South London and Maudsley NHS Foundation Trust

Quality Report

Trust Headquarters
Maudsley Hospital
Denmark Hill
London
SE5 8AZ
Tel: 020 3228 6000
Website: www.slam.nhs.uk

Date of inspection visit: 21-25 September 2015
Date of publication: 22/01/2016

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Maudsley Hospital Ladywell Unit Lambeth Hospital The Bethlem Royal Hospital Foxley Lane Womens Service	RV504 RV509 RV502 RV505 RV536
Rehabilitation mental health wards for working age adults	Lambeth Hospital The Bethlem Royal Hospital Heather Close	RV502 RV505 RV581
Forensic inpatient wards	The Bethlem Royal Hospital	RV505
Child and adolescent mental health wards	Maudsley Hospital The Bethlem Royal Hospital Kent and Medway Adolescent Unit	RV504 RV505 RV5X1
Wards for older people with mental health problems	Maudsley Hospital Ladywell Unit The Bethlem Royal Hospital Ann Moss Specialist Care Unit Greenvale Nursing Home	RV504 RV509 RV505 RV5A3 RV5C5
Community based mental health services for adults of working age	Maudsley Hospital	RV504
Mental health crisis services and health-based places of safety	Maudsley Hospital Ladywell Unit Lambeth Hospital	RV504 RV509 RV502

Summary of findings

	The Bethlem Royal Hospital	RV505
Specialist community mental health services for children and young people	Maudsley Hospital	RV504
Community based mental health services for older people	Maudsley Hospital	RV504
Wards for people with learning disabilities or autism	The Bethlem Royal Hospital	RV505
Community mental health services for people with a learning disability or autism	Maudsley Hospital	RV504

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	Good 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Good** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Good** 
Are Mental Health Services well-led?	**Good** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We have given an overall rating to South London and Maudsley NHS Foundation Trust of **good.**

We have rated two of the eleven core services that we inspected as outstanding, six as good and three as requires improvement.

The trust has much to be proud of and also some significant areas that need to improve. The trust was well led with a dynamic senior leadership team and board. There were also many committed and enthusiastic senior staff throughout the organisation working hard to manage and improve services. The trust recognised that they needed to focus on getting the basics right and the results of the inspection would confirm that this was correct.

The main areas which were positive were as follows:

- Most of the staff we met were very caring, professional and worked tirelessly to support the patients using the services provided by the trust.
- The trust was supporting patients with their physical health. People had their health assessed in a comprehensive manner and were being supported to have any health care needs addressed.
- Staff had access to a wide range of opportunities for learning and development, which was helping many staff to make progress with their career whilst also improving the care they delivered to people using the services.
- The trust was very aware of best practice and was using guidance and research to inform their work. This meant patients were receiving high quality care. For example patients had access to a range of psychological therapies alongside their medical treatment.
- The trust provided many opportunities for patients to be involved in the running and decision making about services. This input was leading to changes across the services.

There were three services that required improvement and on the acute wards for adults of working age the safety was rated as inadequate. The main areas for improvement were as follows:

- The trust had a substantial problem with staff recruitment and retention. There were too few staff to consistently guarantee quality of care especially on the acute wards for working age adults. There were staffing problems in some other areas but these are not as severe.
- The trust needed to make improvements across most of its services in the documentation of risk for individual patients. This is to ensure the information was readily available, accurate and being followed.
- The trust must improve its practices in relation to restrictive interventions such as the use of restraint and seclusion. They have started to tackle this problem but there is much more to be done. The trust must ensure that staff use restraint only as a last resort, that they minimise the use of restraint in the prone position, that they accurately document and record the use of restrictive interventions.
- The trust must also make sure that where it has medical equipment, especially for emergency resuscitation that all the necessary equipment is available, maintained and has parts that are in date.
- The trust had a number of environments that were not safe or where the risks were not being robustly mitigated to keep patients safe.

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 acute wards for adults and the psychiatric intensive care unit we found:

- Staff were not reporting all incidents of restraint and when restraint was recorded, it was not recorded comprehensively according to the Mental Health Act code of practice. This was addressed by the trust immediately after the inspection.
- On Eileen Skellern 1 the environmental risk caused by patients having access to an external fire escape had also not been mitigated.
- Individual risk assessments were not consistently up to date and reflecting the current risks to individuals.
- Some wards had significant staff shortages which had an impact on patient care.
- On Lambeth triage ward seclusion had not been recognised and so patients were not being properly monitored to ensure their safety.
- Emergency resuscitation bags did not all contain the listed emergency equipment or in some cases this equipment was present but out of date.
- Patients whose physical health monitoring had identified that their risks were raised had not all been referred for medical input.

In forensic inpatient wards we found:

- Staff did not always complete patients' risk assessments on admission and these were not regularly updated or reviewed.
- Staff were not clear on the procedures for reporting a safeguarding alert.

In the health based places of safety we found:

- The facilities at the Lambeth place of safety were not safe and the environment was not fit for purpose
- Lewisham health based place of safety had blind spots in both the observation window and the CCTV camera angle that meant that patient safety could not be guaranteed.
- Personal and emergency alarm systems at Lambeth home treatment teams were not regularly checked to ensure that they were working in the event that staff needed to request assistance.

Summary of findings

- There were inconsistencies in where risk assessments completed by home treatment teams were held in electronic care records, which meant that it is was possible for staff (especially in other teams) to miss updates in risk information.

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

- Whilst risk was discussed at zoning meetings some risk assessments were incomplete or very brief which meant there was a possibility that care professionals would not be aware of patients individual needs.
- Medication and sharps were not transported safely between the team base and patients homes.
- Lone working procedures were not consistent or robust across the teams.
- Use of temporary staff and changes to the how the recovery teams were configured meant changes in care co-ordinators for patients and some staff were anxious about case-loads and the acuity of people they were supporting.

In wards for older people with mental health problems we found:

- At Greenvale and Chelsham House there were strong smells of urine by toilet areas.
- Across the wards for older people risk assessments were often completed with insufficient detail to ensure staff would know the necessary details.
- At Greenvale patients were using wheelchairs without footrests and being lifted without the use of the correct equipment. This meant there was a risk of people getting injured.
- At Greenvale and Ann Moss House, medication had run out causing delays in patients receiving medication.

In rehabilitation mental health wards for working age adults we found:

- Whilst work was taking place to reduce high risk ligature points, the existing risks were not being mitigated and ligature cutters were not readily available in the event they may need to be used.
- At Heather Close and the Tony Hillis unit blanket restrictions were in place that did not reflect the needs of people using the service.
- At Heather Close fire safety precautions were not being fully implemented.

In community based mental health services for older people we found:

Summary of findings

- There was inconsistency between the teams and individual workers around when a risk screen or a full risk assessment should be completed. The quality of the risk assessments was variable and they were sometimes tick-box style with little further information added.
- Medication and sharps were not transported safely between the team base and patients homes.
- Many of the care records we reviewed did not contain clear, detailed crisis plans. Some of the carers and patients did not know how to contact someone in the event of a crisis out of hours.
- Lone working procedures were not consistent or robust across the service.

Trust wide we found:

- There was a significant use of prone restraint throughout the trust.

However, the trust was reporting and investigating serious incidents well. Staff were well informed about the lessons learnt from this incidents and using this knowledge to improve practice. Medication was mainly well managed and provided support to patients and staff.

Are services effective?

Good

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

- Patients physical health needs were being assessed and this was mostly done in a thorough manner.
- Patients were assessed using the modified early warning system to identify early deteriorations in their physical health.
- There was a high level of awareness of national institute for health and care excellence guidance and patients had access to a range of psychological therapies.
- Staff were well supported with induction and ongoing training, clinical and management supervision and an annual appraisal. There were opportunities for reflective practice.
- Multi-disciplinary teams worked together well to meet the needs of the patients they were supporting. There were also positive examples of different teams working together and different agencies.

However, across a number of wards and teams care plans had not consistently reflected the identified needs of patients and there was generally poor involvement of patients in care planning.

The rights of informal patients were not consistently understood in a way which protected their rights and gave them correct information about their right to leave the wards or refuse medications. Staff

Summary of findings

understanding of the Mental Capacity Act was variable. Staff working on the mental health wards for older adults did not feel confident in supporting people with dementia and were not being made aware of the training they could access to develop their skills.

Are services caring?

Good

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

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers, were usually involved in decisions about their care.
- Opportunities were available for people to be involved in decisions about their services and the wider trust.

However, on wards for older people although the majority of staff were very caring and thoughtful, the structured observations that were done during the inspection showed that some staff did not communicate well with the patients especially during mealtimes.

Are services responsive to people's needs?

Good

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

- Despite there being great pressures, the services were mostly managing to respond to the needs of patients in a timely manner. The trust was aware of the need to provide consistent care and where needed patients were offered a service in the independent sector if a bed in the trust was not available.
- Teams were providing appointments where possible at times that were suitable for people using the service. If patients did not arrive for their appointment there were arrangements in place to check they were alright.
- The trust provided a good range of therapeutic activities for patients using inpatient services.
- The trust served a very diverse population and there were many positive examples of trying to make services more responsive.
- Complaints were generally managed well and the trust was aware of the need to make responses more timely.

However, patients all need to be informed of what they can do in a crisis out of hours. There were also improvements needed in some areas in the quality of the meals provided and ensuring care was delivered in a manner that maintained people's privacy and dignity.

Are services well-led?

Good

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

Summary of findings

- The trust had a strong executive and non-executive leadership team
- The trust vision was known by staff working across the trust and they understood how this informed their work
- The board assurance framework, whilst continuously being refined was providing the board with the information they needed to perform their role
- The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders and were working to develop this further
- The trust was developing leaders within the trust
- The trust was innovative and looked for ways to improve patient care

However, on the acute wards for working age adults the governance at a team level was not yet stong enough as there were lots of areas of non-compliance to be addressed. The trust needed to complete the fit and proper person checks for the non-executive directors.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Professor Tim Kendall, Director, National Collaborating Centre for Mental Health, Royal College of Psychiatrists', Medical director and consultant psychiatrist, Sheffield Health and Social Care NHS Foundation Trust. Visiting professor, UCL.

Team Leader: Jane Ray, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team of **103** people consisted of:

Nineteen CQC inspectors

Four trainee CQC inspectors

One CQC assistant inspector

One CQC observer from the engagement team

Fourteen allied health professionals

Two analysts

One trainee analyst

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

Nine Mental Health Act reviewers

Fourteen nurses from a wide range of professional backgrounds

Two planners

Four pharmacists

Twelve senior doctors

Six social workers

Two people with governance experience

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of the experience of people who use services, 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, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Sought feedback from patients and carers through attending 8 user and carer groups and meetings and from speaking to members of the local community at an open event at Brixton Market.
- Received information from patients, carers and other groups through our website

During the announced inspection visit from the 21-25 September 2015 the inspection team:

- Visited **71** wards, teams and clinics

Summary of findings

- Spoke with **296** patients and **44** relatives and carers who were using the service
- Collected feedback from **323** patients, carers and staff using comment cards
- Spoke with **524** staff members
- Attended and observed **94** hand-over meetings and multi-disciplinary meetings
- Joined care professionals for **24** home visits and clinic appointments
- Joined **24** service user meetings
- Attended **11** focus groups attended by **185** staff
- Interviewed **6** senior executive and board members
- Looked at **423** treatment records of patients
- Carried out a specific check of the medication management across a sample of wards and teams
- 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
- Observed a board meeting and a quality sub-committee meeting

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

- Acute ward and the psychiatric intensive care unit
- Long stay rehabilitation wards
- Forensic inpatient wards
- Wards for older people with mental health problems
- Ward 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
- Specialist community mental health services for children and young people
- Wards for people with learning disabilities or autism
- Community mental health services for people with a learning disability or autism

We did not inspect substance misuse services or specialist services including the eating disorder, liaison psychiatry, perinatal and improving access to psychological therapies services as part of this comprehensive inspection. We did however do a focused inspection at the National Psychosis Unit, Fitzmary 2 to follow up previous non-compliance.

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

South London and Maudsley NHS Foundation Trust provided mental health services to a local population of 1.3 million people. The trust supported adults, older people and children in the boroughs of Lambeth, Southwark, Lewisham and Croydon. They also provided more than 20 specialist services for children and adults from across the UK as well as providing a range of mental health services internationally.

The trust had an annual turnover of £364 million, employed 4600 staff who provide inpatient care for approximately 5300 patients each year and treat 45,000 patients in the community. In total the trust had more than 230 services including inpatient wards, outpatient and community services.

The trust had four main hospital sites, the Maudsley, the Ladywell Unit at Lewisham Hospital, Lambeth Hospital and the Bethlem Royal Hospital. In total the trust had 830 beds across 9 inpatient sites and 85 community sites.

The services provided by the trust were organised into seven clinical academic groups (CAGs). The aim of the CAGs was to bring together the clinical and academic skills in

Summary of findings

areas such as psychosis and child and adolescent mental health. Each CAG had a clinical and management lead. The core services inspected by the Care Quality Commission sometimes crossed over more than one CAG.

The trust was very proud of the research taking place. They have their own biomedical research centre, hosted jointly with the Institute of Psychiatry, Psychology and Neuroscience Kings College London, which has the aim of translating scientific developments into new ways of screening, detecting, treating and preventing mental illness.

The trust had eleven locations registered with CQC. The trust had been inspected 23 times and at the time of the inspection there were outstanding areas of non-compliance at 3 locations, the Ladywell Unit, the Maudsley and Bethlem Royal Hospital. These were followed up as part of the inspection.

What people who use the provider's services say

Before the inspection took place we met with **8** different groups of patients, carers and other user representative groups as follows:

LGBT user group

Lambeth and Southwark user forum (Mind)

Hear Us

Mind peer group

Trust service user and carer groups – Psych Med, Mood & Anxiety, CAMHS and Older Adults

Through these groups we heard from **103** patients and carers. We also received feedback from **2** independent mental health advocacy services and **4** Healthwatch.

During the inspection the teams spoke to **340** people using services or their relatives and carers, either in person or by phone. We received **323** completed comment cards of which **215** were positive, **41** negative and **67** mixed. We also received individual comments from people through our website or by phone.

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

- Staff treated patients with dignity and respect. They were helpful, professional, caring, friendly and made time to listen.
- People commented that they found their support and treatment helpful and they felt safe.
- There were positive comments about cleanliness in most places
- People commented that they found reception staff very welcoming
- Home treatment teams were good – especially Croydon
- The chief executive was open to change
- Some care co-ordinators were very good
- Some good experiences of user involvement through the involvement register – help with mock inspections, trust help fund the 'hearing voices group', trust helped fund the '4 in 10 group' who worked to run a campaign to reduce discrimination for LGBT service users, service users have opportunities to help with recruitment etc
- The café at the Ladywell Unit was well received
- Psychological therapies were good – although there could be delays in receiving this input

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

- Long waits for psychological therapies
- Mixed feedback on user involvement and choice in decisions about care
- Shortage of ward staff impacting on escorted leave, access to fresh air, cancelled activities and 1:1 sessions
- Interaction with staff variable, some staff spending too much time in the office, staff looking at mobile phones, staff standing looking at people using the service when they eat, staff speaking in another language

Summary of findings

- Lots of agency nurses – lack of consistency of care
- Moves between wards
- Cleanliness especially in showers and toilets
- Variable quality of food
- Not enough activities
- Worried about discharge from trust back to GP and not seen a discharge plan
- Poor communication between trust staff and GP
- Long waiting list for a care co-ordinator
- Not told when an appointment is cancelled
- Care – can be medical model not holistic – not sufficiently recovery focused
- Involvement of carers was mixed
- Impact of 'smoke free' received mixed feedback
- Community meetings on wards were very variable
- Not kept informed about changes in the service ie staff leaving
- Complaints – long response times, not taken seriously
- Restraint used too often
- Alarms on some wards very loud

Good practice

Trust wide

- Throughout the inspection we saw many examples of caring and compassionate staff. Patients also told us about their very positive experiences.
- Staff and patients spoke very positively about the support, guidance and training they received from the trust pharmacy team.

