

# South West London and St George's Mental Health NHS Trust

## Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

## Background to the trust

The trust serves a population of 1.1 million people across the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth and employs more than 2,000 staff who provide care and treatment to about 20,000 people from south west London and beyond at any given time. The trust has more than 100 clinical teams. It has an annual budget of approximately £160 million. The trust moved from a borough based line management structure in April 2017 to a service line management structure.

The service provides the following core services:

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

The trust also provides the following specialist services:

- Specialist eating disorder services
- Substance misuse services
- National deaf services
- Other national specialist services

The trust operates from four registered locations: three hospitals, Springfield University Hospital, Tolworth Hospital and Queen Mary's Hospital, and the Trust HQ. The trust provides 404 beds, local and national, of which 165 are acute beds. It provides community mental health and outpatient services from a number of locations in each of the five London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. The trust also provides community mental health services to deaf people in Cambridge as part of their national service for deaf children and adults.

The trust has been inspected eight times since 2014. We conducted a comprehensive inspection of the trust in March 2016. At that inspection, we rated the trust requires improvement overall. We conducted a further inspection of some of the trust's services in September 2016. Following that inspection, we re-rated the trust as good overall. We rated it requires improvement for one key question (safe) and good for four key questions a (caring, effective, responsive and well-led).

Following our inspection in March 2016, we found areas for improvement in four of the core services we inspected:

- Long stay/rehabilitation mental health wards for working age adults
- Child and adolescent mental health wards

# Summary of findings

- Forensic inpatient/secure wards
- Community-based mental health services for adults of working age

We told the trust that they must make improvements to:

- Rehabilitation services so as to provide more therapeutic activities to support people's rehabilitation and recovery
- Risk assessment and risk management
- Systems for the safe transportation of medicines
- Seclusion practices on the child and adolescent inpatient ward and forensic wards
- Systems for providing managers with information about the performance of their teams and services
- The delivery of managerial and clinical supervision to staff in rehabilitation services and community mental health teams for adults of working age.

These breaches related to the following five regulations under the Health and Social Care Act (Regulated Activities) Regulations: Regulation 9 Person-centred care; Regulation 12 Safe care and treatment ; Regulation 13 Safeguarding service users from abuse and improper treatment; Regulation 17 Good governance; Regulation 18 Staffing.

Since this inspection we have conducted a comprehensive inspection of specialist eating disorder services (in February 2017); and a focused inspection of one acute ward for working age adults in September 2017.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Good** 

## What this trust does

South West London and St George's Mental Health NHS Trust provides mental health services from three main hospital locations in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. This includes a range of inpatient and community mental health. The trust also provides specialist national services for adults, older people, children and young people, people with learning disabilities, and deaf children and adults.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

# Summary of findings

We inspected six services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Community-based mental health services for adults of working age
- Substance misuse services
- Child and adolescent mental health wards
- Specialist community mental health services for children and young people.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led'.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as good because:

We rated all six services we inspected as good. Following this inspection all the trust's services were rated good overall.

- We rated well-led for the trust overall as good.
- The trust had made considerable improvements since the last comprehensive inspection in March 2016. The community-based mental health services for working age adults, long stay/rehabilitation mental health wards for working age adults and child and adolescent mental health wards had all improved their ratings overall and/or in individual key questions. The trust had met all requirement notices made following the March 2016 inspection and a focused inspection in September 2017 in those services we inspected.
- Whilst there had been a number of changes in executive directors, the trust was well-led and the senior team were committed to improving services to meet the mental health needs of local communities. The trust had an open and transparent culture and staff were able to raise concerns. Staff were committed to the working for the trust and felt well supported by their managers and colleagues. An award winning intranet provided accessible information to staff and supported overall engagement.
- The trust was outward looking and engaged well with external partners and stakeholders. The trust was working well with the two other South London mental health trusts through the South London Partnership and this was supporting the introduction of new models of care. The trust was actively engaged in the work of the sustainability and transformation partnership.
- The trust encouraged innovation to improve patient care. Recent developments included a service aimed at preventing admission to hospital, and the introduction of crisis cafes, which were very well liked by service users. More than 40 quality improvement initiatives had been completed by staff or were under way across the trust.
- The trust had effective structures, systems and processes in place to support the governance of the trust, including financial governance. Managers had easy access to performance information to enable them to make improvements. Staff could add local risks to service line risk registers. Risk registers reflected the risks staff told us about. Senior leaders had good oversight of risks. There was an open and positive culture in respect of reporting incidents. Lessons learned were disseminated to staff and used to improve services.

# Summary of findings

- The trust was making good progress with the recruitment and retention of staff. A detailed review of staffing levels on inpatient wards had led to an increase in staffing on most wards. A caseload weighting tool in the community mental health teams was helping to ensure caseloads for individual staff were manageable.
- The trust had a focus on equality and diversity and was supporting the development of staff diversity networks. The trust provided effective communication support to deaf service users through the employment of deaf nursing staff, the provision of British Sign Language interpreters and videos on the trust website. The trust worked well with local communities, including black and minority ethnic communities and schools, to promote and support mental health initiatives. The trust board had a diverse membership. The trust had set up an expert working group to look at the disproportionate number of black men detained under the Mental Health Act.

However:

- Staff did not always follow best practice to ensure the safety of patients after they had received rapid tranquillisation. When patients declined checks of their clinical vital signs, staff did not always return to make further attempts to record these observations. When staff carried out routine checks of patients' vital signs, they did not always escalate results to senior nursing staff or a doctor when indicated by the scoring tool or record why they had not done so.
- Staff did not always store information on patient electronic records consistently so that it could be found easily by others. The patient records system in the substance misuse service was difficult to navigate and staff stored information in different places, which made it difficult to find. The electronic patient record system in the CAMHS community teams was difficult for staff to use and it was easy to input information into the wrong place. Staff in community teams reported regularly being unable to access patient records when the server was down for short periods. Clinical staff found IT support was not always timely and accessible.
- The trust had not consulted effectively with staff around changes to mental health rehabilitation services that had been made. Staff were unhappy with the way they had been involved in discussions about the changes. They continued to be anxious about the future of the service and morale was low.
- Some trust services missed an opportunity to learn from informal or local complaints as they did not keep a record of the complaints to support managers to identify patterns and trends.
- The trust needed to continue to work on the new trust strategy that would provide clear direction and underpin the delivery of high quality sustainable care. Further work was needed to fully implement the leadership development programme for ward and team leaders and managers.

