NHS
Health Education England

Central and North West London NHS Foundation Trust

Core Psychiatry Training and General Psychiatry

Risk-based review (senior leader conversation)

Quality Review report

13 June 2019

Final

Developing people for health and healthcare

www.hee.nhs.uk

THE NHS CONSTITUTION
the NHS belongs to us all

Quality Review details

Training programme	Core psychiatry training and general psychiatry
Background to review	This review was planned following the trainee focus groups held on 22 November 2018 and the senior leader conversation (SLC) on 29 January 2019. At the SLC in January, it was agreed that the Trust would submit proposals to the Postgraduate Dean for quality improvement projects for a clinical fellow post to be funded by HEE. It was also agreed that the Trust would work to ensure appropriate supervision for trainees in psychotherapy. In March and April 2019 several trainees raised concerns around staff safety at the Park Royal Centre for Mental Health and The Gordon Hospital and there was an incident where a trainee was assaulted by a patient, as well as a near miss incident involving a trainee. The Trust liaised with the Head of School and the Deputy Postgraduate Dean (DPGD) regarding the responses to these events and progress in addressing the safety issues raised.
HEE quality review team	Orla Lacey Deputy Postgraduate Dean, North West London Health Education England Vivienne Curtis Head of the London Specialty School of Psychiatry Health Education England Samara Morgan Principal Education QA Programme Manager Visits and Monitoring Team, General Medical Council Louise Brooker Learning Environment Quality Coordinator Health Education England, London Paul Smollen Deputy Head, Quality, Patient Safety and Commissioning Health Education England, London
Trust attendees	The review team met with the following Trust representatives: • Chief Executive Officer • Medical Director • Director of Medical Education • Deputy Director of Medical Education • Head of Medical Education.

Conversation details

	Summary of discussions	Action to be taken? Y/N
1	**Response to safety incidents** On 1 March 2019 a trainee working at the Gordon Hospital was stabbed by a patient on an acute inpatient ward. The trainee sustained non-life altering injuries and had returned to work at the Trust, electing to move to an elder care ward with the support of the Trust management and postgraduate medical education (PGME) team. The Medical Director (MD) advised that the site had been closed to admissions for two weeks immediately following the incident and that the inpatient bed base had been reduced from 19 to 16 beds per ward to reduce pressure on the staff and help manage patient acuity. The incident investigation found that the ward nurses required further training around clinical skills, ward management and multidisciplinary working. A two-week development programme was rolled out to the ward nurses as well as the nursing supervisors and ward managers, which the Chief Executive Officer (CEO) reported was very well-received. Another issue identified during the investigation was a lack of clarity and confidence among staff about the physical search policy, as the patient had been able to bring a knife onto the ward undetected. During meetings with staff following the incident, the MD advised that doctors and nurses at all levels had requested more security guards and routine patient searches. However, the Trust management did not believe this approach was practical or conducive to a good therapeutic environment. The CEO noted that the Care Quality Commission (CQC) also opposed the implementation of a universal search policy. The review team heard that all patients were searched on admission but not on return from leaving the ward. This presented a particular challenge at the Gordon Hospital, as there was no outdoor area within the hospital campus so patients taking leave from the wards went out into the streets. The CEO was in discussion with other executives from the Cavendish group of Trusts regarding the changing patient profiles within London mental health services, increasing acuity and appropriate responses in terms of ward management and security measures. The CEO reported that the Directors of Nursing at the Cavendish group Trusts were working to develop a consistent and robust search policy and reviewing the use of other security measures such as metal detectors, close circuit television cameras and body worn cameras for staff. The Trust already had metal detector gates at the entrance to the adolescent unit and staff in other units had metal detector wands. The MD suggested that staff were sometimes reluctant to use the wands or to conduct admission searches. The Trust aimed to ensure that all security procedures were evidence-based and that staff were confident to use them.	Yes, please see action PSLC1
2	**Section 136 suites** The review team heard that the section 136 suite at the Gordon Hospital remained closed and that the suite at the Park Royal Centre for Mental Health had been closed temporarily following a near miss when a patient became violent, forced entry and set fire to the staff office. The nurses and trainee involved had left the office through a second door and were unharmed, but the MD advised that the suite was to remain	