  Staff were being supported to access a range of training to support them in their specific role over and above the mandatory training. The training also offered opportunities for career progression. An example of this is the implementation of the care certificate for support workers with around 600 staff going through this training in the next two years.
- The trust involved users and carers in many areas of its work and development. An example of this was in child and adolescent services where young people have attended senior team meetings and helped to design a new patient experience survey.
- There were many examples of the trust working in partnership with local statutory and voluntary partners. For example in Croydon the re-ablement project has involved staff from the trust supporting local services so that people receive the support they need without having to access secondary mental health services.
- The trust provided services for a very diverse population and there were many examples of the trust working with groups to meet the needs of individuals using their services. For example the trust worked with the 'Four in Ten project' which is the trusts lesbian, gay, bisexual and transgender user group who developed guidance for staff on how to support people who are transgender.

Forensic inpatient wards

- The wards used a "Buddi" tracker system for patients who went on escorted leave. Patients voluntarily wore a GPS tracker on their ankle. This meant that patients who were at high risk of absconding during their leave could be tracked and returned to the ward. Managers reported that this has reduced the number of patients absconding from the ward. One ward had a patient who requested to use the tracker when they went on leave as it made them feel in control about going into the community.
- The consultant on Norbury ward had completed various research projects including management of inpatient violence and monitoring physical health. One of the projects developed a "medication algorithm", an individualised medication plan for staff

to support patients who were non-compliant or refusing medication. This was recently presented at a trust-wide conference and is in the process of being rolled out across the trust.

- Some patients participated in a restorative justice programme called Sycamore Tree run by the Prison Fellowship. This is a victim awareness programme and patients could learn about taking responsibility for their actions. Staff described a case where restorative justice was used to provide mediation between two patients. Sycamore Tree was due to train staff and run a pilot group on Effra ward. Victims could access a positive prosecution policy where they could go through the restorative justice process even if they were not going down the prosecution route.
- Patients used video link and conferencing facilities for court and meetings. This meant that patients did not need to be handcuffed and attend court. It also saved time and resources required to facilitate a patient attending court.
- River House successfully completed the self and peer-review of the Quality Network for Forensic Mental Health Services through the Royal College of Psychiatrists Centre for Quality Improvement in September 2014.

Rehabilitation mental health wards for working age adults

- Mckenzie and Westways wards were promoting greater independence and had implemented systems so patients could self-administer their medication.

- All the wards encouraged positive risk taking with a lot of patients who went on unescorted leave.

Community based mental health services for older people:

- The trust actively supported research innovations. In Lambeth a research nurse visited the team weekly to recruit participants for research projects and we saw that members of the teams were actively involved in research projects as a result. For example, in Southwark the team operated a 'consent for contact' initiative where every patient was asked if they would like to be contacted about research and their names were then added to a database.
- In Lewisham, the team were utilising the skills of psychology graduates through recruiting them as recovery enablers, to help patients complete their support and recovery plans. This is a project promoting recovery, with Lewisham being an early implementer.

Acute wards for adults:

- The 'Four Steps to Safety' programme which the trust was piloting to work on reducing violence and aggression on the wards had very positive feedback from staff who were involved in the wards which were starting to use it and this meant that the trust was looking at new ways to improve practice.
- The 'Tree of Life' programme had been used across some wards and worked to ensure that coproduction between patients and staff was maximised and that patients' preferences, cultural needs and things which were important to them were recognised in the ward environment.

Specialist community mental health services for children and young people:

- There had been a shared learning event across Southwark and Lambeth CAMHS on the therapeutic assessment of self-harm and the teams were piloting their intervention approach.
- Staff from the CAMHS teams and parents with experience were delivering learning sessions to parents of young people to help them re-build relationships with their children whose behaviour of self-harm, violence and aggression had affected family relationships.
- Young people were involved in decision making about the teams, for example on interview panels for staff.

Child and adolescent mental health ward:

- Young people were actively involved in making decisions about the running of the wards for example helping with staff recruitment.
- The pilot supported discharge service in Kent. This is specialist team which aimed to try and facilitate early discharge.

Community based mental health services for adults of working age:

Summary of findings

- The assessment teams had developed a 12 week stabilisation model with robust scrutiny through daily meetings and duty systems with at least one dedicated referrals co-ordinator.
- The Lambeth hub provided a single point of access for all mental health referrals and was able effectively to screen out cases which do not require input from the trust.
- The South Croydon assessment team had excellent connections with a range of voluntary sector organisations in the borough which input into the development of the service and the quality of care delivered.
- The South Southwark GP liaison clinic in the Camberwell Green practice had reduced the number of referrals to the assessment team. The CAG was considering how this might be expanded.
- The patient network for people with personality disorders in Croydon was an innovative service and the trust was looking to introduce the model in the other boroughs.
- The Lewisham North recovery teams were supporting patients who were taking part in the AVATAR clinical trial. This therapeutic intervention could provide patients with a reduction in the frequency, severity and distress caused by hearing voices.
- The recovery teams were learning about diabetes and mental illness and were encouraging patients to go onto diabetes education courses.
- Peer support workers with experience of using services were based in the Lambeth South recovery team. Staff said the introduction of peer workers was a powerful way of driving forward a recovery-focused approach within teams.

Wards for older people with mental health problems:

- Greenvale was using Namaste Care to provide a structured programme to integrate care with individualised activities for people with dementia.
- The trust created a service user group and carer advisory group (SUCAG) which involved service-users and carers who have experienced the trusts older adults services. The group provided opportunities to review current practice, recruitment, staff training and ultimately supporting each other.

Ward for people with autism:

- Staff at the NAU were recognised as experts in their field. For example, the consultant psychiatrists contributed to a national training scheme run by the Royal College of Psychiatrists to train psychiatrists in the diagnosis and support of adults with autistic spectrum disorders (ASD). Staff held a large grant for research into autism and had published numerous papers.
- The multi-disciplinary team provided a range of interventions to patients with ASD which were person-centred and improved patients' daily living and coping skills. The NAU staff team included an occupational therapist and an activities co-ordinator who were able to engage patients and promote their self-confidence and independence. This approach complied with the NICE guidelines 'Autism in adults: diagnosis and management' (June 2012).
- The MDT worked constructively with the families of patients on the NAU. Staff facilitated a support group for the relatives and carers of patients.

Community mental health services for people with a learning disability:

- The service offered a range of pharmacological, psychosocial and psychological interventions to people with learning disabilities who have mental health needs and in some cases behaved in a way that challenged those supporting them.
- The service had strong links with academic and research work in this area. New ways of working were trialled by the team, such as the use of new assessment tools. Staff described a working environment where expert colleagues assisted them with people's care and treatment by 'casting a fresh eye' on complex situations.
- The service included a member of staff who was responsible for developing appropriate local support for people currently placed in out of borough in-patient hospitals. They had successfully developed with other agencies bespoke services for people with very complex needs which had enabled them to live in their local community.

Summary of findings

- The service provided an in-reach service if people were admitted to hospital and supported ward staff to provide appropriate care and support to people with learning disabilities, including those who were not previously known to the service.
- The service had developed a range of 'easy read' leaflets and tools for people to use.

Mental health crisis services and health based places of safety:

- Physical health monitoring was taking place and embedded in the delivery of care in Lewisham and Croydon home treatment teams demonstrating a good level of evidence based practice.
- A collaborative research project between a local university and the Lambeth home treatment team was being conducted exploring the experiences of people who use home treatment teams.

Areas for improvement

Action the provider MUST take to improve

Trust wide:

- The trust must work to reduce the use of prone restraint used across the trust.
- The trust must complete the fit and proper person checks for non-executive directors.

Forensic inpatient wards:

- The trust must ensure that staff complete a full risk assessment for patients on admission including HCR-20s and regularly review and update risk assessments.
- The trust must ensure that the food is of good quality, appropriate portion size and meets all patients' dietary requirements.

Wards for older people with mental health problems:

- The trust must ensure there are no unpleasant odours of urine by toilet areas at Greenvale and Chelsham House.
- The trust must ensure that across the wards for older people that risk assessments are completed with sufficient detail so that they can be used by care professionals supporting the patients.
- The trust must ensure that at Greenvale the wheelchairs are all fitted with footrests and that these are used. The trust must also ensure that patients are moved safely with the use of hoists where needed.
- The trust must ensure there are medicine management systems in place to regularly check stocked medication at Greenvale and Ann Moss specialist care unit so they are available to use when needed.
- The trust must ensure that all staff supporting patients with dementia are supported to access training on dementia on an ongoing basis so they deliver care confidently based on current best practice.
- The trust must ensure that staff are supported to improve their communication and interactions especially at mealtimes.
- The trust must ensure that across the wards for older people that care is delivered in a manner that considers privacy and dignity including same gender care and closing observation windows on bedroom doors when they are not needed.
- The trust must ensure food provided to patients meets their individual needs including their personal choice, physical needs and religious or cultural preferences.

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

- The trust must ensure that all incidents of restraint are recorded in line with the Mental Health Act code of practice and so the data can be used to drive improvement effectively.
- The trust must ensure that individual patient risk assessments are comprehensively completed and updated during a patient's inpatient stay and that all risks are reflected.

Summary of findings

- The trust must ensure that care plans are comprehensive and holistic, involve patients and are updated with current information during a patient' stay.
- The trust must ensure that risks from environmental risks such as the external fire escape on Eilleen Skellern are robustly mitigated.
- The trust must continue to look at how qualified nursing levels can be improved on the acute and PICU wards.
- The trust must be sure that the use of seclusion on Lambeth triage ward is appropriately recognised so that the necessary monitoring can take place.
- The trust must ensure emergency resuscitation bags contain all the necessary equipment and this must be within date.
- The trust must ensure that patients whose physical health monitoring had raised risks have access to the appropriate medical input in a timely manner.
- The trust must ensure the rights of informal patients are protected with clear information about their right to leave the ward and refuse medication.
- The trust must ensure that governance processes are sufficiently robust that they identify where improvements need to be made.

Mental health crisis services and health-based places of safety:

- The trust must ensure that the current environments used as health based places of safety are made safe and have adequate levels of observation.
- The trust must ensure that the alarm system at the Lambeth home treatment team at Orchard House is regularly checked to ensure it is working order.
- The trust must ensure that risk assessments used by the home treatment teams are stored consistently and are accessible to care professionals who need this information.

Community based mental health services for adults of working age:

- The trust must ensure that there are safe systems for transporting medication, medical waste and sharps.
- The trust should ensure that a consistent approach is used to complete risk screens and risk assessments on the patient records system so they contain the necessary detail to be used by all care professionals.

Rehabilitation mental health wards for working age adults:

- The trust must ensure at Heather Close and McKenzie ward that where there are still high risk ligature points or patients who may harm themselves, that the appropriate steps to mitigate these risks are in place and staff are able to clearly articulate how these are managed.
- The trust must ensure that at Heather Close and the Tony Hillis unit blanket restrictions are not imposed that do not reflect the needs of people using the service.
- The trust must ensure that at Heather Close fire safety precautions are all in place.
- The trust must ensure senior management support local staff and address issues of staffing.

Community based mental health services for older people:

- The trust must ensure that there are safe systems for transporting medication, medical waste and sharps.
- The trust should ensure that a consistent approach is used to complete risk screens and risk assessments on the patient records system so they can be located by all care professionals.

Action the provider SHOULD take to improve

Trust wide:

- The trust should continue to improve the completion rates for mandatory training.
- The trust should ensure all patients are aware of their crisis plan and who to contact in an emergency out of hours.

Forensic inpatient wards:

- The trust should ensure that all safeguarding concerns are reported and documented through a consistent process across all wards.
- The trust should ensure that staff maintain accurate restraint records that includes the specific type of hold, length of time and staff members involved.

Summary of findings

- The trust should ensure there is adequate staffing to provide escorted leave and activities during the day.
- The trust should ensure that staff follow the knocking system to respect patients' privacy in their bedrooms.
- The trust should ensure patients' privacy and dignity is respected on Spring ward where the windows have access to public areas and that patients' rooms are secured when being cleaned.
- The trust should ensure that staff are informed of incidents including lessons learned.
- The trust should ensure that all patients have a physical health assessment completed on admission and that this is documented in their care records.
- The trust should ensure that each patient's care plans are personalised and record the patient's views and involvement.
- The trust should ensure that staff have completed Mental Health Act and Mental Capacity Act training and have a comprehensive understanding of these principles
- The trust should ensure that information is available in easy read format and languages spoken by patients on the wards.

Rehabilitation mental health wards for working age adults:

- The trust should ensure that staff are clear about the observation of patients at 3 Heather Close.
- The trust should ensure that at Heather Close and the Tony Hillis unit maintenance and repairs are carried out in a timely fashion.
- The trust should ensure recruitment processes are ongoing to reduce the dependence on temporary staff who may not all know the services.
- The trust should implement measures to monitor patients who go AWOL. This includes clearly recording for patients on section 17 leave what time they are expected to return. Also consider having photo's of patients to share with the police if they are missing.
- The trust should ensure that staff have considered the vulnerability of patients on mixed gender wards where patients of the opposite gender could enter bedroom areas.
- The trust should ensure that staff at Heather Close can access a defribrillator in a timely manner in the event of an emergency.
- The trust should ensure care plans are reviewed regularly and reflect patient risks and the support they need.
- The trust should ensure that across the rehabilitation wards staff are able to clearly articulate the model of care and how they are promoting patients rehabilitation.
- The trust should ensure on Tony Hillis and Heather Close that staff understand how to apply the Mental Health Act.

Community based mental health services for older people:

- The trust should ensure that comfortable seating is available at all bases.
- The trust should ensure arrangements for lone working are implemented across the teams.
- The trust should ensure staff can confidently apply the Mental Capacity Act.
- The trust should ensure that managers understanding of the safeguarding alert process is cascaded to all staff.
- The trust should ensure that patients and carers know who to contact out of hours in an emergency.
- The trust should ensure patients and carers have copies of care plans.

Wards for older people with mental health problems:

- The trust should ensure food and fluid charts where they are used across the wards for older people are completed correctly.
- The trust should ensure that when patients have their rights explained under S132 that this is recorded. The trust should also ensure that patients are given a copy of their section 17 leave form.
- The trust should ensure that patients and their relatives are involved in assessments.
- The trust should ensure that patients with dementia have access to individual appropriate therapeutic activities across all the wards.

Summary of findings

- The trust should ensure that mealtimes are made pleasant with patients having access to an attractively laid table with condiments.

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

- The trust should ensure that staff continue to increase their completion of mandatory training.
- The trust should ensure the consistency of recording that patients have had their S132 rights explained to them is improved.
- The trust should ensure that staff are aware and have correctly recorded each patients status under the Mental Health Act so their rights can be correctly upheld.
- The trust should ensure staff continue to receive training on the Mental Capacity Act so it can be applied more consistently.
- The trust should ensure that all temporary staff working on the acute wards receive a timely local induction.
- The trust should avoid blanket restrictions for example with-holding access to bedroom keys for patients on acute wards at the Ladywell Centre.
- The trust should continue to look at measures to reduce the numbers of patients who are absent without leave from acute and PICU wards. This includes making environmental changes where needed.
- The trust should ensure medication is stored at the correct temperature by monitoring medication fridge tempratures and clinic room tempratures. Fridges must also be locked to keep medication secure.
- The trust should ensure that where staff are using personal alarms that there are enough for all staff and visitors.
- The trust should ensure all staff have regular supervision.
- The trust should ensure that staff have training on supporting people with learning disabilities or autism spectrum disorder where they are caring for patients with these needs.
- The trust should ensure patients have accesss to enough therapeutic activities including support to access the gym.
- The trust should ensure staff are mindful of peoples privacy and dignity for example closing observation panels in bedroom doors where possible.

