Healthcare Commission

Summary of the intervention at South West London and St George's Mental Health NHS Trust

January 2009

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision-making, and consultative about our processes.

Introduction

In July 2008, the Healthcare Commission was alerted to serious concerns about the care provided to patients at South West London and St George's Mental Health NHS Trust ("the trust"). The concerns related to the John Meyer Ward at Springfield University Hospital in Tooting and the Laurel Ward at Queen Mary's Hospital in Roehampton, and specifically were about the cleanliness of the wards and the lack of engagement between staff and people using the service. We then received concerns of a similar nature regarding the Lavender Ward at Queen Mary's Hospital.

Our investigations team had previously made recommendations to the trust following concerns about the care of patients at the trust, mainly at the Springfield site.

The investigations team decided to undertake a short notice visit to these three wards. A representative from the Mental Health Act Commission accompanied the Healthcare Commission on the visit, which took place in August 2008.

Investigating serious failings in healthcare

The Healthcare Commission is empowered by section 52(1) of the Health and Social Care (Community Health and Standards) Act 2003 to conduct investigations into the provision of healthcare by, or for, an English NHS body. As part of this function we undertake 'interventions' when this is considered to be the most proportionate and practical means of identifying the need for, and bringing about, sustainable improvements in the service concerned.

We aim to help organisations to improve the quality of care that they provide, to build or restore public confidence in healthcare services, and to ensure that the care provided to patients is safe throughout the NHS.

Our approach

We considered that an intervention was appropriate in this case as the most effective way of ensuring that patients were safe and that lessons could be learnt as swiftly as possible.

The intervention by the Commission's investigation team has considered:

- The action taken by the trust in response to known concerns.
- The physical environment provided for patients within the trust.
- The quality of care provided to patients.

- The way in which staff at the trust engage with patients and the quality of that engagement.
- Improvements made by the trust following previous recommendations made by the Healthcare Commission.

The London Strategic Health Authority was informed of the concerns, in line with our standard procedures, and was kept up-to-date with our progress throughout the intervention.

We worked with the trust to establish the extent of the concerns and to make recommendations for improvement where appropriate. As part of this process, we called for documents from the trust for review, and spoke with staff and patients on the three wards that we visited. The investigation team included a representative from the Mental Health Act Commission, who provided advice and guidance throughout the intervention process. We also gained advice from a clinical advisor where appropriate.

As a result of our findings, we have made seven specific recommendations to the trust. The recommendations and the rationale leading to them are set out in this report.

Background

The trust serves a local population of approximately one million people across five London boroughs.

From the mid-1980s, Springfield Hospital, now the trust's headquarters, served only people from Wandsworth and Merton. Today, the trust operates from 100 locations and is responsible for providing complete mental health and social care services to the communities of Kingston, Merton, Richmond, Sutton and Wandsworth, as well as more specialist services to people throughout the UK. It employs approximately 2,700 staff and has an annual budget of £170 million.

The trust provides a diverse range of mental health facilities. They work in partnership with colleagues in primary care, local authorities and the non-statutory sector to promote mental health, supporting those with mental health needs and their families and providing care and treatment.

The three wards we visited were:

John Meyer Ward
The John Meyer Ward is situated within Springfield University Hospital in Tooting. It is a male-only ward, with bed space for up to 10 patients. It is a psychiatric intensive care unit, which treats depression, schizophrenia, first-presentation psychosis, schizo-affective disorder and manic depressive psychosis.
The John Meyer Ward is a trust-wide service. Patients can be referred from the community mental health teams, acute wards within the trust, and prison referrals via the appropriate community mental health team.

Laurel Ward
The Laurel Ward is a new, purpose-built ward, which opened in 2006. It consists of 23 en-suite rooms and is situated within Queen Mary's Hospital in Roehampton. This ward serves as an acute admissions ward for adults requiring close observation, assessment and treatment for depression, schizophrenia, first-presentation psychosis, schizo-affective disorder, manic depression and psychosis.