	closed pending discussions with medical and nursing staff about safety measures. The section 136 suite at St Charles' Hospital had also been temporarily closed after a patient had assaulted staff and damaged all three rooms. Trainees were present during this incident but were unharmed. One room was due to be reopened but the others required further repairs. The CEO was involved in pan-London work to establish an optimal model for section 136 suite provision but was aware that there was particular sensitivity and concern around staff safety given the recent incidents at the Trust and at other hospitals in London. The MD and CEO advised that the Trust was not an outlier in terms of safety issues or incidents, although the Head of School noted that there were comparatively high numbers of trainees raising concerns and contacting the Specialty School and HEE. The CEO suggested that some work was required to ensure trainees had realistic expectations around patient behaviours and safety considerations when working in a section 136 suite or other acute environment.	
3	**Inpatient wards** The MD outlined plans to increase the number of beds on the wards at the Gordon Hospital from 16 to 17. The bed numbers had been reduced from 19 to 16 following the incident in March and the CEO advised that daily safety huddles had been introduced to improve multidisciplinary team communication and ensure that safety concerns were escalated. The Trust had maintained the existing ward staffing establishment when the bed base was reduced and the review team heard that there were no plans to alter staffing levels in future. The CEO reported that the bed numbers and staffing ratios had been agreed based on experience within the Trust, national benchmarking and guidance from the Royal College of Psychiatrists balanced with patient need and affordability. The Trust was also considering alternative workforce strategies and employed nursing associates on some wards with the aim of improving patient experience and allowing more time for non-clinical care. It was acknowledged that the physical environments on some wards were not ideal but the reduction in bed numbers at the Gordon Hospital had allowed some of the less suitable inpatient rooms to be repurposed. There was a common room for trainees at the Gordon Hospital but this was located on a different floor from the inpatient wards and it was suggested that trainees may be using it as an office. A doctors' office and a common room were being built at the Park Royal Centre for Mental Health. The doctors' office was close to the ward and it was hoped that this would increase and engagement between the medical and nursing teams. The Head of School noted that trainees had raised concerns around patients being admitted to acute wards instead of psychiatric intensive care units (PICUs) and a lack of clarity around referral criteria for these patients. The CEO acknowledged that patient profiles were changing and that there were larger discussions within the NHS regarding the increased need for PICU care and the changing boundaries between acute and intensive psychiatric care. The MD reported that the Trust had introduced a bed management tool at the Gordon Hospital to assist with triaging patients in response to these concerns. The CEO advised that the Trust had recently undergone a CQC visit and that this had also highlighted issues around acute admissions.	
4	**Psychotherapy and Balint Groups**	

	The Head of School enquired about the provision of medical psychotherapy training, particularly in the Brent area where there was no substantive consultant in post to supervise the trainees. The Director of Medical Education (DME) reported that a medical psychotherapy consultant was due to start in September 2019 and would provide supervision for trainees' long psychotherapy cases as well as for the Balint group. There was no consultant in place for August although interim cover had been arranged for June and July.	Yes, please see action PSLC4
5	**IT** The Deputy DME (DDME) advised that all trainees were allocated logins to the pathology results system at induction and that a reference guide was being finalised to ensure trainees knew how to resolve access issues and who to contact out of hours if they required assistance. The system provider planned to link the Trust pathology results system with those of other Trusts across north west London to enable staff to access more complete patient records. The DDME noted that there were still some sites, such as St Charles' Hospital, where trainees had to call the laboratory to obtain results, but that results were no longer being sent by fax.	
6	**Alarms** The review team heard that there were sufficient alarms for all staff at each site and that the systems were checked weekly. The Trust had purchased new alarms which alerted the user when the battery needed charging and the CEO advised that staff had been informed of their responsibilities for checking and charging the alarms. The next planned steps were to ensure systems and support were in place for maintaining the alarms and check that processes for checking alarm function were followed.	

Next steps

Conclusion
The review team thanked the Trust representatives for their time and cooperation with the review and continued work with HEE to improve training provision. The review lead advised that the team would feed back to the Postgraduate Dean and would discuss some of the issues raised around safety, section 136 suites and acute inpatient care with other NHS bodies at the Quality Surveillance Group meeting on 19 June 2019. It was agreed that HEE would continue to liaise with the Trust and to monitor feedback from trainees, training programme directors and other NHS arms' length bodies. A further senior leader conversation will be planned for October 2019.

Requirements / Recommendations

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
PSL C1.0	The Trust should provide updates on the progress around this issue and share the final search policy with HEE when available.	Please provide an update regarding the development of the policy. Please provide a copy of the final policy when available.	R1.2
PSL C4.0	The Trust should provide further detail around the planned provision of psychotherapy training in the Brent area.	Please provide details of the arrangements for medical psychotherapy provision to be in place from September 2019. Please present this information at the follow-up review to be organised in October 2019 (see Other Actions section below).	R1.7

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
	None		

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE will discuss the issues raised around safety and the provision of acute inpatient care with other members of the Quality Surveillance Group for north west London.	Postgraduate Dean/Deputy Postgraduate Dean
A follow-up senior leader conversation will be planned for October 2019.	HEE Quality, Reviews and Intelligence team

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Orla Lacey
Date:	19 August 2019

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.