Mental health crisis services and health-based places of safety:

- The trust should ensure that the current environments used as health based places of safety promote people's privacy and dignity.
- The trust should ensure home treatment teams support patients to receive and know how to use their crisis plans.
- The trust should ensure home treatment teams and staff working in the health based places of safety are able to use and record capacity assessments.
- The trust should ensure that home treatment teams complete medication administration records so they include all the necessary information such as records of allergies.
- The trust should ensure that home treatment teams support staff to complete their mandatory training.
- The trust should ensure that home treatment teams communicate with inpatient wards to ensure there is clarity about which patients are on section 17 leave.
- The trust should ensure that staff in the Southwark home treatment team have access to regular supervision.

Specialist community mental health services for children and young people:

- The trust should ensure that the environment at Lambeth is safe for those people who use or work in the service.
- The trust should ensure that infection control audits are carried out across all CAMHS services.
- The trust should continue to monitor and review the services to ensure that all children and young people can access the service in a timely manner.

Summary of findings

- The trust should ensure that all staff have IT equipment and patient record systems that enable them to access the information they need in a timely manner.
- The trust should ensure that there is a consistent approach to the documentation of patient care and treatment, including risk assessments, care plans and consent.

Child and adolescent mental health wards:

- The trust should continue to recruit new staff to fill vacancies and that it ensures safe staffing numbers are met at all times.
- The trust should ensure that it continues to monitor risk assessments and care plans on Acorn Lodge to ensure that all are up-to-date.
- The trust should ensure that it develops a clear timetable for planning, approving and commencing redesign work to separate the wards on the Woodlands unit.
- The trust should ensure that it looks into developing a child friendly menu for Acorn Lodge.
- The trust should ensure that all staff receive regular one-to-one formal supervision.
- The trust should ensure that sufficient staff are trained in using the gym equipment, so young people can access this resource at more times.

Community based mental health services for adults of working age:

- The trust should ensure that all staff carrying out trust business follow the trust's lone working policy.
- The trust should ensure that the South Southwark assessment and liaison team is staffed on a permanent basis and set a target date for completion of this process. Vacancies across the recovery teams must be filled.
- The trust should monitor the number of changes patients are having of care co-ordinators in the recovery teams and keep this to a minimum.
- The trust should ensure patients are routinely involved with developing their care plans and that this is recorded clearly on the records. Patients should be offered copies of their care plans and this should also be recorded.
- The trust should ensure all staff know how to signpost patients to local advocacy services where needed.
- The trust should ensure that all the necessary steps are taken to ensure the equipment used in the teams is safe and in working order. This includes ensuring electrical equipment has regular portable appliance testing (PATs), fridges storing medication can be locked and have their temperatures checked and electrocardiogram machines are working.

South London and Maudsley 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 trusts systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. The application of the Act was overseen by the Mental Health law committee. This committee met quarterly and received activity reports covering the number of uses of the Act, uses of seclusion, breaches of the Act, data on patients who were absent without leave and matters raised by the CQC in Mental Health Act reviews. Administration of the Mental Health Act took place at offices on each of the four main in-patient sites.

Training on the Mental Health Act was mandatory every three years for nursing staff at band five and above. Optional training updates took place once a month. Training sessions were arranged for individual wards at the request of ward managers. These sessions were designed to meet the specific needs of the ward. An e-learning course was available to all staff.

During this inspection, 10 Mental Health Act reviews took place in line with the CQC's duty under section 120 to keep under review the exercise of powers and discharge of the duties conferred or imposed by the Act in relation to the detention of patients. Statutory paperwork was filled in correctly, up to date and stored appropriately.

At one home treatment team, we were unable to find authorisation of leave or written confirmation of discharge for three patients who were receiving treatment at home after a period of detention in hospital. On one ward a patient had been placed under a holding power after his admission for assessment had lapsed. They were then admitted for treatment. On another ward, a patient under a doctor's holding power had been allowed to leave the ward, thus invalidating the holding power, creating potential risks and delaying the requested assessment.

There was significant variation across all ten reviews in the quality and frequency of ensuring patients understood how the provisions of the Act applied to them and their rights to a tribunal, with little evidence of this on at least two wards. The trust's policy was for information to be given to patients once a month. This approach did not necessarily correspond with the specific needs and circumstances of the patients.

On all six adult wards, care planning was inconsistent with the requirements of the Code of Practice. Patients were not always involved in planning their care, care plans did not sufficiently address identified risks and there was a lack of consistency in the frequency of care plan reviews.

There was some pressure on psychiatric intensive care wards, raising concern about the use of triage wards for patients who were particularly unwell. On one triage ward a 'chill-out' room was being used for seclusion. On some wards 'contracts' were arranged for informal patients to stay on the ward and take medication.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a mental health law department that considered the Mental Capacity Act (MCA) and Mental Health Act. The work was overseen by the mental health law committee that reported directly to the board.

The trust had a comprehensive Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) policy. This included flowcharts and checklists to help guide staff. The trust also had a MCA clinical lead.

The trust had introduced mandatory MCA training. This was available on-line but face to face was also available for services which made greater use of the MCA.

The trust carried out an audit in 2014 looking at staff awareness of the MCA and found this was mixed across the services. The inspection found that the staff awareness was still very variable. Further work to improve staffs understanding and application of the MCA was needed on some acute wards, forensic wards, some community based services for older people and home treatment teams.

From December 2014 to the time of the inspection their had been 46 applications made for an authorization of a DoLS. Of these 14 had been authorised mainly in services for older people.

In services for children and young people staff understanding of the Gillick competencies was good and they described how it would be applied when a young person had decided they did not want their family to be involved. This meant that consent for care and treatment was always sought from young people and their families where appropriate.

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

In acute wards for adults and the psychiatric intensive care unit we found:

- Staff were not reporting all incidents of restraint and when restraint was recorded, it was not recorded comprehensively according to the Mental Health Act code of practice. This was addressed by the trust immediately after the inspection.
- On Eileen Skellern 1 the environmental risk caused by patients having access to an external fire escape had also not been mitigated.
- Individual risk assessments were not consistently up to date and reflecting the current risks to individuals.
- Some wards had significant staff shortages which had an impact on patient care.
- On Lambeth triage ward seclusion had not been recognised and so patients were not being properly monitored to ensure their safety.
- Emergency resuscitation bags did not all contain the listed emergency equipment or in some cases this equipment was present but out of date.

- Patients whose physical health monitoring had identified that their risks were raised had not all been referred for medical input.

In forensic inpatient wards we found:

- Staff did not always complete patients' risk assessments on admission and these were not regularly updated or reviewed.
- Staff were not clear on the procedures for reporting a safeguarding alert.

In the health based places of safety we found:

- The facilities at the Lambeth place of safety were not safe and the environment was not fit for purpose
- Lewisham health based place of safety had blind spots in both the observation window and the CCTV camera angle that meant that patient safety could not be guaranteed.
- Personal and emergency alarm systems at Lambeth home treatment teams were not regularly checked to ensure that they were working in the event that staff needed to request assistance.
- There were inconsistencies in where risk assessments completed by home treatment teams were held in electronic care records, which meant that it is was possible for staff (especially in other teams) to miss updates in risk information.

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

- Whilst risk was discussed at zoning meetings some risk assessments were incomplete or very brief which meant there was a possibility that care professionals would not be aware of patients individual needs.
- Medication and sharps were not transported safely between the team base and patients homes.
- Lone working procedures were not consistent or robust across the teams.
- Use of temporary staff and changes to the how the recovery teams were configured meant changes in care co-ordinators for patients and some staff were anxious about case-loads and the acuity of people they were supporting.

In wards for older people with mental health problems we found:

- At Greenvale and Chelsham House there were strong smells of urine by toilet areas.
- Across the wards for older people risk assessments were often completed with insufficient detail to ensure staff would know the necessary details.
- At Greenvale patients were using wheelchairs without footrests and being lifted without the use of the correct equipment. This meant there was a risk of people getting injured.
- At Greenvale and Ann Moss House, medication had run out causing delays in patients receiving medication.

In rehabilitation mental health wards for working age adults we found:

- Whilst work was taking place to reduce high risk ligature points, the existing risks were not being mitigated and ligature cutters were not readily available in the event they may need to be used.
- At Heather Close and the Tony Hillis unit blanket restrictions were in place that did not reflect the needs of people using the service.
- At Heather Close fire safety precautions were not being fully implemented.

In community based mental health services for older people we found:

- There was inconsistency between the teams and individual workers around when a risk screen or a full risk assessment should be completed. The quality of the risk assessments was variable and they were sometimes tick-box style with little further information added.
- Medication and sharps were not transported safely between the team base and patients homes.
- Many of the care records we reviewed did not contain clear, detailed crisis plans. Some of the carers and patients did not know how to contact someone in the event of a crisis out of hours.

Detailed findings

- Lone working procedures were not consistent or robust across the service.

Trust wide we found:

- There was a significant use of prone restraint throughout the trust.

However, the trust was reporting and investigating serious incidents well. Staff were well informed about the lessons learnt from this incidents and using this knowledge to improve practice. Medication was mainly well managed and provided support to patients and staff.

Our findings

Track record on safety

- NHS Trusts are required to submit notifications of incidents to the national reporting and learning system (NRLS). In total 4535 incidents were reported to NRLS between the 1 July 2014 and 30 June 2015. The majority of these incidents were classified as resulting in 'no harm' 61%, or 'low harm' 23%, with 16% resulting in'moderate harm' and 0.6% 'severe harm'. When benchmarked the trust are towards the bottom of the middle 50% in terms of the numbers of incidents being reported compared to other mental health trusts.
- Of these incidents 23% were associated with disruptive and aggressive behaviour including patient to patient incidents, 21% were self-harming behaviours and 18% were incidents relating to admissions, transfers and discharges including missing patients.
- External stakeholders told us that the trust had robust internal systems for identifying, reporting and investigating incidents. The inspection also found that staff working for the trust were confident at reporting incidents.
- The trust also had to separately report serious incidents. Between 1 July 2014 and 31 July 2015, eighty three incidents were reported. Of these fourty one involved the death of a patient. Of these deaths, eleven were reported as a suspected suicide, six were the suicide of an outpatient in receipt of care and nine were the unexpected death of a patient in the community who were in receipt of care. The community services in the psychosis clinical academic group had the highest number of serious incidents with nine suicides, suspected suicides and attempted suicides. The trust has completed benchmarking work with other trusts in the London region and does not believe it is an outlier for serious incidents.
- The trust had recognised that violence and aggression on some inpatient wards continued to be a challenge. The trust had set themselves a target in 2014/15 for 90% of patients to say they felt safe in hospital. Only 81% of patients when asked if they felt safe responded positively and so this priority has been carried over into 2015/16. The trust was piloting work on reducing violence and aggression on the wards called the 'Four Steps to Safety' programme which had very positive feedback from staff who were involved in the wards which were starting to use it. This meant that the trust was looking at new ways to improve in this area.
- The NHS SafetyThermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. There were no services where the levels of incidents reported were a particular concern.

Learning from incidents and duty of candour

- The trust was working to fulfil the regulation relating to the duty of candour. This means they operate with openness, transparency and candour so that if a patient is harmed they are informed of the fact and an appropriate remedy offered. The trust had a candour guardian and all serious incident reports routinely explained how the trust had communicated with patients and their families and how they had been kept up to date. We heard from a number of patients, staff and external stakeholders that the trust was open and transparent in sharing details of safety incidents. Most people felt satisfied with how this is happening, but a few remained unhappy with how their individual concerns had been addressed.

- The clinical commissioning groups fed back that they felt the trust had learnt from incidents and made changes. Examples of this included improving the care for people in terms of tissue viability. They also said work had taken place to improve discharge and transfer of care arrangements.
- Where serious incidents occur the trust has a robust investigation process. Where an internal investigation is deemed to be appropriate the trust use clinicians from another part of the organisation to lead this work. They agree with stakeholders when an external investigation is appropriate and support this process.
- Eight root cause analyses were randomly chosen and reviewed by the inspection team and these had been completed comprehensively. It was however noted that the ongoing challenge is the length of time being taken to investigate and close the incident investigations.
- The trust monitored the numbers of incidents reported on a monthly basis. This included the number of new serious incidents, physical assaults against staff and patients. This data was provided to the board as part of the quality and performance dashboard and trends were identified. In addition a learning lesson report was provided each quarter for the trusts quality sub-committee which looked at serious incidents,complaints, claims and learning from inquests to identify trends and an overview of lessons learnt. Where particular issues were identified thematic reviews looking in more detail were taking place. In addition each clinical academic group (CAG) held a monthly quality and safety governance meeting where incidents were reviewed and lessons were discussed. The key messages from the CAGs were fed back to the trust wide quality and safety meeting.
- The trust had a number of means of sharing learning from incidents and complaints. Immediate risks were shared across the trust in a 'blue light bulletin'. These bulletins that went to all the services highlighted areas where immediate action was needed. The trust also had 'purple light bulletins' for sharing good practice for example from audits and also 'amber bulltins' which were used rarely for information governance. There were also trust wide learning lesson events that took place every few months.
- During the inspection staff were able to speak confidently about the serious incidents that had happened in their area of work and the changes that had been made to the service based on the lessons learnt. Staff all knew about the bulletins.
- 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. However on the forensic wards the procedures for reporting a safeguarding referral were not consistent across the wards. It was unclear whose responsibility it was to raise an alert to the local authority. In some community based services for older people, team members did not know how to make a safeguarding alert.
- Safeguarding training was mandatory. The compliance with safeguarding training for clinical staff in September 2015 was safeguarding adults 78% and safeguarding children 87%.
- The director of nursing was the executive lead for safeguarding. The trusts director of social care managed the safeguarding service. There was a separate adult and children's safeguarding lead. Each clinical academic group (CAG) also had a safeguarding lead role for adults and children and the time available for this role varied according to the demands of the group. Each of the four boroughs had a social care lead who attended the safeguarding boards supported by more senior staff as needed. Safeguarding referrals were made to the relevant local authority, although each borough had a different local system. Work had commenced to streamline and standardise this process. Feedback from stakeholders was that the trust was working well with local authorities to use safeguarding processes to safeguard vulnerable adults and children.

- The trust and stakeholders acknowledged there was a challenge around the collection of data on safeguarding and this made it had to say accurately how many safeguarding referrals had taken place, what were the themes and the outcomes of this work.
- In the six months prior to the inspection there had been 365 incidents reported where the person who completed the alert felt there was a safeguarding vulnerable concern. Of these 74% related to a patients assaulting another patient. There were 22 incidents where an allegation was made that a staff member had assaulted a patient. The data does not show how many of these were referred to the local authority.
- Also in the six months prior to the inspection there had been 78 incidents reported where there had been a safeguarding concern in relation to children, mostly relating to assaults or challenging behaviour whilst an inpatient.

Assessing and monitoring safety and risk

- Stakeholders have said that there was a recurrent theme in serious untoward incidents of detailed individual risk assessments not being in place.
- The trust recognised the need to improve risk assessments as a quality priority in 2015/16, following an audit in the final quarter of the year 2014/15 where 65% of the patients had a risk assessment in place. They set a target of 75% of inpatient and community patients on the care programme approach (CPA) to have a full documented risk assessment.
- The inspection found that the standard of risk assessments needed to improve across many of the services that were inspected. Most staff understood about the risks for the patients they supported. They were communicating well with colleagues about risk in hand-over meetings or in meetings when the care people received was prioritized. The standard of written risk assessments was very variable. The reasons varied between services. Some had delays in preparing initial risk assessments and some risk assessments did not include enough detail or had not been updated as new risks were identified. The storage of risk assessments on the electronic patient record system was very variable and so locating the document in some services could be hard. This meant that there was a risk of care professionals not having access to the correct information and therefore not providing patients with the correct support. This was a particular worry in services where there were a lot of temporary staff who may not know the patients well.
- Whilst most patients knew who to contact in an emergency this was not always the case. However in some teams more work was needed in this area. Some patients being supported by the home treatment teams did not know they had a crisis plan or how to use this. Also some patients and carers being supported by community teams for older people did not know who to contact out of hours in an emergency.