The Laurel Ward is a male-only ward, treating patients aged between 18 and 75 who live in the Wandsworth area and have a severe mental illness. Referrals onto this ward are accepted via a patient's GP, a carer or through self-referrals.

Lavender Ward
The Lavender Ward is also a new, purpose-built ward, which opened in 2006. It consists of 23 en-suite rooms and is situated within Queen Mary's Hospital.

It is a first floor ward for both sexes and serves as an acute admissions ward for adults requiring close observation, assessment and treatment. The ward provides for those suffering severe and enduring mental illness such as

depression, schizophrenia, first-presentation psychosis, schizo-affective disorder and manic depressive psychosis.

Referrals to the Lavender Ward are through GPs, community mental health teams and through the Richmond Crisis and Home Treatment Team.

Action taken following previous concerns raised about the trust

In September 2005, the Healthcare Commission was made aware of a number of concerns about Springfield Hospital by the Mental Health Act Commission and a member of staff based at the trust. These concerns were focused on the high number of untoward incidents, including homicides and patients absconding. We undertook an unannounced visit to Springfield Hospital on 21 November 2005, together with the Mental Health Act Commission.

During the visit, we highlighted our concerns about the following areas:

- Safety – a lack of learning from incidents.
- Governance – very few comprehensive clinical risk assessments in the notes of service users.
- Patient focus – a lack of Care Programme Approach (CPA) procedures being applied to inpatients.
- Accessible and responsive care – some staff reported insufficient time to spend with patients because of the excessive amount of paperwork.
- Care environment and amenities – most of the acute wards visited were environmentally poor, with paint peeling off walls and ceilings, curtains hanging off the rails, and windows that were difficult to see out of. In addition, there had been no fresh air access for patients on John Meyer Ward for weeks.

We were aware that the trust had, at that time, just been placed under new management. It was decided that a Healthcare Commission investigation would inevitably place further pressure on the organisation, at a time when staff morale was low. A great deal was known about the problems at the trust and therefore, in the circumstances, it was judged that an investigation would have been unlikely to discover anything new. The challenge was to ensure that the new management team took action to improve services where necessary.

Due to concerns about the poor environment, lack of clinical leadership and the need for improvement to a number of processes, we made eight recommendations to the trust and the Healthcare Commission's regional team monitored implementation of these. Further information on the trust's progress against these recommendations is documented later in this report.

1. The quality of care provided to patients

Care planning and staff training in relation to the computer system RiO

On all three wards visited, it was evident that staff were experiencing problems with the computer system ‘RiO’, which provides instant access to clinical records. All patient information is held on a central system, which can be viewed and updated online from any service location at any time.

It was clear that not all contact with patients was being recorded by staff, which may suggest that some staff require training to ensure that RiO is used in line with the trust’s policy. Patients appeared to have care plans, but the plans that we reviewed were not specific and were not accessible to the patients or written in a patient-focused format. Furthermore, on the John Meyer Ward, Mental Health Act Commission documentation, mainly regarding patients’ understanding of their Mental Health Act section, was not completed.

Recommendation 1
Care plans need to be written in an appropriate language and in a format that is easily accessible to the individual patient.

Recommendation 2
The trust should address staff training needs in relation to the computer system ‘RiO’, particularly in relation to accessing care plans within the system and printing care plans for the patients.

Access to fresh air

The availability of fresh air on the John Meyer Ward is extremely poor. The environment is stuffy and stale, despite the presence of air-conditioning units. Patients informed us that they have access to fresh air in the garden area approximately five times a day. However, in order to do this, patients are escorted down a steep staircase and through a long corridor in a disused ward. It was evident that this presented risk factors to both staff and patients. We have reviewed the trust’s protocol for access to fresh air and smoking arrangements, and we strongly emphasise the importance of the trust adhering to this policy at all times.

Recommendation 3
The trust needs to ensure that staff on the John Meyer Ward follow the "Protocol for access to fresh air and smoking arrangements" at all times and that access of fresh air is recorded in 'RiO'.