## Are services safe?

Our rating of safe improved. We rated it as good because:

- We rated five of the six services core services that we inspected as good for safe.
- The trust had taken action to ensure that its services had a sufficient number of staff. The trust had increased staffing levels in the mental health wards, which enabled staff to facilitate patient leave and hold one to one meetings with patients to discuss their care more consistently. The new staffing establishments and shift patterns were based on a detailed analysis on information including incidents and acuity levels. Staff in a community team had developed a caseload weighting tool that was to be rolled out to other teams to help ensure care co-ordinators had manageable caseloads. The trust was making good progress in the recruitment and retention of staff, although this proved a constant challenge in community-based teams for working age adults in some boroughs.

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- The trust had effective systems to report and learn from serious incidents, including deaths. Staff reported incidents and they were investigated appropriately. Lessons learned were shared with teams in meetings and at specific events so as to reduce the risk of similar incidents happening again. Staff reporting of incidents involving the restraint of patients had increased as a result of a positive reporting culture. The trust had introduced strategies to reduce violence, aggression and restrictive practices.
- Staff managed medicines safely. The implementation of electronic prescribing and administration records had led to a reduction in medicine errors. Staff in the community-based mental health teams transported medicines safely. This was an improvement since the last inspection in March 2016.
- The majority of staff had completed mandatory training across all of the wards and teams. Shortfalls in training in risk assessment, which had been recently introduced, and in medicines management training for allied health professionals were being addressed.
- Since the last comprehensive inspection in March 2016, there had been improvements in staff understanding of what constituted seclusion in the child and adolescent mental health wards. Lone working and personal safety protocols were now well embedded in the community teams.

However:

- Following the administration of rapid tranquilisation to a patient, staff did not keep adequate records of how often they had attempted to take patients' physical observations. This was contrary to trust policy and national guidance. When a patient's physical health observations were outside of the normal range, staff did not always escalate this to senior nursing or medical staff or record that they had done so. This increased the risk that patients' physical health problems may have gone undetected or not been addressed appropriately. The trust took action to address these issues immediately following the inspection.
- The trust did not always ensure that clinical staff had easy access to important patient information. Inconsistent storage of clinical information on the electronic patient record meant that staff could not easily access all information held about a patient's physical health and other care related matters. The patient records system in the substance misuse service was difficult to navigate. Similarly in the CAMHS community teams, staff found the records system was difficult for staff to use and it was easy to input information into the wrong place. Staff in community teams reported regularly being unable to access patient records when the server was down for short periods.
- In community-based services for working age adults, more than 80% of patient risk assessments were of good quality and accurate. This was an improvement since the last inspection, in March 2016. However, some risk assessments had not been reviewed after incidents or when a patient was transferred from another team. Caseloads in the Wandsworth Early Intervention team were higher than nationally recommended levels.
- Staff did not use and share crisis information with young people and families as well as they could have as the resources were still in development. CAMHS had developed 'what if' plans to use for young people who might need support if their mental health deteriorated, but these were not often used by staff.

## Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- We rated all six services core services that we inspected as good for effective.
- Staff demonstrated excellent working relationships with teams and agencies both internal and external to the trust. This ensured a smooth and clear pathway of care for patients, particularly in the acute care pathway and community-based mental health services for adults of working age. The trust was working with the two other south London mental health trusts in the South London Partnership to the benefit of forensic and child and adolescent inpatient services.

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- The trust had made improvements to ensure that staff received regular clinical and managerial supervision to support them to deliver effective services and develop professionally. The rehabilitation ward had improved staff supervision by 40% since the last inspection in March 2016. The completion of planned staff supervision was high in most areas. Supervision records were saved electronically, easy to find and used to inform future sessions.
- Staff worked with patients to develop person-centred, holistic and recovery oriented plans of care. Services delivered a range of evidence-based therapeutic interventions. Phoenix Ward, the rehabilitation service, had introduced more therapeutic activities aimed at improving patients' individual skills and maximising independence.
- Staff ensured that patients received an assessment of both their physical and mental health needs. A quality improvement initiative had led to an increase in the number of patient cardio metabolic assessments carried out by community staff. Patients had good access to specialists for their physical health needs. Staff had undertaken placements at the local acute hospital to improve their physical health nursing skills.
- Staff received support to fulfil their responsibilities in respect of the Mental Health Act (MHA) and associated code of practice, and the Mental Capacity Act. Staff had received training, understood the requirements of the legislation and acted in accordance with requirements in their day to day work. MHA administrators were knowledgeable and had effective systems in place to monitor the implementation of the MHA. Associate hospital managers had good understanding of their responsibilities.

However:

- Doctors did not always document in detail, discussions with patients about treatment options when obtaining consent to treatment.
- On Lavender Ward, some patients were prescribed medicines to aid sleep for several weeks without evidence of a review by a doctor.
- In the substance misuse service staff had not reviewed the trust's prescribing protocols following the publication of new clinical guidance in July 2017.
- Staff in community-based mental health services for working age adults did not always record when they had explained to patients on a Community Treatment Order, their rights and the conditions of the order.
- Patients in the acute wards for working age adults and psychiatric intensive care unit had limited access to a clinical psychologist. The trust had recognised this and was actively recruiting more clinical psychologists.

## Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- We rated all six services core services that we inspected as good for caring.
- Staff treated patients with kindness and compassion. They were caring and supportive and treated patients and carers with dignity and respect. Feedback from patients and relatives was mostly very positive even in community teams for working age adults that were experiencing staffing difficulties and other challenges.
- Staff provided dedicated support to carers. Two wards ran weekly family clinics to support patients and carers. Lavender Ward had a full time carer support worker. The rehabilitation ward held a group for carers every month. Staff showed good understanding of individual patients' needs.
- Staff involved patients and, where appropriate carers and relatives, in care and treatment decisions, although this was not always documented in care records. The trust was co-producing a service user and carer development and

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involvement plan. This included increasing service user and carer influence on service delivery through participation in staff recruitment and delivering training. Young people were involved in the refurbishment of a waiting area for patients and families. The trust offered volunteer and employment opportunities to people with lived experience and planned to extend this work to harder to reach communities.

- Patients were able to give feedback about their experiences of services via a real-time feedback machine. Staff responded positively to feedback and looked for ways to improve services.

However:

- The child and adolescent inpatient wards did not provide an advocacy service to informal patients. Young people, who were not detained under the Mental Health Act, did not have access to an independent voice to represent their views. Staff in specialist community mental health services for young people did not always clearly record the wishes and views of young people in care records.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- We rated all six services core services that we inspected as good for responsive.
- The trust had clear criteria for people accessing its services and had created clear admission and discharge pathways. Staff mostly met targets to assess and treat patients. Emergency referrals to CAMHS were seen quickly by dedicated, skilled practitioners. Patients in the community had short waits to see a clinical psychologist, although access to psychology for patient in acute wards was more difficult. The trust was recruiting more clinical psychologists to increase psychology provision to inpatients in acute wards.
- Staff worked actively to discharge patients safely and appropriately and avoid delayed transfers of care. In daily bed management meetings managers described any barriers to patient discharge and how they were being addressed. Senior staff supported ward and community staff to facilitate patient discharges and intervened to reduce delays. Despite the pressures on the acute care pathways the trust had placed relatively few patients in beds outside the trust in the last year.
- Patients knew how to complain. The trust met targets for complaint responses in most cases. Young people felt listened to when they raised concerns.
- The services offered interventions to improve patients' social networks, education and employment. Patients attended courses at the recovery college. The trust provided two community-based recovery cafes that were open in the evenings and at weekends, in partnership with a third sector provider. The cafes were well used and highly valued by services users.
- Services were recovery oriented and offered a range of meaningful and therapeutic activities. Staff actively followed up patients who did not attend appointments
- Staff enquired about, considered and acted on the diverse needs of patients and their families. Some teams had an LGBT champion and signposted LGBT+ patients to relevant local groups and useful websites. Staff worked closely with a specialist local authority team to support young people from the local South Korean community referred to CAMHS. Staff on inpatient wards asked about patients' cultural and religious needs and supported patients with the provision of appropriate meal menus and access to spiritual support. Staff in the East Wandsworth CMHT worked closely with the local mosques. The trust provided effective communication support to deaf service users through the employment of deaf nursing staff, the provision of British Sign Language (BSL) interpreters, and BSL videos on the trust website. Premises were accessible to people with physical disabilities. The trust worked well with local communities, including BME communities, to promote and support mental health initiatives.

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However:

- The rehabilitation ward did not record and track complaints at a ward level. In the child and adolescent inpatient wards and substance misuse service staff did not routinely record local or informal complaints. These may have been missed opportunities for learning. Complaint response letters to patients tended to be written in over formal language, even when responding to young people. Responses could have shown more empathy.
- Patients using community mental health teams for working age adults, particularly in Kingston, Richmond and Merton, reported that they often struggled to get through to staff when they telephoned the trust's contact centre.
- Some children and young people said the hospital food was of a poor quality and not very appetising. The soundproofing of therapy rooms in the substance misuse service was not adequate and conversations could be overheard.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Whilst there had been a number of changes in executive directors, the trust was well-led and the senior team were committed to improving services to meet the mental health needs of local communities. The changes in the chief operating officer and director of HR had led to some areas of work taking longer than anticipated.
- The culture of the organisation was open and transparent. Staff felt able to raise concerns and acknowledge areas for improvement. Most staff enjoyed working for the trust and felt well supported by their managers and teams. Staff engagement was enhanced by an award winning intranet, which provided very accessible information.
- The trust was outward looking and engaged well with external partners and stakeholders. The trust was working well with the two other South London mental health trusts through the South London Partnership and this was supporting the introduction of new models of care as well as facilitating learning and sharing functions to maximise the use of resources. The trust was actively engaged across five boroughs in the work of the sustainability and transformation partnership.
- The trust encouraged innovative solutions to improve patient care. This included the development of the Lotus Suite, a service aimed at supporting people intensively for a short period of time, thus preventing an admission to hospital. The trust had also commissioned crisis cafes with third sector partners, which were well liked by the people using them. The quality improvement programme, whilst still in its early stages was supporting staff to develop ideas to improve trust services. For example, a focus on cardio-metabolic assessment in the community was supporting patients with their physical health needs.
- The trust had effective structures, systems and processes in place to support the governance of the trust including financial governance. This included board sub-committees, service line committees and team meetings. There was a clear trust risk register monitoring how risks were mitigated and staff at all levels could contribute to this. The quality of data had improved and team managers had access to local dashboards to help inform their work. However, the volume of data was very high and front line staff said inputting data could take too long.
- The trust was co-producing a service user and carer development and involvement plan. Whilst this was still being finalised it included aspirational but also realistic proposals for the extension of co-production across the trust services. This included increasing service user and carer influence and control through participation in recruitment and delivering training. It also provided personal opportunities such as access to volunteering and employment opportunities. There were plans to extend the work with harder to reach communities.
- The trust had systems in place to report and learn from serious incidents including patient deaths. However, further work was needed to improve the timescales for incidents being investigated.