Potential risks

Safe staffing

- The trust had a workforce strategy. One part of this was for the number and proportion of nurses in the workforce to reduce and for there to be an increase in the numbers of psychologists and psychotherapists who at the time of the inspection were 16% of the workforce. The trust had carried out a review in 2014 of nurse staffing levels across the services. This had identified a number of areas where staffing levels needed to be increased. As a result of this the number of vacancies increased.
- In April and May 2015 the vacancy rate for the trust was 20%. In May 2015, fifteen wards reported that over 20% of their shifts had breached the safe staffing levels. This was identified as an extremely high risk for the trust and monthly safe staffing reports were going to the board.
- The trust had an e-rostering system in place across the whole organisation. This supported the ward and team managers to plan and deploy their staff effectively and ensure staff with the correct skills were working. The trust operated a bank and worked with NHS Professionals where agency staff were needed. The e-rostering system aimed to identify vacant shifts so that temporary staff could be booked as needed. Sometimes an unqualified staff member would be used as a partial measure when a qualified member of staff was not available.

Detailed findings

- Between February and April 2015 there were 36,550 shifts filled by bank or agency staff. The CAG with the highest usage was psychosis CAG with 18,117 shifts. There were 3,405 shifts not filled in the same time period. 1,526 of these were in psychosis CAG.
- Staff sickness for the same period was 3.05% which was the fifth lowest of all mental health trusts in the country. Staff sickness had improved following sickness management being addressed in a more robust manner. Staff who were off work as a result of incidents of violence and aggression were channelled through the sickness management programme. We were told that there was sensitivity to the fact that the absence resulted from an incident at work and support was available including counselling. Staff we spoke to during the inspection expressed their concerns about this approach. The trust was working to make itself a healthier workplace providing support to staff to improve their health and access support from occupational health when needed. The trust was also working to improve staff retention and had introduced the use of exit interviews.
- The trust had an active programme of constant recruitment for key groups of staff including inpatient nursing, community nursing and administrative roles. This function had been centralized which was leading to more staff coming into post and at a faster pace. Some of the recruitment strategies included focused campaigns, working with newly qualified nurses to provide practical assistance with the application process, improved branding with use of social media and working to convert bank and agency staff into permanent staff. In the 8 weeks prior to the inspection the psychosis CAG had recruited to over 50% of it's vacancies. The number of new starters was greater than the same timescale in the previous year. The trust was also trying to be creative based on individual services. For example in Kent where they managed a child and adolescent inpatient service where there were over 50% staff vacancies they had tried ideas such as offering temporary accommodation, looking at the use of lease cars and at the time of the inspection had reduced the bed numbers. Assessment centres had been booked up to May 2016 to keep recruitment progressing.
- The Royal College of Nursing survey in the summer of 2014 found that 65% of respondents from the trust said their unit had too few qualified staff and 59% of respondents said they were caring for unsafe number of patients. In the 2014 NHS staff survey the trust scored in the worst 20% of all mental health trusts for the percentage of staff working extra hours and the trust scored worse than the national average for staff feeling pressure to attend work when feeling unwell, and work pressure felt by staff.
- The main concern that was raised at focus groups and staff interviews related to staffing levels, especially in acute wards for working age adults. We also heard that there are times on the main inpatient sites when there was not a band 6 nurse in charge at night especially at the Maudsley. Nurses felt this was very unsafe as there was no-one with sufficient experience to take charge in the event of a serious incident such as a fire.
- The inspection found that maintaining safe staffing levels was a challenge across the trust as most services were struggling with recruitment and access to temporary staff in the meantime. The wards facing the greatest difficulties were the acute wards. Across the acute wards, on the four sites, there were 85 vacancies for qualified nurses and 36 vacancies for health care assistants. The highest vacancy levels were on Lewisham triage ward and Bridge House North which both had 7 vacancies. All managers were able to request additional staff when they needed them. Bank and agency staff were used frequently to try and ensure safe staffing levels were reached and to cover the close observations of patients who were most at risk. However temporary staff were not always available. In June and July 2015, Lambeth triage ward had not met it's safe staffing levels 75% of times. Over the same period, June and July 2015, Bridge House, at Lambeth Hospital had not met the safe staffing targets set by the trust on 64% of shifts.
- The trust was trying to mitigate these challenges of maintaining safe staffing levels. Bed numbers had been reduced on the Lewisham and Croydon triage wards, the female PICU at the Maudsley, the Kent and Medway inpatient CAMHS service and Chelsham House a ward for older people. However, there was an impact on patient care on the acute wards. This included reduced access to outside areas, cancelled activities and 1:1

sessions with nurses not taking place. We also heard from experienced staff about how stressful they were finding the work as they had to keep the wards running smoothly with lots of new or temporary staff.

- The trust was struggling to meet targets for mandatory training. In September 2015 most mandatory training was below the target of 85%. The trust was taking a number of actions including reviewing the scheduling of courses to reduce the numbers of staff not attending, promoting e-learning for hard to release staff, attendance at mandatory training was part of the new performance development review form, ensuring the message was clear about the importance of training and ongoing monitoring of attendance. Information provided to staff on what mandatory training they have to complete was being simplified. Robust monitoring of mandatory training levels by CAG was completed at monthly operational performance review meetings.
- Across most community teams there were arrangements in place for lone working to ensure staff whereabouts were known, staff could contact colleagues for help and where needed visits were carried with more than one member of staff. However in some of the community based mental health services for adults and older people, these arrangements were not being followed.

Safe and clean environments on wards and at community team bases

- The trust provided services from a very variable range of physical environments across 4 hospital and 85 community sites. The trust had an estates strategy which provided a structure for an ongoing estate refurbishment programme. There were a number of major schemes taking place during the inspection as well as plans for more going forward. For example the Jim Birley unit at the Maudsley had been decanted to the Ladywell Unit for a major refurbishment programme. An example of another capital project that was ongoing was an upgrade to the staff safety alarm system.
- During the inspection the team saw or heard about all the environmental improvements which had taken place. The physical environment we were most concerned about was the health based place of safety at Lambeth Hospital where there were numerous ligature points. The door to the room was not suitable and did not have a suitable locking mechanism for situations where it might be used as a seclusion room. The viewing window into the room was marked, scratched and dirty. This resulted in poor visibility and an inability to observe service users and maintain their safety in the room. Observation of patients using the health based place of safety at Lewisham hospital was also not safe due to blind spots in the room. The trust has plans to move the health based places of safety to a new centralised facility at the Maudsley but there was an immediate need to make the facilities safe.
- Other inspection reports highlight areas where the environment needed improvements. Heather Close and the Tony Hillis unit were mentioned as areas where maintenance and repairs needed to take place.
- We found that facilities were generally clean. Infection control and health & safety were monitored through audits. Hotel staff working across the services were asked to keep an eye on things that needed to be maintained and complete 'spot light reports' as needed. Stakeholders felt there were good systems of governance in place to maintain standards of infection control. We did however find that at Greenvale and Chelsham House which were services for older people that there were unpleasant odours of urine by toilet areas. The cleaning methods were not working. The trust said they were reviewing the cleaning products. In the specialist community health services for children and young people infection control audits were not always taking place and so it was not possible to be confident that children were protected from these risks.
- The inpatient services had patient led assessments of the care environment (PLACE). Overall the PLACE assessments that took place between February and June 2015 showed a significant improvement from the previous year and placed the trust above the national average for all trusts. The assessments looked at cleanliness 99%, food 89%, privacy and dignity 95%, condition and maintenance 98% and a new assessment looking at environments for people with dementia which scored 98%. During the inspection some patients did tell us that the toilet and showers in communal areas could become soiled or blocked.
- The trust had undertaken environmental risk assessments of ligature point risks in the mental health

inpatient areas during the last year and these identified high risk ligature points and how those risks should be mitigated. There was a programme to reduce inpatient ligatures. All the minor work was completed, about two thirds of medium works and half of major works. The major schemes required planning permission, such as replacing windows in certain buildings. The trust focused on individual risk assessments as the main means of keeping patients safe and is most areas we found this was working well. In a few areas the mitigating actions were not happening in a robust manner. For example on Eileen Skellern the female PICU staff were not carrying out observations in line with the risk assessment. In addition a patient had climbed up an external fire escape when staff should have been observing that area to prevent incidents from occurring. Also at Heather Close and McKenzie ward staff were not able to articulate the actions they were taking to mitigate risks for patients who might harm themselves in this way.

- We looked at whether patients using mixed gender inpatient services were provided with 'same sex accommodation' to promote their privacy and dignity. The trust had reported no breaches in same gender care. It was noted that on some of the rehabilitation wards, whilst bedroom areas were separate male patients could enter female areas and staff needed to be mindful of the potential vulnerabilities of the patients.

Physical interventions

- The trust had a policy on preventing and managing violence and aggression. At the time of the inspection this was being updated and did not refer to the Department of Health guidance "Positive and Pro-active Care". The policy says that physical interventions should only be done 'as a last resort in an emergency'. The policy also says that 'in exceptional circumstances where the service user is in a prone (face down) position, this should be for the shortest possible period of time and the service user moved into the supine (face up) position.
- For the six months from December 2014 to May 2015 there had been 1042 incidents of restraint. Of these 256 (25%) were in the prone position. Of these prone restraints 58% involved the administration of rapid tranquillization.
- The trust used the promoting safe and therapeutic model of training.The training reflected the needs of staff working in different services. For example staff working with older people received training appropriate for this work.
- We found that staff were aware of the trusts policy. However on the acute wards and to a lesser degree on the forensic wards restraint was not always being reported and did not include the necessary details to be able to review the incident itself and identify trends.
- In the six months prior to the inspection seclusion was used 232 times. There were variations in the use of seclusion between different services. Higher use was found in the CAMHS inpatient services at the Bethlem and also in the psychiatric intensive care unit at the Ladywell Unit.
- We were concerned about the use of seclusion for a number of reasons. The records of seclusion in the forensic service were not all fully completed, which meant it was not always possible to know if patients had received appropriate medical and nursing monitoring during their time in seclusion. On the triage ward in Lambeth some patients were being asked to remain in the 'chill out' room as part of their planned care without it being recognised that seclusion was taking place and therefore without the necessary safeguards. This was raised and addressed at the time of the inspection.
- Between the 1February 2015 and the end July 2015 there were 465 incidents of patients detained under the Mental Health Act who were absent without leave (AWOL). Eighteen percent (85) of these incidents were patients who had absconded whilst residing on the ward. The majority of these patients were being cared for on the triage, acute and psychiatric intensive care wards. The trust was starting to monitor numbers of patients absconding and this was reported on the trust performance dashboard. The trust had also participated in a London wide benchmarking process and this showed that whilst the trust had the highest numbers of detained patients who were absent without leave, once this was analysed against numbers of beds the trust was the third highest. No serious incidents were recorded as having taken place whilst the patient was AWOL, but there was a risk of an incident occurring. A number of actions had taken place. This included a policy review considering this area of risk, training for ward leads,

identification of hotspots where environmental changes were needed. Other work that was in progress included developing an electronic patient form that could be emailed to the police quickly, completing environmental work for example the entrance to the Ladywell Unit, completing a review of AWOLs and reviewing the impact of the new policy. This work needs to be progressed including environmental changes as a patient was observed absconding from the Johnson ward PICU by climbing over the garden fence during the inspection. In the forensic services the trust was using a patient tracking device for patients going on leave as a way of managing risk. This had resulted in low levels of AWOL's in this service.

- Within some services there were examples of blanket restrictions. For example patients at the Tony Hillis unit which are rehabilitation services were not able to make their own hot drinks or have access unaccompanied to the garden. At Heather Close all the patients including informal patients were told to be back at 8pm. This was a blanket approach and not based on individual care plans.

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.
- There were a few exceptions to this. At Greenvale staff were seen using wheelchairs without footrests. On some acute wards, bags of emergency resuscitation equipment did not contain all the necessary equipment or this was out of date. There were other similar findings in other community teams.

Medication

- The pharmacy department was open five days a week and on a Saturday morning on the Maudsley site. There were pharmacists on call out of hours, and senior staff on site had access to emergency drug cupboards. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients normally had access to medicines when they needed them.
- Pharmacists visited all wards each week, the number of visits per week varied depending on the patient turnover. We saw pharmacists completed the medicines management section on the medicines administration record for every patient to confirm medication reconciliation had occurred. Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP.
- Pharmacists attended the ward rounds on the majority of wards and supported the home treatment teams at their weekly review meetings. However the trust community mental health teams did not receive a clinical service from the trust pharmacy. On several wards medication information sessions were available to patients if they wanted information about the drugs they were prescribed.
- Staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. In all of the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety.
- The trust carried out a wide range of medicines related audits to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, missed doses, recording of allergies, medicines reconciliation, and safe and secure handling of medicines. These audits showed that improvements were being made, but further improvements were needed to ensure medicines were managed safely. The trust already had action plans in place to address the issues they had identified prior to our inspection.
- The trust audited the use of antibiotics. An antibiotic audit in July 2015 showed that for all patients who had been prescribed an antibiotic the indication was recorded and prescribing was in line with trust guidelines although the duration of treatment was not specified in all cases.
- The trust audited the use of rapid tranquilisation between April 2014 and March 2015. Areas of concerns identified were physical monitoring was not evident for more than half of the patients administered intra-muscular (IM) medication and none of the patients had

evidence of monitoring every ten minutes for the first hour after IM administration. Action plans had been put in place following this audit, and improvements had been made.

- The trust had done an audit of the covert administration of medicines in 2014 which showed there were no cases found where a patient was found to have capacity to consent to treatment but medicines were still given covertly. It did identify aspects of the record keeping which needed improving.
- We saw the trust had partly responded to the 2010 National Patient Safety Agency (NPSA) rapid response alert 'reducing harm from omitted and delayed doses' by doing an annual audit to check how many doses were omitted. The last audit results in November 2014 showed there had been no significant improvement from the previous year when an average of one percent of prescribed regular doses had a blank prescription box. The annual audits did not check if there were any delayed doses of critical medicines but only if they were omitted.
- Medicines errors and incidents were reported quarterly. These were reviewed by the medicines safety committee and the drug and therapeutics committee. Information to staff was communicated to staff via quarterly medicines bulletins. Examples of learning from incidents included giving patients a clozapine warning card which detailed the actions to be taken if a patient presented with a range of symptoms. This was a result of a patient having their clozapine incorrectly stopped by a local accident and emergency department.
- When people were detained under the Mental Health Act, the appropriate legal authorities for medicines to be administered were in place and were kept with prescription charts so that nurses were able to check that medicines had been legally authorised before they administered any medicines.
- During the inspection we did find a few areas where medicines management needed to improve. At Greenvale and Ann Moss House which are community based wards for older people and have the medication dispensed by a community pharmacist, the medication was sometimes not available when needed and so stock control needed to improve. For the community teams for adults and older people the transporting of medication, medical waste and sharps needed to be reviewed as this was not happening safely. At Greenvale and some of the acute wards fridges holding medication were not locked or the temperatures were not monitored.

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:

- Patients physical health needs were being assessed and this was mostly done in a thorough manner.
- Patients were assessed using the modified early warning system to identify early deteriorations in their physical health.
- There was a high level of awareness of national institute for health and care excellence guidance and patients had access to a range of psychological therapies.
- Staff were well supported with induction and ongoing training, clinical and management supervision and an annual appraisal. There were opportunities for reflective practice.
- Multi-disciplinary teams worked together well to meet the needs of the patients they were supporting. There were also positive examples of different teams working together and different agencies.

However, across a number of wards and teams care plans had not consistently reflected the identified needs of patients and there was generally poor involvement of patients in care planning.