How staff engaged with people who use the service

In terms of staff engagement with patients on the John Meyer Ward, there was a group session running during our visit, with which a number of the patients were engaged. Patients were also able to play table tennis with staff for a certain period of time. Furthermore, we acknowledge that staff were engaging with patients, sitting and talking with them. We also observed a notice board, which timetabled the activities available for patients for the week. While we recognise that the staff on the ward are managing particularly disturbed patients, we recommend that the trust reviews whether more activities could safely be made available to the patients.

On the Laurel Ward, we observed an activity timetable on a communal notice board. However, there was little evidence of meaningful, therapeutic activities taking place on the ward. We observed very few staff interacting with patients throughout our visit and the majority of staff remained in the staff office. Similarly, there was little evidence of any activities taking place on the Lavender Ward, although it was reported that the ward offers an art therapy group. We were also informed that the Lavender Ward is in the process of recruiting a member of staff to coordinate ward activities.

On both Laurel and Lavender wards, we observed a computer room that we were told patients could use and have supervised access to the internet. However, throughout our visit these rooms remained locked, despite the fact that 'computer time' was the named activity while we were on the wards. In addition, a patient from the Lavender ward told us that patients are frequently denied access to the computer room and he had been informed by staff that the internet was not currently working.

Recommendation 4
The trust needs to place a greater emphasis on engaging with, and providing a range of therapeutic activities for, patients.

Suitability of films available for viewing by patients

In the television rooms in both Lavender and Laurel wards, we observed that films of an extremely aggressive and violent nature were available. There did not appear to be any risk-led assessment to determine whether certain patients should, or should not, have access to such graphic material.

Recommendation 5
The trust needs to ensure that the films available to patients are suitable in nature, taking into account individual patients' risk factors. It would be appropriate for the trust to review its policy relating to this matter.

Cleanliness of ward and ward environment

In terms of the physical environment on the John Meyer Ward, it was apparent upon approaching the building in which the ward is situated that the building is in extremely poor condition. The trust has recognised that the John Meyer Ward is not the ideal physical environment for caring for patients, and is currently constructing a new building in which the ward will be situated. This is due to open in spring 2009. In the interim, we have concerns that patients continue to be accommodated in a building which is in such a poor state of repair.

The ward manager informed us that the two available shower cubicles had recently been deep cleaned. However, on viewing the shower facilities, there was a strong odour of mould and the cubicles were visibly dirty. In addition, the toilet facilities were being cleaned during our visit, yet they remained dirty with an unpleasant odour.

The area that was used for seclusion on the ward was dirty and there was a strong, unpleasant odour in both the bedroom and the bathroom areas. One room within this area was also used as storage for what looked like disused equipment.

Recommendation 6
The trust needs to ensure that the state of repair and cleanliness of the wards is of an acceptable standard.

Location of the nursing observation point

On the Lavender Ward, staff raised concerns regarding the nursing observation point, which consists of a table positioned in the middle of two long corridors along which patients' bedrooms are situated. The main nursing station is positioned a considerable distance away from this secondary observation point. We were informed that there are not enough staff for more than one nurse to be at that point during the night, and it is potentially unsafe for a member of staff to be there alone.

We have reviewed the trust's 'environmental risk assessment pro-forma and record' which relates to the three wards visited. Whilst the document identifies

possible environmental risks associated with lone working and provides control measures such as recommending that all staff wear personal alarms it does not specifically address the current location of the nursing observation point or the way in which it is staffed throughout the night.

Recommendation 7
The trust should undertake a risk assessment regarding the current location of the nursing observation point. It may also be necessary for the trust to reconsider the location of this observation point, or the way in which it is staffed throughout the night to ensure the safety of patients and staff.

2. General observations in relation to the John Meyer Ward

Throughout our visit, the behaviour of four of the nine patients on the John Meyer Ward was unsettled and appeared particularly difficult for staff to manage. Staff reported that this impacted on the other patients and staff's ability to provide a therapeutic environment for patients. In addition, we noted that the ward was not running at full capacity as one patient had been transferred to prison and one patient had absconded while being escorted to St George's Hospital the previous day. This raised some concerns regarding the staff's ability to safely manage patients when the ward is operating at full capacity.