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- The trust was making good progress with the recruitment and retention of staff. The time to recruit was taking an average of just six weeks. A number of nurse development programmes were taking place or in progress, which were providing attractive job opportunities with career progression. A detailed review of staffing levels on inpatient wards had led to an increase in staffing on most wards. Changes resulting from the review included an increase in staff on 9-5 shifts, increased supernumerary shifts for band 6 nurses, backfill for band 7 nurses on leave and an increase in band 4 staff.
- The trust was undertaking a large estates modernisation programme. Plans for the redevelopment took into account the need to maintain patient safety and patient experience while building works took place.
- The trust was supporting the development of staff equality and diversity networks. As a provider of national mental health services for deaf children and adults the trust provided effective communication support to deaf service users through the employment of deaf nursing staff, the provision of British Sign Language (BSL) interpreters, and BSL videos on the trust website. The trust supported hearing staff working in deaf services to learn BSL. The trust worked well with local communities, including BME communities, to promote and support mental health initiatives. Diversity was encouraged on the trust board.

## Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in three services we inspected:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Specialist community mental health services for children and young people

For more information, see the outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including breaches of one regulation of the Health and Social Care Act 2012, Safe care and treatment. There were two areas the trust must put right in relation to this regulation. In addition we found 39 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality.

For more information, see the Areas for improvement section of the report.

## Action we have taken

We have issued one requirement notice to the trust. That meant that the trust had to send us a report saying what action it would take to meet this requirement.

Our action related to breaches of two legal requirements in one service.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

# Summary of findings

## What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

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

- Lavender Ward and Rose Ward held family clinics every week. Patients and their carers or family could meet with staff to discuss the patient's care and treatment. Staff provided clear information to carers and families about the patient's illness.
- On Lilacs Ward an ex-patient had provided training for staff on how to care for transgender patients.
- Lavender Ward had a full time carer support worker. This post was funded by a mental health charity.
- On Rose Ward, patients were provided with three cards coloured red, amber and green. The colours indicated how distressed the patient felt, with red being the most distressed, and green the least. Patients wrote on the back of the cards how they felt and what might help them. These cards helped patients who were unable to verbalise their distress and risks.

### Community-based mental health services for adults of working age

- Staff in the teams worked closely with other agencies to support patients. For example, the consultants in some teams met with local GP practices. Senior staff attended care pathway meetings that including a range of health professionals for each borough. This ensured a smoother pathway for discharge. The teams worked very well with third sector providers and with inpatient wards so that patients could leave hospital as soon as they were well enough. The Morden RST team worked closely with the Imagine charity in Wimbledon to support patients at the point of discharge. The recovery cafés in Wandsworth and Merton provided a supportive resource that both patients and staff told us they found helpful.

### Specialist community mental health services for children and young people

- Where services had identified patterns in self-harm behaviours, they had developed a trust wide plan to address and reduce it. For example, staff identified that several young people presented at emergency departments having misused a particular substance over short period of time. The service worked with external organisations, to notify them and also to put together information packs for young people about the dangers of the substance. Staff worked closely with emergency department staff when these incidents took place in order to offer their specialist knowledge and support. There had been a reduction in these incidents since.
- In Richmond CAMHS, the service had developed a social group for young people aged 14 to 17 years, offering social skills training. Once established, young people and parents began to run this group in place of staff and relocated the group to a local café.
- The trust set up a CAMHS emergency care team in response to the level of acuity and pattern of young people going to emergency departments in a crisis. This was a dedicated team who worked across local acute hospitals to assess young people who attended the emergency department. These staff were able to offer assessments and appropriate onward referrals to suitable services.

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## Areas for improvement

Action the trust **MUST** take is necessary to comply with legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality.

### **Action the trust MUST take to improve**

We told the trust that it must take action to bring services into line with two legal requirements. This action related to one service.

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

- The trust must ensure that in the hour following rapid tranquilisation, staff attempt to take patients' physical observations in accordance with best practice and record this.
- The trust must ensure that staff take patients' physical observations and, when scores are elevated, escalate these to senior nursing and medical staff

### **Action the trust SHOULD take to improve**

We told the trust that it should take action to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These 39 actions related to the whole trust and six services.

#### **Trust wide**

- The trust should ensure the trust strategy is completed to provide clear direction to the delivery of high quality sustainable care.
- The trust should ensure the leadership development programme is fully implemented especially for front line ward and team managers to ensure they have the skills to deliver their role.
- The trust should continue to work towards incidents being addressed within the target timescale.
- The trust should continue to implement the work needed to comply with the accessible information standard.
- The trust should ensure that staff can access the occupational health service in a timely manner. They should also ensure staff performance issues are concluded in a timely manner.
- The trust should continue to work towards complaints being addressed within the target timescale and for the responses to use less corporate language and convey more empathy.
- The trust should review the data used to monitor performance throughout the trust to see if this can be reduced.
- The trust should ensure staff have access to IT support that is timely, effective and accessible for clinical staff.
- The trust should ensure that when change is being managed, that consultation with staff and representatives takes place at an early stage.
- The trust should complete the process of obtaining enhanced rather than standard disclosure and barring service checks for non-executive directors.

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

- The trust should ensure that patients' risk assessments are detailed, and are updated following risk incidents.

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- The trust should ensure that the number of beds on larger wards is reduced as soon as possible in line with guidance from the Royal College of Psychiatrists.
- The trust should ensure that staff complete mandatory training related to risk assessment (RATE) and medicines management (for allied health professionals).
- The trust should ensure that medicines are stored at the correct temperature, and when they are not that action is taken and documented promptly, to ensure medicines are safe for patients prior to use.
- The trust should ensure that staff on Ward 1 and Ward 3 receive an annual appraisal.
- The trust should ensure that staff document discussions with patients about treatment options in detail when obtaining their consent to treatment.
- The trust should ensure that medical staff on Lavender Ward review the prescription of 'as required' medicines to aid sleep in line with trust policy and document the review has taken place.
- The trust should ensure that the recruitment of more clinical psychologists to support patients in acute wards is completed in a timely manner, so that patients have easier access to psychologically informed care and treatment.
- The trust should ensure that staff are aware of the Freedom to Speak Up Guardian service.

## **Long stay/rehabilitation mental health wards for working age adults**

- The trust should ensure that senior leaders actively engage front line staff in the development of rehabilitation services and address staff anxieties about service changes.
- The trust should ensure the ward has appropriate systems to monitor the progress of complaints and safeguarding referrals at a local level.