The rights of informal patients was not consistently understood in a way which protected their rights and gave them correct information about their right to leave the wards or refuse medications. Staff understanding of the Mental Capacity Act was variable. Staff working on the mental health wards for older adults did not feel confident in supporting people with dementia and were not being made aware of the training they could access to develop their skills.

Our findings

Assessment and delivery of care and treatment

- 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 in the community mental health services for people with a learning disability assessments took several appointments to fully complete because of the complexity of people's needs. For example, some people could not easily communicate verbally. Care records included referrals the team had made to speech and language therapists in order to begin the process of establishing ways of communicating with the person. People and relatives told us that the team strove to involve people in their assessment using non-verbal methods of communication, such as using pictures, if necessary. In contrast to this we found that on some wards for older people, relatives could have been involved more in the assessment process.
- In adult community services the trust had introduced a new integrated assessment process which streamlined the assessment process between the trust and the local authority.
- Previous inspections by the Care Quality Commission had identified a number of concerns about the quality of care plans. This included inconsistencies in documentation, lack of evidence of patients and carers being involved, unclear recording of progress and lack of a recovery focus. The trust had developed a care plan audit tool and this had shown that aspects of care planning were proving challenging to complete. Each CAG was looking at plans to improve the quality of care planning.
- At this inspection the care plans still needed to improve, particularly on some of the acute and forensic wards and adult community services. They needed to be more holistic, up to date, and involve the patient in their development.

Good

Are services effective?

- The trust had a quality priority in place alongside a target set by commissioners with the aim of identifying and treating patients physical health needs. For eligible inpatients they were monitoring the percentage who had as part of their physical health assessment, six key metabolic cardio-vascular tests. When this was audited in 2014-15 this had reached 92% in period from January to March 2015. The same targets are in place for this year.The same tests were also being monitored for patients accessing the early intervention service. Stakeholders also reported that they had seen an increase in patients on anti-psychosis drugs having tests for lipids and blood sugar levels.
- The trust also monitored the percentage of inpatients who had an annual physical health check. In May 2015 this had been completed for 94% of inpatients. The inspection found that the physical health assessments were mostly in place and completed thoroughly. It was only in forensic services where a few patients had not had their assessment in a timely manner.
- We found that some patients were recieiving very good physical health care. For example in the forensic inpatient services there was an on-site health centre offering input from a GP, dentist and optician.
- The trust was making good use of the modified early warning system to monitor and identify when patients physical health was deteriorating so that appropriate treatment can be sought.
- The trust had become smoke free in October 2014. The trust had established a number of aspirational targets for 2015-16 to monitor the smoking status of patients in hospital and the community and record how many were offered nicotine replacement therapy or behavioural support to quit smoking. They were also monitoring the numbers of clinical and advisory staff who were completing the appropriate level of training. The results were not yet available.

Outcomes for people using services

- The trust had a wide range of measures in place agreed with commissioners, other stakeholders such as NHS England 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 framework had incentivised the trust to deliver improvement. A number of targets were set for example, to improve discharge communication with GPs, monitor outcome measures for patients using the eating disorder service and assuring the appropriateness of unplanned CAMHS admissions.
- The trust ensured it maintained the care it provided and the associated procedures in line with the latest guidance. Assurance around the monitoring of national institute for health and care excellence (NICE) guidance was by the trust quality sub committee. The quality sub committee was multi-disciplinary and was attended by clinical directors from the different CAGS. The committee had the following responsibilities in relation to NICE: ratified decisions about appropriate clinical leads for each specific NICE guidance; ensured an organisational gap analysis took place when relevant NICE guidance was issued; reviewed and agreed dissemination and implementation plans, and considered if the identified action was adequate and appropriate; reviewed and agreed plans to monitor uptake/audit of implementation of NICE guidance; monitored progress against agreed dissemination, implementation and audit plans.
- During the inspection we saw staff referring to NICE guidance and demonstrating a high awareness of how services were meeting the guidance. Many of the services had access to a range of psychological therapies in line with the guidance.
- The trust drug and therapeutics committee reviewed new NICE guidance quarterly. A summary of the guidance issued and prescribing status of medications was updated quarterly on the trust website. All relevant NICE guidance was included in summary form in the Maudsley prescribing guidelines.
- The trust was compliant with the patient safety alerts issued by NHS England. Trusts were required to nominate a board level director responsible for medicines safety, a medication safety officer, and form a trust-wide medicines safety committee. The trust medical director was the director responsible for medicines safety and the deputy director of pharmacy

was the trust medication safety officer. The medicines safety committee was chaired by the trust medical director and the committee had met five times since October 2014.

- The South East London clinical commissioning groups (CCG) had formed an area prescribing committee. Croydon CCG has its own prescribing committee. Both committees assessed the suitability of all drugs for use in primary and secondary care within their geographical area. If a new drug was approved, this information was uploaded onto the intranet so that it could be accessed in between editions of the Maudsley prescribing guidelines.
- The Maudsley prescribing guidelines in psychiatry were used to promote rational, cost effective prescribing. Applications to approve new drugs for use in the trust were submitted to the new drugs panel, a subgroup of the area prescribing committee. The trust drug and therapeutics committee no longer had the authority to approve new drugs for use in the trust.
- The trust participated in the national prescribing observatory for mental health annual audit programme. The trust pharmacy collected and submitted data for these audits. For example, the 2014 results for prescribing to patients with a personality disorder showed that the trust had the lowest proportion of patients for whom psychotropic medicines were prescribed for more four weeks. It is best practice for treatment to be limited to four weeks at any time. Where the results showed a need for improvement, action plans had been implemented. For example the results for the prescribing of anti-dementia drugs had led to more work with GPs to support best practice prescribing.
- The trust participated in the 2014 national audit of schizophrenia, the purpose of which was enable clinicians who worked in the community to assess the quality of their prescribing of antipsychotic drugs. The results showed the trust performed better than the average national sample. For example rates of high dose antipsychotic (2%) and polypharmacy (2%) remain low in the trust (10% and 11% respectively in the national sample). A higher proportion of patients in the trust (81%) than in the national sample (71%) felt involved in the decision about their prescription.
- The trust recognised that clinical audit was an essential part of improving quality. The trust carried out 10 non-financial audits in 2014-15. These included area such as quality governance, research and development, working with strategic partners, risk management arrangements and mandatory training. From October 2014 to March 2015 the trust carried out 25 clinical audits across a range of services. Some of these were to check compliance with targets set by commissioners. Examples included audits of physical health checks, smoking cessation, risk assessments, use of MHA, culture and care plans, carer involvement and discharge documentation. During the inspection we saw audits being completed and the results being used to make improvements to services.
- In terms of measuring outcomes for individuals the trust was also using the paired 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 wide range of other outcome measures dependent on the needs of the individual to see how patients were progressing.

Staff skill

- The trust provided a four day corporate induction for all staff. We heard from a range of staff that this training was very helpful.
- In addition staff received a local induction that supported them to understand their specific role in the services. We heard that in most areas this was very good. On the acute wards we did find that some temporary staff were not receiving a timely induction which could mean that they would not understand how they were expected to perform their role.
- Staff talked positively about the training opportunities they received. This was provided through the trusts education and training department, with partner organisations and through the recovery college. Examples included the adult mental health programme which was available across two boroughs to support staff in adult community teams to deliver best practice and evidence based interventions with patients with the aim of reducing patient relapses. Another example was the use of simulation training to give staff practical support in addressing complex situations they are likely to encounter in their work. Many staff talked about the

opportunities they received to study for advanced academic qualifications. For example we heard about the care certicate which over 600 support workers were having the opportunity to complete over the next two years. However in services for older people, staff did not always feel confident in supporting people with dementia. There were a range of training options available on dementia as part of other courses and through training provided from members of the multi-disciplinary team. The trust needed to ensure that these were more widely advertised and that staff were actively supported to access them so that they are able to provide appropriate care to patients.

- Stakeholders said the junior doctors particularly commended the learning and development opportunities. Examples included expert witness training for those working in forensics, access to simulation training around challenging clinical scenarios and access being available to the Kings College London educational resources such as the library services.
- The trust expected all staff to have completed an annual appraisal. At the time of the inspection 99% of staff had received an in year appraisal. The trust was now moving on to look at the quality of the appraisals. They had developed a tool to track and view appraisal completion and performance outcomes to provide transparency of ratings given to individual employees. This will show for example if certain managers are giving lower ratings.
- 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 and many told us that this had improved, although the frequency was variable between services. It was noted that on wards and teams where there were staffing challenges that supervision was less frequent for example of the acute and CAMHS inpatient wards.
- The trust expected staff to have access to regular team meetings and we found that these were usually taking place and in most services there were also meetings providing opportunities for reflective pratice 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 complied with the medical revalidation statutory requirements. In 2014-15, 86% of the trust doctors had completed their appraisal and the rest were deferred with a clearly identified reason.
- The trust aimed to celebrate the success of staff who lived the trust's values while delivering excellent care. They had a 'make a difference' staff award scheme and any staff or teams could be nominated. Award ceremonies took place four times a year. In addition there was an employee of the year award.

Multi-disciplinary working and inter-agency work

- Staff spoke favourably about internal multi-disciplinary work. We observed 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. Meetings took place with appropriate frequency and involved a detailed discussion of each patient's progression, behaviour and risks and displayed a good understanding of each patient's needs.
- 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 ongoing challenges in working with GPs and sending them timely information including a completed care plan, risk assessment and GP discharge summary. A clinical audit showed that of the discharge information checked only 24% contained all the information that should be sent to the GP. In addition the discharge summaries are not reaching the GPs within the target of 7 working days. For adults only 60% arrived in this timescale whilst for older people and CAMHS it was only 37%. Work was taking place to identify the reasons for the delays and how this

can be improved. Measures being introduced included more training for junior doctors, the use of discharge template and the appointment of a physical health nurse who started around the time of the inspection.

- The trust worked with four London boroughs, Lewisham, Southwark, Lambeth and Croydon. The trust had a director of social care. The boroughs each had a lead who would be working in an integrated service but also had time available for liaison work. The feedback from the boroughs was that whilst they valued the borough leads, the organisation of the trust into CAG's was challenging in terms of ensuring high quality integrated care and services as well as working collaboratively with primary care and the third sector. They also talked about how the CAG's appear to work independently of each other which may lead to problems for patients moving between them. It was also felt that boroughs could sometimes be engaged earlier around service developments and improvements. They recognised that the trust had produced a draft social care strategy and that this recognised the need to align social care and trust priorities.
- We found examples of good inter-agency work and also some challenges. We heard of where the trust was working with key stakeholders such as the police, voluntary sector, housing providers and primary care to meet the needs of patients. For example in Lewisham the dementia information and advice service called Mindcare was a good example of multi-agency working. We were also told by staff about the impact of reductions in social care funding on access to social workers to support the discharge planning process.
- The trust had also worked effectively with other trusts in partnership with other agencies. The chief executive was clinical director of the London mental health strategic clinical network. This set out recommendations for commissioning mental health crisis services across London in response to the crisis care concordat.

Information and Records Systems

- The trust had an IT strategy and investment programme with most work taking place in the next 12-18 months. The aim was to ensure staff had access to the right information at the right time, regardless of location. The trust had started to replace old computers with laptops and tablets. The trust was also undertaking a number of measures to deliver better working IT systems and access to data in a meaningful form to staff, patients, carers and researchers.
- The trust was using the 'patient journey system' (ePJS) for patient records. Throughout the inspection we were told by staff that they found the system challenging to use. The trust was implementing an ePJS redesign programme. This was a complex piece of work that aimed to reduce duplication, support staff to access the right forms to use, provide a summary of each patients details that was easy to update and improve the security of patient information.

Consent to care and treatment

- The trust had a mental health law department that considered the Mental Capacity Act (MCA) and Mental Health Act. The work was overseen by the mental health law committee that reported directly to the board.
- The trust had a comprehensive Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) policy. This included flowcharts and checklists to help guide staff. The trust also had a MCA clinical lead.
- The trust had introduced mandatory MCA training. This was available on-line but face to face was also available for services which made greater use of the MCA.
- The trust carried out an audit in 2014 looking at staff awareness of the MCA and found this was mixed across the services. The inspection found that the staff awareness was still very variable. Further work to improve staffs understanding and application of the MCA was needed on some acute wards, forensic wards, some community based services for older people and home treatment teams.
- From December 2014 to the time of the inspection their had been 46 applications made for an authorization of a DoLS. Of these 14 had been authorised mainly in services for older people.
- In services for children and young people staff understanding of the Gillick competencies was good and they described how it would be applied when a young person had decided they did not want their family to be involved. This meant that consent for care and treatment was always sought from young people and their families where appropriate.

Good

Are services effective?

Assessment and treatment in line with Mental Health Act

- The trusts systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. The application of the Act was overseen by the Mental Health law committee. This committee met quarterly and received activity reports covering the number of uses of the Act, uses of seclusion, breaches of the Act, data on patients who were absent without leave and matters raised by the CQC in Mental Health Act reviews. Administration of the Mental Health Act took place at offices on each of the four main in-patient sites.

- Training on the Mental Health Act was mandatory every three years for nursing staff at band five and above. Optional training updates took place once a month. Training sessions were arranged for individual wards at the request of ward managers. These sessions were designed to meet the specific needs of the ward. An e-learning course was available to all staff.
- During this inspection, 10 Mental Health Act reviews took place in line with the CQC's duty under section 120 to keep under review the exercise of powers and discharge of the duties conferred or imposed by the Act in relation to the detention of patients. Statutory paperwork was filled in correctly, up to date and stored appropriately.
- At one home treatment team, we were unable to find authorisation of leave or written confirmation of discharge for three patients who were receiving treatment at home after a period of detention in hospital. On one ward a patient had been placed under a holding power after his admission for assessment had lapsed. They were then admitted for treatment. On another ward, a patient under a doctor's holding power had been allowed to leave the ward, thus invalidating the holding power, creating potential risks and delaying the requested assessment.
- There was significant variation across all ten reviews in the quality and frequency of ensuring patients understood how the provisions of the Act applied to them and their rights to a tribunal, with little evidence of this on at least two wards. The trust's policy was for information to be given to patients once a month. This approach did not necessarily correspond with the specific needs and circumstances of the patients.
- On all six adult wards, care planning was inconsistent with the requirements of the code of practice. Patients were not always involved in planning their care, care plans did not sufficiently address identified risks and there was a lack of consistency in the frequency of care plan reviews.
- There was some pressure on psychiatric intensive care wards, raising concern about the use of triage wards for patients who were particularly unwell. On one triage ward a 'chill-out' room was being used for seclusion.
- On some wards 'contracts' were arranged for informal patients to stay on the ward and take medication.

Good

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 **good** for the following reasons:

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers, were usually involved in decisions about their care.
- Opportunities were available for people to be involved in decisions about their services and the wider trust.

However, on wards for older people although the majority of staff were very caring and thoughtful, the structured observations that were done during the inspection showed that some staff did not communicate well with the patients especially during mealtimes.

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 on the National Autism Unit we observed many interactions between staff and patients. Without exception these interactions demonstrated that staff respected patients. During a group activity staff supported patients to make their own hot drinks and encouraged them to interact with others and express their views. Staff were very attentive to those patients who expressed themselves quietly and ensured they participated as much as possible.
- The comment cards and feedback from user groups showed that where there were negative comments these were found more in inpatient services. The negative comments were spread across services rather than being clustered on particular wards. Examples of concerns raised by patients included staff spending too much time in the office, staff looking at their mobile phones, staff standing looking at people while they ate and staff not listening and speaking to each other in another language.
- Staff attitude accounted for 13% of complaints in 2014-15, but this was a 25% reduction from the previous year.
- The trust had a priority to stop patients needing to queue. A recent audit showed that across 53 wards, 24% of patients queued for medication and 32% patient queued for food.
- We also found in some areas that there was room for improvement. For example on some of the wards for older people during mealtimes there was a clear lack of interaction between some staff members and patients and staff were observed to stand with their arms folded, staring at patients while they were eating with minimal or no conversation. Staff could be heard discussing their workload with each other which was not appropriate.

