Central and North West London NHS Foundation Trust

Quality Report

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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

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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

Summary of findings

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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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.

Summary of findings

- 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

Summary of findings

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

Summary of findings

- 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.

Are services responsive to people's needs?

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

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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

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- 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.