric liaison service been in reducing the number of beds required, particularly in a crisis? **ANSWER:** The psychiatric liaison service has not reduced the number of beds required but has assisted bed management and reduced the overall pressures and waiting in Accident and Emergency to access a bed. Linked to the psychiatric liaison service, CNWL piloted a discharge lounge over the winter which saved approximately 16 admissions and this is currently being more fully evaluated. **QUESTION:** Have the section 136 protocols been rolled out in Hillingdon and how have the Police on the Heathrow site been involved? **ANSWER:** This information would best be obtained via the LBH mental health commissioner, who would have the most up to date information about 136 suite activity via the Hillingdon social work team. **QUESTION:** How effective were the MH training events for the GPs? Was the aim to encourage patients to be supported in primary care as long as possible or better understanding of the pathway into secondary care? What was the feedback from the GPs? **ANSWER:** The first workshop was attended by approximately 60 people and focused on supporting people in primary care as long as possible and urgent care pathways to secondary care. A second workshop is planned (rescheduled from March). Feedback was very positive. There has also been a programme of training for practice managers (mental health first aid training delivered by MIND) which has 100% positive feedback.

		QUESTION: How has the 24/7 out of hours CAMHS service changed the patient experience at the hospital? **ANSWER:** It is a bit too soon to say but the service was developed following extensive engagement with service users.
	RECOMMENDATION 4a – That Cabinet endorses the Community Risk MARAC which is to be provided by Hillingdon Metropolitan Police and the Council's Anti Social Behaviour and Community Safety Team to better support residents with mental ill health.	
	RECOMMENDATION 4b – That Cabinet commends the improvements in service by the Hillingdon Metropolitan Police Service when dealing with people in a mental health crisis and notes that no persons were detained in a police cell in this Borough under Section 136 in 2014.	
	RECOMMENDATION 5 – That the Cabinet Member for Social Services, Health and Housing asks the CCG to review the provision of safe transport to enable individuals with mental health issues to be transported to a place of safety in a safe, timely and dignified way and report back to the Cabinet Member and External Service Scrutiny Committee.	A piece of work has been commissioned in partnership with all North West London CCGs looking into the issues around safe transportation of mental health service including out of hours. This was initiated to improve a person's experiences of being under a Mental Health Act section, and enhance the way in which multi agencies collaborate and respond to a person in an urgent mental health crisis; when the individual has been detained and/or requires conveyance to an Accident and Emergency department. Draft Multi agency protocols for section 136 and urgent conveyancing have now been developed (March 2015), with a supporting action plan to support finalisation of the content and next steps required to implement 24/7/365 NWL-wide Section 136 in line with the Concordat, Community and Secondary Setting Access Standards and the NICE Quality Standard 14 (Ensuring the use of Emergency Departments only where this is consistent with concerns about urgent healthcare requirements and, the use of Police Stations, only in exceptional circumstances and where it is medically safe to do so). Locally these standards will inform commissioning of wider mental health and well-being pathways across the whole system including, for example, single points of entry into secondary care, social care provision and liaison

		psychiatry services. This work will be overseen by the Hillingdon Mental Health Transformation Group. Background Information: London Mental Health Crisis Commissioning Guide Summary 1. Crisis telephone helplines 2. Self-referral 3. GP support and shared learning 4. Emergency departments should have a dedicated area for mental health assessments 5. which reflects the needs of people experiencing a mental health crisis 6. People should expect all emergency departments to have access to on-site liaison psychiatry services 24 hours a day, 7 days a week, 365 days a year 7. Mental Health Act Assessments and AMHPs 8. Police and mental health providers should follow the London Mental Health Partnership Board section 136 Protocol and adhere to the pan London section 136 standards 9. Commissioners should ensure that crisis and recovery houses are in place as a standard component of the acute crisis care pathway and people should be offered access to these as an alternative to admission or when home treatment is not appropriate 10. People should expect that mental health provider organisations provide crisis and home treatment teams, which are accessible and available 24 hours a day, 7 days a week, 365 days a year 11. All people under the care of secondary mental health services and subject to the Care 12. Programme Approach (CPA) and people who have required crisis support in the past should have a documented crisis plan 13. Services should adopt a holistic approach to the management of people presenting in crisis. This includes consideration of possible socioeconomic factors such as housing, relationships, employment and benefits

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EXTERNAL SERVICES SCRUTINY COMMITTEE - WORK PROGRAMME 2015/2016

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

REASON FOR ITEM

To enable the Committee to plan and track the progress of its work in accordance with good project management practice.

OPTIONS OPEN TO THE COMMITTEE

Members may add, delete or amend future items included on the Work Programme. The Committee may also make suggestions about future issues for consideration at its meetings.