Involvement of people using services

- On most wards there were regular community meetings taking place which enabled patients to have some involvement in the services they were receiving. For example, on Bethlem adolescent unit there was a young person's opinion group as well as a discussion group with the ward manager. The young people had been supported to write a letter to staff detailing how they wished to be cared for. This was displayed prominently in the ward. The rehabilitation wards had community meetings once a week, where patients discussed issues including complaints and activities for the week. There was a suggestion box on wards which patients could use to make comments on the service and the actions were displayed on wards.

Good

Are services caring?

- Patients were supported to attend meetings about their care and support and to be actively involved in planning their ongoing care and treatment. For example, at the National Autism Unit a patient showed us his care plan in relation to developing his independent living skills. The patient said the care plan was set out in a slightly different way from the standard format at his request. He said the occupational therapist (OT) had fully involved him in drawing up the care plan. In another instance, an informal patient told us he felt he had full control over the content of his care plan and said he reviewed it regularly with his named nurse. Also at Woodlands House young people said they were able to attend the ward round and put forward their views about their care. They were given feedback about decisions immediately after the ward round. Staff said young people were involved in planning their care.
- Each borough had advocacy arrangements in place. People who used the services told us that had information available about the advocacy services and could access these as needed.
- 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. For example, in the community based mental health services for older people patients were given information packs at the initial assessment stage. In Lewisham and Southwark these were personalised to the individual needs of the patient. The packs contained information about medication and treatments including potential side effects and information on how to make a complaint.

Good

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 **good** for the following reasons:

- Despite there being great pressures, the services were mostly managing to respond to the needs of patients in a timely manner. The trust was aware of the need to provide consistent care and where needed patients were offered a service in the independent sector if a bed in the trust was not available.
- Teams were providing appointments where possible at times that were suitable for people using the service. If patients did not arrive for their appointment there were arrangements in place to check they were alright.
- The trust provided a good range of therapeutic activities for patients using inpatient services.
- The trust served a very diverse population and there were many positive examples of trying to make services more responsive.
- Complaints were generally managed well and the trust was aware of the need to make responses more timely.

However, patients all need to be informed of what they can do in a crisis out of hours. There were also improvements needed in some areas in the quality of the meals provided and ensuring care was delivered in a manner that maintained people's privacy and dignity.

Our findings

Right care at the right time

The trust also worked with clinical commissioning groups, local authorities, people who use services, GPs and other local providers to understand the needs of the people in the four boroughs where local mental health services were provided. The trust also provided many specialist services where patients came from across the country and in some cases across the world to receive care.

Acute care for working age adults:

- The average bed occupancy rate, including patients on leave, for acute wards between April 2014 and the end of March 2015 was 103%. This was highest on Wharton ward 126%, Bridge House (female) 116%, Clare ward (male) 132% and Eileen Skellern 2 113%. Luther King ward had an occupancy of 100% of available beds. The non-availability of 5 beds was due to a 12 week refurbishment programme. The Royal College of Psychiatrists recommend that optimum occupancy rate is 85%.
- The boroughs of Croydon, Lambeth and Lewisham operated a 'triage' model where people were admitted initially to the respective triage ward. The expected length of stay on triage wards was up to five days for brief treatment and assessment to be carried out. People were then either discharged home with support from a community team, including the crisis teams if necessary or transferred to another ward for a longer period of assessment or treatment. We were told that around 50% patients were admitted for a longer stay in hospital and 50% of patients were discharged after being admitted to a triage ward. This ensured that there was a thorough assessment period. Management of the triage services was in a different CAG from the longer term assessment and treatment wards.
- Apart from the triage wards which were borough focused, the psychosis CAG provided a model of care which did not allocate specific beds to a particular local area. Attempts were made as far as possible to ensure people were placed nearest there home areas but it would be within the trust as far as possible. The trust used external placements out of area when patients required an admission and beds were not available. On the day our inspection visit started, there were 25 external placements in acute beds of which 22 were outside London.
- Staff on the acute wards told us that they had the impression that there was a shortage of intensive care beds in the trust and accessing intensive care beds

could be problematic. We were told that this meant higher levels of acuity were managed on the acute wards. The trust had plans to open another male PICU the following year.

- Between April 2014 and March 2015 the average percentage rate of delayed discharges based on YTD figures across all acute services was 6.5%. The highest was 27% at Clare Ward (female), 23% at Luther King and 22% at Nelson Ward. The lowest was 3% at Croydon Triage (male) and 0% at Croydon Triage (female and unisex).
- The wards had a policy of protecting leave beds on a short term basis (one or two nights) so that if a patient went on leave they would return to the same bed. However, long term leave beds were used for admissions.

Psychiatric intensive care

- The average bed occupancy for the year between April 2014 and the end of March 2015 for PICU beds was 110%. This figure includes leave. The recommended maximum occupancy level according to the Royal College of Psychiatrists is 85%.
- At the time of our inspection, there were 8 men and 1 woman placed in external psychiatric intensive care beds. 6 of these beds were in south London.
- A discharge coordinator had been recruited to focus on supporting the discharge of patients who were being cared for and treated in hospitals in the independent sector. At the time of our inspection, there were no current delayed discharges. Between April 2014 and March 2015, 41% of discharges from Eileen Skellern 1 had been delayed. In the same time periods, it had been 17% for Eden ward and 24% for Johnson ward.
- Staff at the Maudsley site, explained that patients were usually transferred to acute wards when they were well enough to be cared for in a less secure setting. Discharges or transfers were considered to be delayed 24 hours after staff had indicated that the patient was ready to move to another ward. Delays were not lengthy and did not seriously impact the capacity of the PICU to take new admissions.
- The clinical lead for the three PICUs in the trust told us that there could be delays in finding beds for patients who needed to be transferred to low or medium secure services. There were few beds available in these services. There could also be significant delays in transferring patients who were on a Ministry of Justice restriction. There could be long waiting times for approval for patient transfers in these circumstances.
- The length of stay for patients on Eileen Skellern 1 was between 26-28 days. An audit had been carried out of length of stay on the unit and associated clinical outcomes for patients admitted between 1 October 2014 and 31 March 2015. The audit showed that the average length of stay on Eileen Skellern 1 was 27 days. Three patients had stayed longer than the eight week maximum stay recommended by the national association of psychiatric intensive care and low secure units. At discharge 86% of patients were transferred to an acute ward, 6% to home treatment teams and 4% to a forensic service.

Home treatment teams:

- The home treatment teams which were based in each of the four boroughs, operated between the hours of 8am and 10pm every day (apart from the Lewisham home treatment team which operated between 8am and 9pm), with out of hour access to crisis services being offered by psychiatric liaison services based at local accident and emergency departments.
- During the hours when the teams were working new referrals were assessed within 24 hours of referral to the teams. If this was not possible, as well as informing the person that they could attend accident and emergency if they needed they were also sign posted to other organisations such as the Samaritans.
- When the patient was an inpatient a joint assessment with the home treatment team and any keyworker or care co ordinator would take place within 7 days of the team receiving a referral. This helped to begin initial discharge planning and facilitate joint working with other services.
- Staff would agree the frequency of appointments to meet the individual needs of the patient.
- People who used the service told us that cancellation of appointments was unusual and the appointments were quickly re-arranged. Staff reported letting people who used the service know when they would be delayed in attending their appointment or visit to their home.

Good

Are services responsive to people's needs?

- Across the home treatment teams, there was a good approach to working with people who were hard to engage. Missed appointments were discussed during handover meetings and there was a clear escalation process to manage the of non engagement.
- Delays in discharging patients from the home treatment teams were commonly caused by housing issues and challenges in arranging joint discharge meetings with other services.
- The trust did not have an out of hours crisis line service though plans were in place to develop and introduce this service. Some of the patients we spoke with reported that they sometimes had difficulty accessing help out of hours but when they made contact with the home treatment teams, they were very helpful and supportive.

Health based places of safety:

- A triage system had been put in place where police contacted the section 136 management team when a section 136 had been placed on a person. This helped to identify a suitable place of safety and whether it was open before the person was brought to the place of safety. Staff reported this had helped to identify an open and available place of safety if there had been closures due to staffing shortages. The staff we spoke with reported that there were still occasions where the police had brought a person to a closed place of safety, though systems were in place to help mitigate this.
- The trust had fedback that the measures implemented to manage demands on health based places of safety has resulted in stopping the use of police custody suites as alternatives to places of safety. However, the closure of places of safety at times meant that patients may have been escorted by the police to an available place of safety in another area. This meant that people would not have received care in the area they live in and having to travel to another area could impact on the individual experience of the person using services in a time of crisis.
- In the event of person under the age of sixteen being brought to the place of safety there was clear guidance in the operational policy about setting up a joint review with CAMHS specialists. The staff we spoke with fedback that admitting a child or adolescent to a place of safety happened infrequently. When this had occurred, staff reported that the joint working was quick and effective to assess and source an appropriate place of care.

Other inpatient services

Wards for older people with mental health problems:

- Referrals were discussed in the MDT meetings and then an assessment was carried out by the manager. At the time of our visit Chelsham House was mainly admitting patients with a dementia diagnosis and patients with more challenging needs were being transferred to Aubrey Lewis 1 and Hayworth Ward. This was due to environment refurbishment works, however once the works were complete the wards will revert back to their usual admission criteria.
- Average bed occupancy over the last 6 months was 82% and 3 out of the 5 wards were more than 95% occupied. Ann Moss House was not accepting any admissions due to refurbishments taking place. Overall there was good access to a bed when a patient returned from leave.
- Hayworth ward had an average length of stay of between 60 to 90 days. Staff were aware of the need to involve the relevant teams early to plan discharges. Chelsham House had five delayed discharges over the previous six months. These were mainly due to waiting for nursing home placements.

Child and adolescent mental health wards:

- Average bed occupancy over the last 6 months was high. Four wards had bed occupancies higher than 85%. The numbers of beds in use at Woodlands House in Kent had been reduced to 20 because of staff shortages. Initial bed management decisions were taken centrally by trust bed managers.
- At the time of the inspection the areas covered by the service had 51 young people placed in services outside of the trust. Some of these were due to requiring more specialist services, the others were due to lack of capacity in the service.
- Acorn Lodge was a national specialist service. It received referrals from across the country.

Good

Are services responsive to people's needs?

- If a young person was on leave for over seven days the wards would look to use their bed. At Woodlands House, there was also a day patient service, with two spaces on each ward. Staff said there was a lot of pressure on beds. Young people from out of area, particularly from London, were sometimes admitted then transferred when a bed became available closer to home.
- The trust did not have a CAMHS psychiatric intensive care unit. If a young person required this support, they would have to be transferred to another service. Staff told us they felt this meant they sometimes cared for young people with higher needs on the wards, rather than transfer them to another service.
- Community staff were invited to CPA meetings but did not always attend. There were sometimes delays to discharge because of difficulty linking young people into community services or waiting for suitable accommodation to be identified.

Wards for people with autism:

- The National Autism Unit (NAU) was a national resource. New referrals to the NAU were made by commissioners from around the country. At the time of the inspection it was fully occupied. Some patients told us they regularly left the ward for short periods of home leave and they experienced no problems with this.
- If an NAU patient required intensive care this was always provided within the NAU.
- The MDT worked in partnership with commissioners to plan the patient's discharge from the NAU. For clinical reasons, some patient had lengthy stays on the NAU. This was because of the complexity of their needs.

Forensic inpatient wards:

- Beds were not always available and wards operated a waiting list. Managers could not say how long patients needed to wait for a bed as prison referrals took priority. Staff always planned patients' admissions and discharges.
- Some patients were placed out of area in a private bed. Approximately half of these placements were outside of London. Six patients were referred to private bed over the last five month period.
- River House had a clinical pathway meeting every Wednesday to discuss referrals and discharges. Transfers between wards occurred when a patient from another ward was secluded on Norbury ward and remained on Norbury ward as a patient. Staff identified patients who were suitable for move on from Norbury ward every Monday.
- A few patients had a delayed discharge as a result of court procedures or wait for suitable accommodation.

Community mental health services:

Community based mental health services for adults of working age:

- The assessment teams all had target times for responding to referrals. Depending on the levels of risk this was either 24 hours, seven days or 28 days. Staff at the South Southwark assessment team said that some cases that should have had seven day responses actually had 28 day responses because of the pressure of work.
- None of the recovery teams had target times to see new referrals. All of the recovery teams were able to assess urgent referrals. Urgent referrals were prioritised and there was minimal delay in these individuals being offered appointments for an assessment. The recovery teams had clear criteria for those who could benefit from the service. Where referrals were inappropriate, referrers were signposted elsewhere.
- The assessment teams were always able to see urgent cases quickly and were always able to get a psychiatrist to see patients where necessary. In the recovery teams psychiatrists had emergency appointments and the teams had duty systems, which meant that patients in crisis did not have to wait a long time to be seen.
- All the assessment teams had a total caseload that varied month to month between 200 and 300 cases but this included outpatient appointments or psychiatrist only involvements.
- The assessment teams were all responsive to patients who self- presented. Staff in the Croydon assessment

team said that GPs would often encourage patients just to turn up at the team base rather than making referrals. The assessment teams responded promptly when patients contacted them by phone.

- The assessment teams processed any referral that was made to them and did not exclude any patients who would benefit from being seen.
- The Lambeth assessment team benefitted considerably from the Lambeth hub to which GPs sent all referrals initially. The Croydon assessment team benefitted from the home treatment, MAP treatment and psychosis recovery teams picking up ward referrals and 7 day follow up request for patients discharged from hospital.

- At Lambeth South and Lewisham North recovery teams, referrals came via the assessment and liaison teams or from the wards. The teams had processes in place to visit patients who were due to be discharged from hospital. The teams provided the individual with an appointment in the community for the following week to ensure that there was no delay in access to treatment.

- Referrals came from a variety of sources for the Croydon recovery teams. These teams were able to take referrals from general practitioners (GPs), hospitals, home treatment teams and also self-referrals. The ability to take self-referrals meant that individuals did not have to attend a GP appointment to request a referral to the teams. This helped to speed up the process.

- Patients were given choices with appointments and the assessment teams had begun extended hours pilots to facilitate patients and GPs. The South Southwark and Croydon assessment teams were open until 7pm Monday to Thursday, and 6.30pm on Friday. The Croydon assessment team was planning to start opening on Saturdays.

- When patients' needs could no longer be met by the recovery teams there was a "step up" process for those who might be going into crisis and the teams could refer the patient to the home treatment team. Those patients who no longer needed the intensive service provided by the recovery teams could be "stepped down" to the low intensity treatment teams / primary care teams or to GPs.

- The South Southwark assessment team experienced difficulty referring patients on to the treatment and psychosis recovery teams and the patients of the Croydon assessment team faced long waiting times to be seen and offered treatment in the Croydon Integrated Psychotherapy Service. Staff told us the waiting times were up to six months for assessment and a further 18 months for treatment. Staff said they felt this was unacceptable.

- The Croydon recovery teams said that they had difficulty with some discharges, as some GPs were reluctant to prescribe antipsychotic medication. These teams had been working with GPs around this issue and to improve the discharge process for patients.

Community based mental health services for older people:

- The Trust standard for seeing new non urgent referrals was 10 days. Although the team in Lambeth told us they were meeting this target, the other teams fell short of this. In Croydon we were told that new, non urgent referrals are seen within 20 days and in Lewisham we were told they were seen within 15. Despite this, none of the teams operated waiting lists which was positive. In addition, all of the teams were able to respond very quickly to urgent referrals, usually the same day.
- In all four teams, there was a quick response to crisis situations and the duty systems appeared to be working well. This was particularly good in Southwark, where a dedicated duty "sub-team" comprising a duty person, a duty back-up, a duty manager and a duty doctor were available to respond each day. We also saw minutes of the duty handovers and they were comprehensive and robust in relation to team response to crisis.
- The four teams offered services to adults aged 65 and above with mental health difficulties and adults of any age with dementia. Those with memory problems were

referred to the memory service. Those in crisis requiring more than one visit per week were usually referred to the home treatment teams. Across the teams, the referral process between the services was generally well organised.