## **Community-based mental health services for adults of working age**

- The trust should ensure staff update risk assessments, especially following transfer to the community teams from other teams within the trust.
- The trust should consider reviewing the telephone line for patients trying to reach the community teams in Kingston, Richmond and Merton to ensure the teams can be accessed quickly.
- The trust should continue to review caseload sizes in the Wandsworth EIS to ensure they do not exceed national recommendations.
- The trust should ensure staff explain patients' rights in respect of Community Treatment Orders and record they have done so.

## **Substance misuse services**

- The trust should ensure that staff record the frequency of the cleaning of physical health equipment and that yellow sharps disposal bins are labelled correctly.
- The trust should ensure that staff record patient information on the electronic database in a consistent manner
- The trust should ensure that staff collate the informal or local complaints that relate to the clinical team in order to maximise learning
- The trust should review the substance misuse service prescribing protocols to ensure they take account of new UK clinical guidance published in July 2017.
- The trust should consider how the soundproofing of therapy rooms in the service can be improved.

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## Child and adolescent mental health wards

- The trust should consider how informal patients on Corner House and Aquarius Ward can have access to independent advocacy.
- The trust should review the meals supplied to Aquarius Ward and Corner House to ensure the food is of a good quality and delivered in a portion size to meet the needs of the young people.
- The trust should consider how communication between school staff and Corner House staff could be improved.
- The trust should ensure there is a system in place that maximises the services' ability to learn from local or informal complaints.

## Specialist community mental health services for children and young people

- The trust should ensure the electronic patient records system meets the needs of the staff and patient information is stored consistently to facilitate retrieval by staff.
- The trust should ensure that 'what if' plans are fit for purpose so staff can use these where helpful and the new system of sharing information on what to do in a crisis is fully embedded in practice.
- The trust should ensure all services have appropriate fire safety practices in place, including signing in and out of buildings.
- The trust should ensure young peoples' views, wishes and preferences are recorded in care notes.
- The trust should ensure connectivity and IT problems do not interfere with staff being able to carry out their work.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

### We rated the trust as good because:

- Whilst there had been a number of changes in executive directors, the trust was well-led and the senior team were committed to improving services to meet the mental health needs of local communities. The changes in the chief operating officer and director of HR had led to some areas of work taking longer than anticipated.
- The culture of the organisation was open and transparent. Staff felt able to raise concerns and acknowledge areas for improvement. Most staff enjoyed working for the trust and felt well supported by their managers and teams. Staff engagement was enhanced by an award winning intranet, which provided very accessible information.
- The trust was outward looking and engaged well with external partners and stakeholders. The trust was working well with the two other South London mental health trusts through the South London Partnership and this was supporting the introduction of new models of care as well as facilitating learning and sharing functions to maximise the use of resources. The trust was actively engaged across five boroughs in the work of the sustainability and transformation partnership.
- The trust encouraged innovative solutions to improve patient care. This included the development of the Lotus Suite, a service aimed at supporting people intensively for a short period of time, thus preventing an admission to hospital.

# Summary of findings

The trust had also commissioned crisis cafes with third sector partners, which were well liked by the people using them. The quality improvement programme, whilst still in its early stages was supporting staff to develop ideas to improve trust services. For example, a focus on cardio-metabolic assessment in the community was supporting patients with their physical health needs.

- The trust had effective structures, systems and processes in place to support the governance of the trust including financial governance. This included board sub-committees, service line committees and team meetings. There was a clear trust risk register monitoring how risks were mitigated and staff at all levels could contribute to this. The quality of data had improved and team managers had access to local dashboards to help inform their work. However, the volume of data was very high and front line staff said inputting data could take too long.
- The trust was co-producing a service user and carer development and involvement plan. Whilst this was still being finalised it included aspirational but also realistic proposals for the extension of co-production across the trust services. This included increasing service user and carer influence and control through participation in recruitment and delivering training. It also provided personal opportunities such as access to volunteering and employment opportunities. There were plans to extend the work with harder to reach communities.
- The trust had systems in place to report and learn from serious incidents including patient deaths. However, further work was needed to improve the timescales for incidents being investigated.
- The trust was making good progress with the recruitment and retention of staff. The time to recruit was taking an average of just six weeks. A number of nurse development programmes were taking place or in progress, which were providing attractive job opportunities with career progression. A detailed review of staffing levels on inpatient wards had led to an increase in staffing on most wards. Changes resulting from the review included an increase in staff on shifts, increased supernumerary shifts for band 6 nurses, backfill for band 7 nurses on leave and an increase in band 4 staff.
- The trust was undertaking a large estates modernisation programme. Plans for the redevelopment took into account the need to maintain patient safety and patient experience while building works took place.
- The trust was supporting the development of staff equality and diversity networks. As a provider of national mental health services for deaf children and adults the trust provided effective communication support to deaf service users through the employment of deaf nursing staff, the provision of British Sign Language (BSL) interpreters, and BSL videos on the trust website. The trust supported hearing staff working in deaf services to learn BSL. The trust worked well with local communities, including BME communities, to promote and support mental health initiatives. Diversity was encouraged on the trust board.