We noted that the bedroom that the Mental Health Act Commission had previously raised concerns about regarding poor cleanliness had been cleaned to an acceptable standard and was odour-free.

3. Progress made in relation to the previous Healthcare Commission intervention at the trust

The trust, as requested, provided evidence in relation to their progress against the recommendations made following the Mental Health Act Commission and Healthcare Commission joint visit in 2005. The Healthcare Commission had previously followed-up these recommendations and had acknowledged that the trust had taken steps to meet all eight of the recommendations made. We wanted to ensure that action taken to implement these recommendations remained in place and that the trust continued to make progress in the areas previously highlighted. These recommendations are attached in the appendix, for ease of reference.

In relation to recommendation 1, we have reviewed the "Protocol for access to fresh air and smoking arrangements" policy and acknowledge that this policy attempts to find a balance between safety and the rights of patients. While the policy describes good practice in relation to the physical transfer pathway of patients, during our visit to the John Meyer Ward there was little evidence that the shift co-ordinator was allocating a member of staff to monitor the CCTV camera in the nursing office until all patients were safely transferred to the garden or back on the ward.

Recommendation 2 proposes that the trust participates in the pilot of the Healthcare Commission's "risk self-assessment tool" and acts on any learning from the findings. However, as this tool was not piloted nationally, the trust was unable to participate. The trust has, instead, implemented a three-tier programme of clinical risk and vulnerability training. The Mental Health Act Commission assisted with the scripting for films that recreated a number of incidents and showed how they may have been approached differently. The trust has provided a variety of evidence, including evidence of clinical risk and vulnerability training and information about the Risk Identification Board, to demonstrate the positive progress they have made in this area.

In relation to the third recommendation, the trust has provided evidence which demonstrates improvement and monitoring in communication between clinical staff and patients with regard to consent, the rights of patients, and medication and its side effects. We are aware that the Mental Health Act Commission is still in discussion with the trust regarding:

- Authorised leave for detained patients
- Consent to treatment
- Aftercare and Care Programme Approach (CPA)
- Information regarding patients' rights.

The fourth recommendation related to the implementation of the CPA. During our visit to the wards, there was evidence that the CPA was being routinely

used. However, some concerns remain regarding the involvement of patients in this process, as mentioned previously in section 1.

Recommendation 5 stated that the trust should audit the assessment and treatment of physical healthcare, and take action to improve the quality of this care to users of the service. The trust has provided evidence of audits being undertaken and training in relation to physical health issues.

The sixth recommendation said that the trust should seek advice on ways to improve the physical environment and the safety of staff and users of services on the John Meyer Ward. The trust has shown evidence of its progress, providing evidence of an external inquiry report into the death of a member of staff and subsequent action plan. However, as noted in section 1, the trust should take further steps to ensure the safety of staff and patients and improve the ward environment.

The seventh recommendation was that the acute care forum should monitor progress on the safety of female patients, bed management and therapeutic activities. Progress has been made in relation to these areas including providing single sex wards for both male and female patients. However, some concern remains regarding the availability of therapeutic activities for patients as mentioned in the observations above.

The eighth recommendation related to the provision of fresh air in line with the standards and procedures set out in the trust's policy for the John Meyer Ward. The trust has addressed this recommendation by supplying a copy of its "Protocol for access to fresh air and smoking arrangements". As stated in recommendation 1, while this policy appears to appropriately address this issue, the trust needs to ensure that the policy is properly adhered to at all times.

Conclusions

Following concerns that were raised with the Healthcare Commission regarding the quality of care to patients including the cleanliness of the wards and the lack of engagement with patients, we have undertaken a focused review of these concerns, as well as looking at action taken by the trust in response to our intervention at the trust in 2005. Our main focus was to ensure that the quality of care was of an acceptable standard. This has not been a full investigation of all aspects of the services provided by the trust. It has focused on the appropriateness of current arrangements in place at the trust in three locations.