- The teams operated a service 9am and 5pm, Monday to Friday service. However, all of the teams told us that they would offer flexibility to meet patients needs and to reduce risk. In our review of MDT minutes in Lewisham we saw that Muslim patients were offered their depot injections after sundown during Ramadan.
- In all of the teams we inspected we were told that appointments usually run on time and are only cancelled in exceptional circumstances. Patients said they are informed if appointments are running late.

Community mental health services for people with a learning disability or autism:

- There was a single point of contact for all four teams. Overall, the service received approximately two new referrals a week. The Band 7 nurse who managed the service screened new referrals to ensure they met the service's criteria. Representatives from all of the teams and from across all disciplines met together each week to confirm the acceptance of referrals. Accepted referrals were then passed to the relevant team to arrange an initial assessment. If referrals were identified as high risk the receiving team was asked to prioritise them for action.
- Generally people were seen within six weeks of referral for an assessment in accordance with the trust target. Referrals to the Lambeth, Lewisham or Southwark teams which were solely for psychology input could wait for longer than this, sometimes for up to ten weeks, depending on the availability of therapists. The Croydon Team was not commissioned to provide a psychology service. A community psychiatric nurse told us that in the past, whilst people were on a waiting list for psychology, the psychology team gave appropriate professional guidance to the rest of the team. Staff said this meant that people received appropriate support whilst they were awaiting psychological intervention. Relatives described a service that was able to respond promptly when they contacted them and did not raise any concerns about the staffing of the service.
- The manager of the service used a tracking system to monitor the progress of referrals, including those which were not accepted, to provide clear data on the performance of the service and to identify trends and areas for development. Managers had taken note of the different pattern of referrals across the boroughs. For example, the Croydon team received a higher proportion of people living in care settings rather than their family. This was due to the large number of private care homes and supported living projects in the area. The psychiatrist from the Croydon team was working with providers of care and other agencies through the Croydon learning disabilities partnership board to develop effective ways of meeting the mental health needs of this group of people.
- None of the teams were commissioned to provide a 24 hour service. Staff gave people information on their recovery and support plans about how to contact their GP or accident and emergency services in the event of an out of hours crisis.
- Criteria for the service were clear and focused on the complexity of people's mental health needs. In Lambeth, Lewisham and Southwark referrals were also accepted for the psychology service only.
- People told us they were able to choose when they had their appointments and staff were reliable and kept their appointments with them. We observed that staff were on time with their appointments.

Specialist community mental health services for children and young people:

- There was a duty system across the teams which reviewed and prioritised referrals using clear criteria on a daily basis. Urgent referrals could be seen immediately. Team managers monitored the referrals and allocations to clinicians. This meant that services were able to prioritise care and treatment for young people with the most urgent need.
- The trust did not have agreed target times for urgent and non-urgent referrals to be assessed and receive the treatment. They were working with commissioners to develop these targets. Lambeth CAMHS reported waiting times had improved from ten months to five months for non-urgent referrals with a plan to reduce to 18 weeks by the end of the year. In Southwark staff said there was a wait of up to five months for family therapy. In

Good

Are services responsive to people's needs?

Croydon a standard letter was being sent to young people referred to the service advising the waiting list was over one year for non-urgent referrals. Semi-urgent referrals were seen within 25 weeks. There was a target of one year to reduce this to within the 18 week waiting time target.In Lewisham the neurodevelopmental team had 70 people who were identified as waiting since February 2015 and 100 children were waiting to be seen for ADHD medication. Whilst all these waiting times were of concern, the trust continuously monitored the referrals to prioritize the allocations to clinicians. They also worked closely with commissioners to identify how improvements to the service could be made.

- The CAMHS teams accepted referrals from general practitioners and a range of professionals and other agencies. Young people could refer themselves to the service.
- Services were mostly provided between the hours of nine to five during the week and most young people and their families were seen at the team sites. Staff told us there were some later clinics available and it was possible to conduct visits at alternative sites. Young people and their families said home visits had occurred. We observed flexibility around appointment times being offered by staff to suit the needs of the young person and their families. Staff told us that appointments are rarely cancelled however in the event of un-planned absence of staff, non-urgent appointments may be cancelled. This meant that as far as possible people could access care and treatment at a time to suit them.
- Young people could access specialist CAMHS help outside of normal opening times by going to accident and emergency departments at acute hospitals.
- Waiting lists for talking therapies across the service varied. There were historically long waiting lists for young people to be seen following referral. In Lambeth we were told 278 people were waiting up to ten months to be seen twelve months ago. This had reduced to 130 people waiting since April 2015. People told us about their long wait to be seen by services following referral. However there were clear plans to address the waiting lists, including recruitment of staff, changes in systems and the development of criteria for accessing services. The vision was to reduce the waiting time to 18 weeks.

However all four services we inspected reported that they were able to provide a safe service because they had systems in place to ensure young people who were at risk were seen promptly.

- There was a trust policy for young people in transition to adult mental health services. This is the planned movement of young people from child centred to adult orientated healthcare systems. Staff described joint team working using the care programme approach. However staff reported it was often difficult to engage in joint working until the young person reached 18 years. This meant that it was difficult to plan, deliver and co-ordinate care for young people at times.
- Where young people were being discharged from the services, CAMHS teams ensured that identified services on discharge for the young people were in place.

Accessibility of appointments:

- Some patients told us that they were not aware of their crisis plan or who to phone in an emergency. External stakeholders told us they had heard of cases where patients had been given a phone number to call in an emergency where there was no answer. The trust needs to make sure robust crisis plans are in place for each patient.
- All of the community teams told us that they were proactive in trying to engage with those who were reluctant to accept involvement from mental health services. For example, in Southwark the team for older people used creative ways to engage, such as going to see patients in public places where they were likely to be, or offering patients alternative appointment times. In Lewisham, the team manager had developed a new 'no reply' protocol in response to improvements following a serious incident some years ago. The protocol outlines what staff need to do in the event that a patient does not answer the door for a visit as expected. We reviewed this protocol and it appeared to be very robust. The staff we spoke to within the team were aware of the protocol and felt that it worked well.
- The assessment teams actively followed up patients who were reluctant to engage, discussing all such cases at morning handover and MDT meetings. A minimum offer to any patient was two appointments followed by an opt in letter. Depending on levels of risk, the patient

would be visited at home, or an appointment negotiated through family or the GP. High risk cases were referred to the home treatment teams or AMHP duty for joint visits.

- In the recovery teams some patients found it difficult to engage with services. Services actively attempted to engage with these patients. This included conducting home visits. Services made multiple attempts to contact individuals. As a result of a serious incident, the Lambeth South recovery team ensured that they had at least one face to face contact with patients every four weeks. If they were unable to locate the individual or be assured of their well-being the patient was reported to the police as a missing person.
- 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 and comfortable environments. 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.
- On some wards the privacy and dignity afforded to patients could be improved. For example in the wards for older people the privacy and dignity of people using the service on Hayworth ward was not being upheld. Throughout our visit, the observation windows of all bedrooms on this ward were kept open by staff and were used by staff to carry out checks on people when they were in their rooms. People using the service were unable to close these windows themselves and had to ask staff to do this using a key if they wanted some privacy. We saw a male staff member carrying out observation checks on the female corridor during our visit to Hayworth ward. Curtains were used on other wards to help ensure the privacy and dignity of people using the service. Staff members on other wards were observed to be knocking on bedroom doors and awaiting a response.
- On a few rehabilitation wards we found that the facilities were not available for patients to make telephone calls in private.
- The feedback about meals in inpatient services varied. Most people said they were satisfied with the food. On the forensic wards patients said that the food was of poor quality and quantity. Management were aware of this issue. Staff on different wards reported this to the food company provider six months ago. Staff attended meetings with the food company to try and improve the food quality. However, patients said there was no improvement. Some patients said that the food did not always meet their dietary requirements, for example one patient with diabetes and another who required a soft food diet. On some wards patients could prepare and cook their own meals with staff support and supervision.
- On the wards for older people food was an issue since the introduction of 'cook chill' meals. All services commented on the poor quality of food and the lack of patient involvement in choosing foods. The provision of cultural foods needed to be specifically requested but was not always arriving. Relatives bought in foods for their relatives. The tables were set with a table mat, cutlery but no condiments. There were no table cloths or serviettes to enhance the meal time experience. At Greenvale care unit there was no option to have a cold drink along with their meal and we were told that drinks were served afterwards.
- At Acorn Lodge which was a service for younger children a more 'child-friendly' menu needed to be introduced.
- On all wards hot drinks and snacks were available although arrangements for how these were accessed varied.
- Access to therapeutic activities were generally very good for people using inpatient services. For example on the forensic wards patients could access a variety of activities including baking, toastie and smoothie making, art, bingo, music groups, gardening creative writing and cycling. This year, five patients won Koestler awards for their paintings. Some wards had table tennis and pool tables. However, patients said there were limited activities available on weekends. On the rehabilitation wards patients were positive about the activities on offer on all wards and felt there was a good

choice available. On Heather Close there was only one occupational therapist and activity co-ordinator for 30 patients but other staff got involved if necessary. An example of this would be escorting a patient to college. On Westways patients were supported to access appropriate activities by the two occupational therapists. On the Tony Hillis unit patients said that they would like more access to the gym which could only be used at limited times when a gym instructor was available.

- On the wards for older people the trust was using the Namaste Care approach at Greenvale which was a structured programme integrating compassionate care with individualised meaningful activities for people with advanced dementia. In other wards there was a need to further develop individual activities for people with dementia.

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 produced an annual equality report and progress reports on how it was implementing the objectives.
- The trust had five equality objectives - for all service users to have a say in the care they get, for service users to feel safe in trust services, for staff to treat service users and carers well and help them achieve the goals they set, for the trust to roll out and embed the five commitments it has made for staff and for staff to show leadership on equality issues through their communication and behaviours.
- In February 2015 there was an audit about how culture was addressed in peoples care plans. This found that recording on ethnicity was good. Recording on religion was not always in the right place. There was more room for family involvement and the need to consider cultural and spiritual needs in peoples care plans.
- Equality and diversity training was mandatory. It was available on-line and through classroom learning. In May 2015, 62% of staff had completed the training. Additional workshops had taken place for decision makers on the development and use of equality impact assessments to improve policy and service development.
- The trust used interpreters and steps had been taken to make the booking easier. They had commissioned 'Disability Go' to assess and produce on-line accessibility guides for the Maudsley, Bethlem and Lambeth. They were working with a group called 'four in ten' to develop guidance for staff working with people who are trans-gender.
- Across the trust the inspectors found that most services had considered access for people with mobility issues, meeting peoples spiritual and cultural needs and providing information in accessible formats. In a few areas this could be improved.

Learning from concerns and complaints

- Information about how to complain was displayed on posters, leaflets and on the trust website. Easy read complaints information was available, this had been translated into the 10 most commonly spoken languages in the four boroughs. An audio version was also available on the trust's website. A separate leaflet was available where complaints related to LGBT concerns. The complaints and patient advice and liaison services (PALS) publicity material was reviewed in quarter 1 and 2 of 2015/16. Patients felt generally well informed about how to make a complaint. The exception to this was at Heather Close where patients felt there was a lack of information on how to make a complaint and how these were resolved by staff.
- Complaints could be made by email, phone and post. Some were escalated from concerns raised at clinical academic group (CAG) meetings. The trust held monthly forums with PALS to discuss and share complaints information. The trust was planning to re-instate PALS surgeries from October 2015 to capture concerns at a local level. Monthly performance management reports were shared with each CAG which included information

relating to complaints. This included information on the numbers of complaints that had been reopened or referred to the parliamentary health service ombudsman.

- Complaints were triaged and allocated to clinical leads for investigation. The person leading the investigation made contact with the complainant either by telephone or arranged a face-to-face meeting. If a complainant was unhappy with the outcome of the investigation this could be escalated and would be reviewed by the director or nursing or medical director.
- The trust received 564 formal complaints from 1 April 2015 – 31 March 2015. This was a slight increase of less than 0.5% from the previous year when 562 complaints were received. Five complaints were referred to the PHSO. At the time of our inspection three of these had not been upheld and two were still under investigation.
- Of the complaints received to 31 March 2015, 55% were either upheld or partially upheld. A satisfaction survey was sent to a sample of complainants when their complaint had been investigated and the outcome fedback to them. The response rate to this satisfaction survey was low, at around 15%. Responses to the survey indicated that complainants satisfaction with the complaints process directly correlated to whether their complaint had been upheld or not. Whilst the trusts electronic records system was used to determine some protected characteristics of complainants such as ethnicity, there was little evidence that other protected characteristics such as age, disability, gender reassignment, civil partnership and marriage, pregnancy and maternity, religion and belief, gender, and sexual orientation were being monitored.
- The trust aimed to acknowledge complaints within 3 days, and respond within 25 days. At the time of our inspection the average time taken to respond to complaints was 36 days. Each complaint was seen and signed off by the director of nursing before closure. The trust recognised the need to improve response times and a joint event with stakeholders was planned to review the complaints process and make it more efficient and user friendly. The trust was also introducing the monitoring of response times on a monthly basis.
- Systems were in place to learn from complaints. A quarterly report was prepared for each CAG that detailed themes from complaints and lessons learnt. Lessons learned were discussed at committees and governance meetings, where recommendations were shared and developed. Clinical leads produced highlight reports for sharing within the CAG. In inpatient settings, community and team meetings on the wards were used as a means of sharing learning and changes made as a result. The trust's bulletin system was used to communicate more urgent changes that may be needed based on learning from complaints. We were told that the trust planned to introduce a quarterly 'learning lessons' event.
- The trust had achieved a 25% decrease in complaints about staff attitude, and a 30% decrease in complaints about communication in the year 2014 –15 when compared to the previous year. We were told that this had been achieved as these themes had been identified and made a trust priority.
- Training on how to manage complaints was provided to staff during corporate induction. Specialist training was provided to staff at band 6 level and above who were involved in investigating complaints. This was based on the trusts policy and aimed to promote a systematic and consistent approach to investigating complaints.
- We reviewed nine complaint files and responses provided to complainants by the trust. Seven of the responses were not prompt and fell outside of the trust's 25 working day response timeframe for various reasons such as complexity of the issues raised. In four of these cases update letters to keep the complainant informed of delays were not sent. One complaint that we reviewed was acknowledged eight days after it was raised. Apologies for delays in responding to complainants were however included in final responses.
- Comprehensive details of the investigations undertaken were available for each complaint that supported the decisions made. Response letters to complainants were detailed and addressed each issue raised in the original complaint. Information relating to advocacy services and further recourse available to complainants was included in response letters.

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 strong executive and non-executive leadership team
- The trust vision was known by staff working across the trust and they understood how this informed their work
- The board assurance framework, whilst continuously being refined was providing the board with the information they needed to perform their role
- The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders and were working to develop this further
- The trust was developing leaders within the trust
- The trust was innovative and looked for ways to improve patient care

However, on the acute wards for working age adults the governance at a team level was not yet stong enough as there were lots of areas of non-compliance to be addressed. The trust needed to complete the fit and proper person checks for the directors.