## Use of resources

We do not yet review the use of resources in our inspections of NHS mental health providers.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ May 2018	Good ↔ May 2018				

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↓ May 2018	Good ↔ May 2018				
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ May 2018	Good ↑ May 2018	Good ↔ May 2018	Good ↑ May 2018	Good ↑ May 2018	Good ↑ May 2018
Forensic inpatient or secure wards	Requires improvement ↔ Jun 2016	Good ↔ Jun 2016				
Child and adolescent mental health wards	Good ↑ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018
Wards for older people with mental health problems	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016
Community-based mental health services for adults of working age	Good ↑ May 2018	Good ↑ May 2018	Good ↔ May 2018	Good ↑ May 2018	Good ↑ May 2018	Good ↑ May 2018
Mental health crisis services and health-based places of safety	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016
Specialist community mental health services for children and young people	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018
Community-based mental health services for older people	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016	Good ↔ Dec 2016
Community mental health services for people with a learning disability or autism	Good ↔ Jun 2016	Good ↔ Jun 2016	Good ↔ Jun 2016	Good ↔ Jun 2016	Good ↔ Jun 2016	Good ↔ Jun 2015
Substance Misuse Services	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
<b>Overall</b>	Good ↑ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018	Good ↔ May 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Child and adolescent mental health wards

Good   

## Key facts and figures

We inspected two teams that provide tier four child and adolescent mental health services (CAMHS) at South West London and St George's Mental Health NHS Trust. At the time of inspection, there were twelve patients on Aquarius Ward and four patients on Corner House. Seven young people were detained on Aquarius Ward and one young person was detained on Corner House.

Aquarius Ward is a twelve-bed inpatient service for young people aged 12-18 who have a serious mental illness e.g. psychosis, bipolar affective disorder, depression, severe anxiety disorders, obsessive compulsive disorder and emerging personality disorder. The service offers both planned and emergency admissions.

Corner House is a six-bed national specialist assessment and treatment unit for deaf children and adolescents aged 8 – 18 years, with severe complex emotional and psychological problems.

During the inspection visits, the inspection team:

- visited Aquarius Ward and Corner House, and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with five carers of patients who were using the service
- spoke with the ward managers of both wards
- interviewed ten staff including psychiatrists, nurses, occupational therapists, occupational therapy technicians, healthcare assistants, and the senior managers for the CAMHS service line
- reviewed nine care records of patients
- attended and observed a goal setting group on Aquarius Ward, a healthy living group and lunchtime on Corner House
- checked the clinic rooms and medicine management on both wards
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff kept appropriate records of patients' care and treatment. Risk assessments were completed on admission and reviewed regularly and care plans were up to date. At the last inspection in March 2016, on Aquarius Ward, a new template for care planning had been introduced, but was not fully embedded. During this inspection, we found the team had fully embedded the new care plan template.
- Staff used de-escalation techniques before restraint was used. Staff ensured physical health observations were carried out following rapid tranquilisation, in line with national guidance. There was excellent recording of this by staff on Aquarius Ward.

# Child and adolescent mental health wards

- Staff participated in regular clinical audits, which helped ensure the quality of the services delivered on the wards. Staff received regular supervision and appraisals. At the last inspection in March 2016, on Aquarius Ward, records of supervision sessions were not kept securely or consistently. During this inspection, we saw evidence that supervision records were stored securely and consistently on the trust's electronic database.
- Feedback from patients and carers was generally positive. Young people and carers felt involved in their care and treatment.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care, including an outdoor area and an onsite school. The trust had onsite accommodation, near to but separate from the ward, where parents and carers could stay when visiting their child, as some lived far away from the units.
- Ward managers created a culture in which staff felt supported. Staff told us they felt respected, supported and valued by their team. Staff were committed to delivering quality improvements in the wards.
- At the last inspection in March 2016, staff did not recognise that using the low stimulus room and preventing young people from leaving was seclusion. The necessary safeguards were not in place for young people. During this inspection, we found this was no longer the case. Staff followed trust policy and ensured the necessary safeguards and reviews of seclusion were completed in these circumstances.
- At the last inspection in March 2016, the ward manager on Aquarius Ward was unable to provide accurate figures for compliance with mandatory training. During this inspection, we found this was no longer the case. The ward's mandatory training compliance rate was 87%.

However:

- The wards did not provide an advocacy service to informal patients. This meant that the young people who were not detained under the Mental Health Act did not have access to an independent voice to represent their views and wishes on the wards.
- Some patients said the food was of a poor quality and was not appetising. For example, patients on Corner House said meals were often overcooked or undercooked, and the portions were small.
- Ward staff did not keep a log of local, informal complaints, which could have made it more difficult to identify trends, and was a missed opportunity for learning.
- Staff on Corner House felt that communication with the onsite school staff could be improved to the benefit of the children and young people.

## Is the service safe?

**Good** ● ↑

Our rating of safe improved. We rated it as good because:

- Clinic rooms were fully equipped with appropriate equipment that was well-maintained. There was adequate medical cover day and night and a doctor could attend the wards in an emergency. Corner House, the ward for deaf young people, had several adaptations to ensure the safety of deaf patients and staff.
- Staff managed and responded to changes in patients' risk. Staff were trained in safeguarding, knew how to identify children at risk and followed the trust's process of reporting.

# Child and adolescent mental health wards

- Staff used de-escalation techniques before restraint was used. Staff ensured physical health observations were carried out following rapid tranquilisation, in line with national guidance. There was excellent recording of this on Aquarius Ward.
- Staff managed medicines safely. Medicines were stored securely and prescribed and administered in line with national guidance.
- Wards were appropriately staffed with suitably qualified and experienced staff. Staff were up to date with mandatory training.
- At the last inspection in March 2016, staff did not recognise that using the low stimulus room and not allowing young people to leave the room amounted to seclusion. As a result the necessary safeguards were not put in place for young people. During this inspection, we found this was no longer the case, staff followed trust policy and ensured the necessary safeguards were completed.
- At the last inspection in March 2016, the ward manager on Aquarius Ward was unable to provide accurate figures for compliance with mandatory training. During this inspection, we found the manager had easy access to accurate training data. The ward's mandatory training compliance rate was high at 87%.

## Is the service effective?

Good ● → ←

Our rating of effective stayed the same. We rated it as good because:

- Ward staff took a holistic approach to assessing, planning and delivering care and treatment in line with current evidence based guidance. Care plans were person centred and covered all aspects of patients' needs.
- Staff assessed and monitored patients' physical health well. Staff ran healthy living groups on Corner House. Staff provided a range of evidence based therapeutic interventions to support the recovery of children and young people.
- The teams included or had access to the full range of specialists required to meet the needs of the young people on the wards.
- All staff received regular clinical and managerial supervision, annual appraisals and reflective practice sessions.
- Staff participated in regular clinical audits, which helped ensure the quality of the services delivered on the wards and drive improvement.
- At the last inspection in June 2016, on Aquarius Ward, a new template for care planning had been introduced, but was not fully embedded. During this inspection, we found the team had fully embedded the new care plan template.
- At the last inspection in June 2016, on Aquarius Ward, records of supervision sessions were not kept securely or consistently. During this inspection, we found that supervision records were stored securely and consistently.