INFORMATION

1. The Committee's meetings tend to start at either 5pm or 6pm and the witnesses attending each of the meetings are generally representatives from external organisations, some of whom travel from outside of the Borough. The meeting dates for the remainder of the municipal year are as follows:

Meetings	Room
Thursday 17 September 2015 - 6pm	CR6
Thursday 8 October 2015 - 6pm	CR3 & CR3a
Tuesday 17 November 2015 - 6pm	CR6
Tuesday 12 January 2016 - 6pm	CR6
Tuesday 16 February 2016 - 6pm	CR3 & CR3a
Tuesday 15 March 2016 - 6pm	CR5
Tuesday 26 April 2016 - 6pm	CR5

Scrutiny Reviews

2. At its meeting on 17 June 2015, the External Services Scrutiny Committee agreed that its first major review would be in relation to alcohol related presentations at Accident and Emergency amongst children and young people in Hillingdon. This review will be undertaken by a 'task and finish' Working Group. The Members for this Working Group are yet to be determined.

Future Topics

3. Also at its last meeting, the Committee made the following suggestions for possible future single meeting or major review topics and update reports:
    - Female genital mutilation (FGM)
    - Child Sexual Exploitation (CSE)
    - Probation Service
    - frequent callers (links between the police, health services and Council services)
    - Drug treatment and substance misuse update

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APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2015/2016 WORK PROGRAMME

NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.

Shading indicates completed meetings

Meeting Date	Agenda Item
17 June 2015	**Major Review**: Consideration of a scoping report and the formulation of a Working Group to undertake a major review on behalf of the Committee
14 July 2015	**Health** Performance updates and updates on significant issues: • The Hillingdon Hospitals NHS Foundation Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • The London Ambulance Service NHS Trust • Local Medical Committee • Local Dental Committee • Public Health • Hillingdon Clinical Commissioning Group • Care Quality Commission (CQC) • Healthwatch Hillingdon **Update on the implementation of recommendations from previous scrutiny review:** • Policing and Mental Health
17 September 2015	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: • London Borough of Hillingdon • Metropolitan Police Service (MPS) • Safer Neighbourhoods Team (SNT) • London Fire Brigade • London Probation Area • British Transport Police • Hillingdon Clinical Commissioning Group (CCG) • Public Health
8 October 2015	**Prevent** Update on counter terrorism work being undertaken in the Borough.

Meeting Date	Agenda Item
17 November 2015	**Health** Performance updates and updates on significant issues: • The Hillingdon Hospitals NHS Foundation Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • The London Ambulance Service NHS Trust • Local Medical Committee • Local Dental Committee • Public Health • Hillingdon Clinical Commissioning Group • Care Quality Commission (CQC) • Healthwatch Hillingdon **Major Review:** Consideration of final report from Policing and Mental Health Working Group
12 January 2016	
16 February 2016	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: • London Borough of Hillingdon • Metropolitan Police Service (MPS) • Safer Neighbourhoods Team (SNT) • London Fire Brigade • London Probation Area • British Transport Police • Hillingdon Clinical Commissioning Group (CCG) • Public Health **Update on the implementation of recommendations from previous scrutiny reviews:** • Policing and Mental Health • Child Sexual Exploitation • Family Law Reforms
15 March 2016	

Meeting Date	Agenda Item
26 April 2016	**Quality Account Reports & CQC Evidence Gathering** To receive presentations from the local Trusts on their Quality Account 2014/2015 reports and to gather evidence for submission to the CQC: • The Hillingdon Hospitals NHS Foundation Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • The London Ambulance Service NHS Trust • Hillingdon Clinical Commissioning Group • Care Quality Commission (CQC) • Healthwatch Hillingdon • Local Medical Committee • Local Dental Committee • Public Health
TBA	**CQC Inspection of London Ambulance Service NHS Trust** To review the findings of the CQC report in relation to its inspection of LAS that was undertaken in June 2015
Possible future single meeting or major review topics and update reports	• Female genital mutilation (FGM) • Child Sexual Exploitation (CSE) • Probation Service • frequent callers (links between the police, health services and Council services) • Drug treatment and substance misuse update

MAJOR SCRUTINY REVIEW BY WORKING GROUP

Members of the Working Group:

- Councillors TBA

Topic: Alcohol related presentations at Accident and Emergency amongst children and young people in Hillingdon

Meeting	Action	Purpose / Outcome
ESSC: 17 June 2015	Agree Scoping Report	Information and analysis
Working Group: 1st Meeting - Time / Date / Room TBC	Introductory Report / Witness Session 1	Evidence and enquiry
Working Group: 2nd Meeting - Time / Date / Room TBC	Witness Session 2	Evidence and enquiry
Working Group: 3rd Meeting - Time / Date / Room TBC	Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: 17 November 2015	Consider Draft Final Report	Agree recommendations and final draft report
Cabinet: 17 December 2015	Consider Final Report	Agree recommendations and final report

Additional stakeholder events, one-to-one meetings and site visits can also be set up to glean further information.