In summary, we have reviewed the concerns raised regarding the safety of patients at the trust. The trust has been open and has co-operated fully. We recognise the challenges which the trust faces, particularly in relation to the John Meyer Ward and the restriction regarding the poor fabric of the building. The trust has provided considerable evidence to demonstrate ongoing improvements in a number of areas, such as providing single sex accommodation and the three-tier programme of clinical risk and vulnerability training. However, we have identified seven recommendations for action by the trust and these are set out below. The trust has accepted the findings in this report and will need to provide assurance that action has been taken in response to these recommendations.

We have shared this report with the strategic health authority responsible for the management of the trust's performance, and the PCTs that commission its services. For its part, the Healthcare Commission will review progress against the recommendations in the report after six months.

Summary of recommendations

The trust has accepted all the recommendations in this report and has already started work to ensure that the necessary changes are made.

Recommendation 1: Patient-centred planning
Care plans need to be written in an appropriate language and in a format that is easily accessible to the individual patient.

Recommendation 2: Staff training in relation to the computer system 'RiO'
The trust should address staff training needs in relation to the computer system 'RiO', particularly in relation to accessing care plans within the system and printing care plans for the patients.

Recommendation 3: Access to fresh air
The trust needs to ensure that staff on the John Meyer Ward follow the "Protocol for access to fresh air and smoking arrangements" at all times and that access of fresh air is recorded in 'RiO'.

Recommendation 4: How staff engage with people using the service
The trust needs to place a greater emphasis on engaging with, and providing a range of therapeutic activities for, patients.

Recommendation 5: Suitability of films available for viewing by patients
The trust needs to ensure that the films available to the patients are suitable in nature, taking into account individual patients' risk factors. It would be appropriate for the trust to review its policy relating to this matter.

Recommendation 6: Cleanliness of ward/ward environment
The trust needs to ensure that the state of repair and cleanliness of the wards is of an acceptable standard.

Recommendation 7: Location of the nursing observation point
The trust should undertake a risk assessment regarding the current location of the nursing observation point. It may also be necessary for the trust to reconsider the location of this observation point, or the way in which it is staffed throughout the night to ensure the safety of patients and staff.

Appendix: Previous recommendations from the 2005 visit

Case: [342/as]

The recommendations made following the Mental Health Act Commission and Healthcare Commission joint visit to the trust in 2005 were as follows:

Previous recommendation 1
As a matter of urgency, the trust should undertake a risk assessment of the patient physical transfer pathway within John Meyer Ward. This should be conducted in conjunction with the non-clinical risk department, senior nursing staff from John Meyer Ward and include the Prevention and Management of Violence and Aggression training team. (this recommendation was verbally feedback to the previous chief executive at the end of our unannounced visit).

Previous recommendation 2
Participate in the pilot of the Healthcare Commission "risk self-assessment tool" and act on any learning from the findings.

Previous recommendation 3
Ensure there is effective communication between clinical staff and patients with regard to consent, patient rights, medication and its side effect, and monitor these areas actively.

Previous recommendation 4
Identify key performance indicators with regard to the implementation of the Care Programme Approach (CPA) and that these are monitored routinely. This must pay particular attention to the lack of use of CPA on admission and also on John Meyer Ward.

Previous recommendation 5
Audit the assessment and treatment of physical health care and take action to improve the quality of this care to users of the services.

Previous recommendation 6
Seek advice from the Psychiatric Intensive Care Advisory Service which is a subsidiary of the National Association of Psychiatric Intensive Care Units (NAPICU), on ways to improve the physical environment and the safety of staff and users of services on John Meyer Ward until the new unit is available.

Previous recommendation 7
Request that the acute care forum monitor progress on the following areas:

a. Safety of female patients
b. Bed management
c. Therapeutic activities
d. Bed occupancy and the arrangements for service users sleeping on other wards.

Previous recommendation 8

The trust should review its provision of fresh air in line with the standards and procedures set in its own policy for John Meyer. Both in relation to John Meyer and across the Trust it should respond to the Mental Health Act Commission's recommendation in its ninth Biennial Report "that service commissioners and providers should agree specific standards for access to fresh air, recreational, educational and therapeutic activities, and monitor their availability and uptake taking account of patients' views".