However:

- Staff on Corner House felt that communication with the onsite school staff could be improved to the benefit of the children and young people.

## Is the service caring?

Good ● → ←

# Child and adolescent mental health wards

Our rating of caring stayed the same. We rated it as good because:

- Feedback from patients and carers was generally positive. Patients said staff were very friendly and they did a good job in supporting their needs and involved them in their own care. They said staff were caring and respected their privacy.
- Parents and carers said staff were caring, professional and were good at involving them in the young person's care and treatment.
- We observed good interactions between staff and the young people on the wards. On Corner House, all conversations were interpreted through use of British sign language, which supported young people's specific communication needs.
- Staff recognised some young people had travelled long distances from their home, and supported young people to use Skype as a means of video communication to keep in regular contact with families and carers.

However:

- The wards did not provide an advocacy service to informal patients. This meant that young people, who were not detained under the Mental Health Act, did not have access to an independent voice to represent their views and wishes on the wards.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Staff started planning a patient's discharge upon admission and regularly discussed discharge in weekly ward rounds and regular care programme approach (CPA) meetings.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care, including an outdoor area.
- On Corner House, adaptations had been made to the ward to promote the safety of the deaf staff and patients. British Sign Language interpreters were routinely present on the ward during the day.
- Complaints information was displayed on the wards. Patients and carers said they knew how to complain and felt listened to by staff when they raised concerns.
- The trust had onsite accommodation, near to but separate from the ward, for parents and carers to stay when visiting their child, as some lived far away from the units.

However:

- Some patients said the food was of a poor quality and was not appetising. For example, patients on Corner House said meals were often overcooked or undercooked, and the portions were small.
- Local or informal complaints were not routinely recorded, which may have led to a lost opportunity for learning.

## Is the service well-led?

Good   

# Child and adolescent mental health wards

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles.
- All staff said there was good team working. Staff felt positive and proud about working for the provider and their team. Staff described their teams as supportive and caring. Staff sickness on both wards was low.
- Staff knew how to use the whistleblowing process. The Freedom to Speak Up Guardian service was advertised on the wards.
- There were good governance systems in place to ensure managers had the necessary oversight of their team's individual performance. Managers addressed performance in regular staff supervision and team meetings.
- Staff concerns matched those on the risk register. Managers regularly discussed the risk register in clinical governance meetings and managers' supervision.
- Staff on both wards were actively involved in quality improvement projects. This demonstrated a drive and commitment to improve the services young people received.

## Areas for improvement

We found four areas for improvement in this service. See the Areas for improvement section above.

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

Good   

## Key facts and figures

The acute wards for working age adults and psychiatric intensive care units, provided by South West London and St George's Mental Health Trust, provide inpatient acute mental health care and treatment to people living in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.

The trust operates eight acute admission wards and one psychiatric intensive care unit at three locations:

Springfield University Hospital:

- Ward 1 – a 13 bed psychiatric intensive care unit for men
- Ward 2 – an 18 bed acute admission ward for men and women
- Ward 3 – a 20 bed acute admission ward for men and women
- Ellis Ward – a 12 bed acute admission ward for men and women
- Jupiter Ward – a 23 bed acute admission ward for men and women

Queen Mary's Hospital:

- Laurel Ward – a 23 bed acute admission ward for men
- Lavender Ward – a 23 bed acute admission ward for men and women
- Rose Ward – a 23 bed acute admission ward for women

Tolworth Hospital:

- Lilacs Ward - a 23 bed acute admission ward for men and women

During the inspection we visited all of the wards.

At the last comprehensive inspection in March 2016, the services were rated as good for being safe, effective, caring, responsive and well-led.

We also carried out a focused inspection of Ward 2 in September 2017. We issued two requirement notices following that inspection, concerning safe care and treatment and staffing. As this was a focussed inspection, the overall ratings for the services were not changed. We re-inspected all of the key questions on Ward 2 during the current inspection to see if there had been improvements.

Our inspection of acute wards for adults of working age and psychiatric intensive care units, between 27 February and 1 March 2018, was announced and was part of a larger inspection of core services operated by the trust, in addition to inspecting how well-led the trust was.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited each of the wards, looked at the quality of the physical environment, and observed how staff communicated with patients

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

- spoke with 58 patients
- spoke with all of the ward managers and two modern matrons
- spoke with the clinical director for the services
- spoke with 28 other members of staff including nurses, health care assistants, occupational therapists, doctors, student nurses and a clinical psychologist
- looked at 44 care and treatment records
- attended and observed three multi-disciplinary team meetings
- attended and observed a patient activity group and a ward community meeting
- undertook a specific check of the medicines management on six wards
- looked at policies, procedures and other documents relating to the running of the services

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Wards were led by skilled, knowledgeable and experienced managers. Ward managers had easy access to detailed information about the performance of their ward that helped identify shortfalls and supported their commitment to drive improvements in patient care. Staff took part in quality improvement initiatives aimed at reducing waste, reducing violence and aggression on the wards and improving the physical health and well-being of patients.
- Staff treated patients with kindness and compassion and offered support to carers. Patients described staff in positive terms highlighting their caring, friendly and supportive approach. Two wards ran weekly family clinics to support patients and carers and Lavender Ward had a full time carer support worker in post. Staff enabled patients to give feedback about their care and experience via real time feedback devices and in regular community meetings. Staff acted on feedback.
- Staff came from diverse backgrounds and offered support to patients that took account of their spiritual, cultural and religious needs. Some staff wore rainbow lanyards, which showed the wards were trying to be inclusive and supported patients to discuss their sexuality. A former transgender patient provided training for staff on Lilacs Ward on how to care for transgender patients.
- Staffing levels had been increased across all wards to make them safer and ensure that patients could go on leave and have regular one to one time with staff. Staff planned patient discharges proactively.
- The wards had improved reporting of incidents and restraints and had introduced strategies to reduce violence and aggression and restrictive practices on the wards. Staff learned from complaints and serious incidents and made improvements so as to reduce the risk of reoccurrence.
- Patients had a comprehensive physical health assessment shortly after admission. Staff promoted healthier lives and supported patients to stop smoking and improve levels of exercise and diet.
- On Rose Ward, patients were provided with coloured cards that they could use to indicate to staff how distressed they felt and what could help them. The cards helped patients who were unable to verbalise their distress and risks.