Our findings

Vision values and strategy

- The trusts vision was 'everything we do is to improve the lives of people and communities we serve and promote health and well being for all'. This was being achieved through treating serious mental illness effectively, working in partnership to promote mental wellbeing and supporting others by sharing our clinical knowledge and expertise.
- The trust had five immediate priorities, getting the basics right. These were people – ensuring safe staffing, real opportunities to develop new skills and career progression and investing in staff wellbeing; places – buildings we can feel proud of; platforms – IT that works for everyone; informatics to support data driven decision making; partnerships – working closely together with people who use services, family, friends and carers, professionals and other stakeholders; quality – equipping everyone with the skills and support to improve quality across the organisation.
- The trust had five commitments to patients. These were based on the premise that 'our staff work in ways that build mutual, respectful relationships with each other, with people when they use our services and their family, friends and carers'. These were to be caring, kind and polite; be prompt and value your time; take time to listen to you; be honest and direct with you; do what I say I am going to do.
- The trust also has a long term strategy and over the next five years this included – transforming local services, moving towards prevention, building on specialist services for people with complex and intensive care needs, managing costs and ensuring long term sustainability, continued commitment to research approach.
- Staff had a high awareness across the services of the trusts vision, priorities and commitments. These were displayed throughout the trust.

Governance

- At the start of the inspection, there was a presentation from the trust to the inspection team. This highlighted the work of the trust that was a success, the challenges and the areas for improvement. These reflected the findings of the inspection and showed that the trust knew where work was needed.
- The trust had a robust board assurance process in place. This identified the top areas of risk and the measures of progress for assurance. It included operational and strategic risk. This was supported by a

quality and performance dashboard, which was clear and easy to follow. The trust was continuing to refine the quality and performance dashboard to reflect the trusts changing priorities.

- At the time of the inspection there were four committees that were sub-committees of the board. These were the audit committee, business development committee, renumeration committee and the quality committee. The quality committee provided the board with assurance in relation to the care delivered to patients. They received reports from each of the clinical academic groups and a number of other sub-committees reflecting staff, service user and carer experience, clinical effectiveness & compliance and patient safety & safeguarding. The quality committee also requested and received feedback on particular themes. The meeting we attended received a report on whistle-blowing looking at the current policy, themes from whistle-blowers, how concerns were addressed and how the system could be improved. Examples of other themes which had been covered included violence and aggression on wards, ligature points and staff training. There were also updates on areas of significant risk such as safer staffing and recruitment.
- The services provided by the trust were organised into seven clinical academic groups (CAGs). The aim of the CAGs was to bring together the clinical and academic skills in areas such as psychosis and child and adolescent mental health. Each CAG had a clinical and management lead. Each CAG had monthly meetings, which reviewed areas of risk including incidents and complaints and shared learning. Staff were aware of these meetings and had received feedback.
- The inspectors found that at a ward or team level the availability and use of management information was currently quite limited. Managers had access to training data which was not always accurate and results of audits showing the completion of patient records in the electronic patient record system and feedback from the online patient surveys. The trust had piloted a tool called quality effectiveness and safety trigger tool (QuESTT) on 23 wards to provide an early warning system to managers and alert them to concerns that could impact on quality and safety, such as increasing vacancies or levels of sickness, and lead to poor care. The tool was completed by ward managers using both data from the ward and data provided to them centrally. The results were discussed at the CAG meetings and scores were monitored and reported to the quality sub-committee. This was being rolled out across other wards and evaluated. The inspection of the acute wards for adults of working age concluded that governance was not yet suffiently robust for these services as there were lots of areas where improvements needed to take place to keep patients safe.

Leadership and culture

- The executive board consisted of five executive directors who were the most senior managers responsible for the day to day running of the trust. The chief executive had been in post for nearly two years. The chief operating officer had come into post just shortly before the inspection and it was hoped that they would improve operational oversight.
- The trust also had a chair, who started in January 2015. He was also chair of a national charity and vice-chair of a clinical commissioning group. There were 6 other non-executive directors. Two of the non-executive directors will be reaching the end of their term of office in the next year and the chair was mindful of need to bring people with appropriate skills as replacements. A board meeting was observed and was very well managed, with a strategic focus and provided a good balance of challenge and support. There was a clear understanding of roles and participation of board members.
- A board development programme was in place with regular away days. This focused on equipping board members with skills to understand the work of the trust. It also included a programme of deep learning covering broader topics with examples such as value based healthcare, team work and healthcare integration.
- We met a group of governors as part of the inspection. The trust had 40 governors. The role of the governors in terms of holding the board to account was clearly defined. Some governors felt that there was scope for them to be more actively involved in supporting the work of the trust in performing this role. The chair recognised when he joined the trust that the governors had not been effectively engaged. Whilst there had been progress, clarifying how they perform their role is an area for ongoing work. The induction programme for governors was being updated. A governor away day was

being planned for the month after the inspection. Governors participated in a number of committees including a bid group. This was where small grants of up to £750 were awarded to projects that improved patient experience, combatted social isolation and increased mental well-being. Other ideas being developed included non-executive directors spending more time with governors and having governor observers at all committees.

- The chief executive and chair both recognised the importance of ongoing engagement and the need to set a new tone of openess. Both spend a lot of time visiting services. They have also held 30 open forums to meet people and receive feedback. There was also an annual trust conference open to all.
- The inspection team heard lots of positive feedback from staff about the executive directors. Many said they felt confident in the chief executive and that he was bringing about positive changes. Some talked about the trust still having a top-down approach but many were aware that changes were being made. The trust acknowledged the need for further investment in middle managers where performance could be more variable. The chief executive talked about the need to ensure difficult things were done with kindness. There were also many examples of how people felt well led at a team level and about their positive experiences of team working.
- Stakeholders fed back that the trust took it's engagement work with commissioners seriously and made appropriately senior managers available for this work. They felt the meetings worked well and looked at high level reviews of quality and also had in depth discussion where needed. The Royal College of Nursing said senior management was approachable and receptive to partnership working, however the HR department can be slow and difficult to work with.

Engagement with people and staff

- 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. The NHS staff survey in 2014 showed that whilst engagement had improved and staff felt satisfied with the quality of work and patient care they were providing and able to raise concerns about unsafe clinical practice, there were still areas where the trust was performing less well. This included staff feeling the trust did not provide equal opportunities for career progression, staff experiencing harassment, bullying and abuse from patients or relatives and staff experiencing discrimination at work.
- The trust had developed a workforce equality objective. Each CAG was developing its own response to the results of the staff survey. Other trust wide actions included the ongoing collection of workforce equality and diversity data. This included monitoring the outcomes of appraisals and disciplinaries. A staff conference had taken place with a focus on equality. Focus groups were taking place seeking feedback from front-line black and minority ethnic staff on how issues from the staff survey can be addressed. The trust was also re-promoting the role of bullying and harassment advisors.
- During the inspection the teams heard about a few local examples of where staff were feeling bullied, which was often down to relationships with a manager. The details of these allegations were shared with the trust and they gave assurance that they would support individuals and teams as needed.
- The trust had a whistle-blowing process. Staff knew about this process but most said they would feel comfortable raising any concerns with their line manager. In the last year the trust had received 8 whistle-blowing concerns and they had been individually investigated. The quality committee had asked if whistle-blowing concerns should go to a contact more external to the trust.
- The trust was actively seeking to increase the diversity and number of people engaged with involvement activities. There was a trust wide service user and carer engagement committee. There was a service user and carer advisory group associated with each CAG. Each CAG had a patient involvement lead and there was a trust team. In the services for older people the user and carer group was involved with staff recruitment and training. The group were working on the 'power of story project' which aimed to gather and share stories of older adult service-users including carers and the staff within the trust. The main focus of this project was to support people to tell their story.

Good

Are services well-led?

- The trust facilitated involvement through a number of measures. They had increased the number of volunteers registered with the trust and 45% of these were people with lived experience and they knew that many moved on to further education and employment. They also ran an 'involvement register'. This was a bank of people who provided their skills and expertise to support the trust to improve services. Involvement register members could take part in up to 30 hours of opportunities a month and receive payment for their time. Examples of this included helping with recruitment, training staff and assessing services. The trust also provided a recovery college with 60 courses and workshops co-produced by peer recovery trainers (people with lived experience of mental ill health).
- The new friends and family test was rolled out by the trust and overall 83% of respondents would recommend the trust to family and friends. The trust also used an online patient survey form to collect patient experience data. This system was going to be replaced by the trust.

Fit and Proper Person Requirement

- The trust was in the process of meeting the fit and proper persons requirement (FPPR) to comply with 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 fit and proper persons report was presented to the trust board in July 2015. The report outlined the checks required for directors currently in post, but did not explicitly state that checks would be carried out for future appointments, or outline procedures for on-going annual checks of fitness.
- The report identified which posts would be subject to the FPPR test. Those identified were; the trust chair; non-executive directors; chief executive officer, chief operating officer; chief financial officer; medical director; director of nursing; director of human resources; director of organisation and community and the commercial director. The trust had networked with other London trusts to ensure parity in the posts required to meet the FPPR. However, since the presentation of the report to the board discussions were underway as to whether additional post holders, for example the director of estates should also be required to meet the FPPR test.
- Checks required by the trust for those as identified as needing to meet the FPPR test included checks of criminal record, employment history, professional registration and an internet search to check for insolvency and bankruptcy. In addition identified post holders were required to complete a self-declaration form addressing the FPPR test. Proofs of identity and right to work were not identified as requirements by the report, although it is recognised that these are standard requirements of the DBS check.
- The trust had undertaken a review of the information they held for identified executive director and non-executive director posts to ensure they were meeting the standard.
- We reviewed 10 personnel files, these included the chair, six non-executive directors and three executive directors; the majority of whom had been in post prior to the FPPR coming into force in November 2014. Where checks on identified directors were required these had already been carried out or in some instances were in progress, for example one non-executive director had not completed their self-declaration form and this was being followed up.
- There were other gaps in some non-executive directors' personnel files that had not been identified and were not being followed up. For example, three non-executive directors did not have criminal records checks on file. One non-executive director had no references available and a second non-executive director had only one reference available. Professional registration checks had not been completed for two non-executive directors.
- We looked at the personnel files of three executive directors subject to the FPPR. For each information required by the self declaration was available as were professional registration checks where applicable, employment checks and criminal record checks. Insolvency and bankruptcy checks had been undertaken.

Good

Are services well-led?

Quality improvement, innovation and sustainability

- The trust had a close clinical and academic partnership with the Institute of Psychiatry, Psychology and Neuroscience Kings College London. The institute was Europe's largest centre for research and post-graduate education in psychiatry, psychology, basic and clinical neuroscience. It was the most cited research centre for psychiatry outside the US. The trust and institute have a joint research and development office which was committed to ensuring the research was of a high scientific and ethical standard. They hosted the NIHR mental health biomedical research centre and dementia unit. These centres aimed to speed up the process by which the latest medical research findings improved patient care. The inspectors did hear examples of how this research was informing the care delivered by the CAGs.
- The trust also participated in external peer review and service accreditation. This included the accreditation for inpatient mental health services where 4 wards at the Maudsley, 4 wards at Lewisham Hospital, 2 wards at the Bethlem and 2 wards at Lambeth Hospital were accredited, four of which were rated as excellent. Also the quality network for inpatient CAMHS where 3 services were participating and one was rated as excellent. Other accreditations included the memory services national accreditation programme where the Croydon memory service was accredited. The electroconvulsive therapy accreditation service where the Bethlem and Maudsley services were accredited as excellent. The forensic inpatient services at River House were also part of the forensic quality network. The Croydon home treatment team was also accredited.
- The trust had a variety of leadership development opportunities in place. A management and leadership development programme was in place. Learning took place through modular sessions and self directed learning. There were three levels for staff moving into their first management post, staff preparing to take on more senior roles and a programme for leaders. We heard from managers about how they had access to this training and found it helpful.
- The trust clearly understood the need to deliver better care in a challenging economic environment. In order to achieve this they were working with commissioners and other partners to continue redesigning the local services. Whilst working on this longer term transformation programme the trust was also making cost improvements. The trust was in the process of procuring a quality improvement partner. They would work with the trust during the next three years to embed quality and values across all disciplines.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. In acute wards for adults of working age: Some patients did not have care plans that met their individual needs. Patients needed to be offered more opportunities to be engaged in developing their care plans. In rehabilitation mental health wards: This was because at Heather Close and the Tony Hillis unit blanket restrictions were in place that did not reflect the individual needs of people using the service. In wards for older people with mental health problems: Meals across the wards for older people did not meet peoples individual preferences or cultural needs. Some staff did not interact well with patients especially during mealtimes. In forensic inpatient wards: Meals across the forensic wards did not meet peoples individual preferences or needs.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 9(1)(2)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured that care and treatment was provided in a safe way for patients. In acute wards for adults of working age: Staff were not reporting or recording the details of each use of restraint which meant the use of restraint could not be monitored. Individual risk assessments were not consistently up to date and reflecting the current risks to individuals. On Lambeth triage ward seclusion had not been recognised and so patients were not being properly monitored to ensure their safety. Emergency resuscitation bags did not all contain the listed emergency equipment or in some cases this equipment was present but out of date. Patients whose physical health monitoring had identified that their risks were raised had not all been referred for medical input. In forensic inpatient wards The trust had not ensured that all patients' risks were appropriately assessed.

This section is primarily information for the provider

Requirement notices

In mental health crisis services and health based places of safety:

The facilities at the Lambeth place of safety were not safe due to the risks from ligature anchor points and the environment was not fit for purpose.

Lewisham health based place of safety had blind spots in both the observation window and the CCTV camera angle that meant that patient safety could not be guaranteed.

Personal and emergency alarm systems at Lambeth home treatment teams based at Orchard House were not regularly checked to ensure that they were working in the event that staff needed to request assistance.

There were inconsistencies in where risk assessments completed by home treatment teams were held in electronic care records, which meant that it is was possible for staff (especially in other teams) to miss updates in risk information.

In rehabilitation mental health wards:

The trust had not ensured on the rehabilitation wards that whilst work was taking place to reduce high risk ligature points, the existing risks were not being mitigated and ligature cutters were not readily available in the event they may need to be used.

In wards for older people with mental health problems:

At Greenvale and Chelsham House there were strong smells of urine by toilet areas.

Across the wards for older people risk assessments were often completed with insufficient detail to ensure staff would know the necessary details.

This section is primarily information for the provider

Requirement notices

At Greenvale and Ann Moss House, medication had run out causing delays in patients receiving medication.

In community based mental helth servicesfor adults of working age and older people:

Medication and sharps were not transported safely between the team bases and patients homes.

Risk assessments were recorded inconsistently in different places and were not always completed thoroughly to reflect patient risks.

Trust wide:

There was still a significant use of prone restraint.

This was a breach of Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Patients were not protected from abuse and improper treatment. In acute wards for adults of working age: The rights of informal patients was not consistently understood in a way which protected their rights and gave them correct information about their right to leave the wards or refuse medications. This is a breach of regulation 13(7)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The trust had not ensured the premises and equipment used by the patients was appropriately secure, suitable and maintained In acute wards for adults of working age and psychiatric intensive care units: On Eileen Skellern 1 the environmental risk caused by patients having access to an external fire escape had also not been mitigated. In rehabilitation mental health wards: At Heather Close fire safety precautions were not being fully implemented. In wards for older people with mental health problems: At Greenvale patients were using wheelchairs without footrests and being lifted without the use of the correct equipment. This meant there was a risk of people getting injured. This was a breach of Regulation 15 (1)(a)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust had not put systems or processes in place to ensure the acute wards are compliant with the regulations. This was a breach of regulation 17(1)

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing In acute wards for adults of working age: The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed. Some wards had significant staff shortages which had an impact on patient care. In wards for older people with mental health problems: The trust had not ensured staff had appropriate training to enable them to carry out their duties. Staff did not feel confident in caring for people with dementia and were not supported to access training. This was a breach of regulation 18(1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The trust had not ensured that patients were treated with dignity and respect: In wards for older people with mental health problems: On Hayworth ward observation windows in bedroom doors were continuously open. This was a breach of regulation 10(1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The information in schedule 3 must be available in relation to each person employed:

The trust must ensure the checks are completed for each of the non-executive directors.