However:

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

- Staff did not always record patients' physical observations, or attempts to take clinical observations, after rapid tranquilisation had been administered, in line with trust policy and national guidance. Staff on the PICU recorded patient refusals to have physical observations but did not record revisiting the patient and trying to complete these observations a second time.
- Staff did not always record patients' physical health observations with the correct frequency and when scores were elevated did not always escalate the concern to a senior nurse or medical staff.
- Five wards had 23 beds, more than the 18 beds recommended by the Royal College of Psychiatrists.
- Although most patients' risk assessments were detailed and updated following risk events; nine of the 36 we reviewed were not.
- Medicines were not always stored at the correct temperature. When this was identified, staff did not record whether they had escalated this to a pharmacist or were taking steps to address it.
- Some staff had not yet completed mandatory training related to risk assessment (RATE training) and medicines management (for allied health professionals). There were low staff appraisal rates for nursing staff on Ward 1 and Ward 3.
- Staff stored clinical information, particularly in relation to patients' physical health, in different places on the electronic patient record, which meant that it could be difficult for staff to find it when they needed to. Doctors did not document discussions with patients about treatment options in detail when obtaining consent to treatment from patients.
- On Lavender Ward, some patients were prescribed medicines to aid sleep for several weeks. There was no record that these 'as required' medicines were reviewed frequently enough, in line with trust policy and best practice guidance, and continued to be required by the patient.
- Although the trust was actively recruiting more clinical psychologists, in the meantime patients had limited access to a clinical psychologist.
- Very few staff in this core service said they were aware of the Freedom to Speak Up Guardian service and how to make contact.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- In the hour after rapid tranquilisation, staff did not always attempt to record patients' physical observations four times. This did not follow best practice or reflect the potential risks associated with rapid tranquilisation. The trust took action to address this immediately following the inspection.
- When patients' physical health observations were outside of the normal range, staff did not always escalate this to senior nursing or medical staff. This increased the risk that patients' physical health problems may go undetected or not be addressed. The trust took action to address this immediately following the inspection.
- Five of the acute wards had 23 beds. Royal College of Psychiatrists' guidance is that wards should have a maximum of 18 beds to provide safe and effective care and treatment.
- Although most patients' risk assessments were detailed and up dated following risk events some were not and did not include possible triggers for risk incidents.

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

- Medicines were not always stored at the correct temperature. When this was identified, the risks were not always escalated.
- Some staff needed to complete mandatory training related to risk assessment and medicines management.
- Inconsistent storage of clinical information on the electronic patient record meant that staff could not easily access all information held about a patient's physical health.

However:

- Nursing staffing levels on all of the wards had been increased and ensured the wards were safe; patients could have leave and one to one meetings with staff to discuss their needs.
- The trust had focussed on improving the recording of restraint and was introducing measures to reduce levels of restraint. The Dynamic Appraisal of Situational Aggression (DASA) was being introduced on acute wards and the psychiatric intensive care unit. DASA is a tool used to predict potential violence. DASA assists staff to intervene before an incident occurs.
- Ligature risk assessments on Lavender Ward, Laurel Ward and Rose Ward contained pictures of ligatures on the ward.
- Staff had received training in safeguarding, knew how to recognise potential abuse and made appropriate referrals to the local authority safeguarding team.
- Staff reported incidents appropriately. Lessons learned from incidents were identified and shared with ward teams.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Patients had a comprehensive physical health assessment shortly after they were admitted to hospital.
- Medicines were prescribed in line with guidance from the National Institute for Health and Care Excellence.
- On Rose Ward, patients were provided with coloured cards that they could use to indicate to staff how distressed they felt and what could help them. The cards helped patients who were unable to verbalise their distress and risks.
- Patients were encouraged to live healthier lives. Staff that were trained in smoking cessation were available on every ward to support patient to reduce or stop smoking. Patients were encouraged to eat healthily and take exercise.
- A dietitian attended all of the wards on a regular basis.

However:

- There were low appraisal rates for nursing staff on Ward 1 and Ward 3.
- Doctors did not document discussions with patients about treatment options in detail when obtaining consent to treatment.
- On Lavender Ward some patients were prescribed sleeping medicines for several weeks. There was no record that these medicines were reviewed in line with trust policy and best practice guidance and continued to be required.
- Although the trust was actively recruiting more clinical psychologists for the acute wards, in the meantime patients had limited access to a clinical psychologist.

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

## Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Almost all patients described staff as friendly, caring and supportive. Staff interacted with patients in a kind and compassionate manner.
- On Lavender Ward and Rose Ward, the weekly family clinic supported patients and their carers or family. Patients, and carers or relatives could meet with staff to discuss the patient's care and treatment. Staff provided clear information to carers and families about the patient's illness.
- Lavender Ward had a full time carer support worker. This post was funded by a mental health charity. Staff provided support to carers.
- All of the patients on all of the acute wards and psychiatric intensive care unit were able to access an independent advocate. Information regarding advocacy was on display in all of the wards.
- Each of the acute wards had a real-time feedback machine. This machine was available for patients to provide feedback on their care and treatment at any time.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Staff on all of the wards proactively planned for patients' discharge. Wards had recently recruited discharge coordinators to assist with this process.
- Patients were able to access pastoral and spiritual support and faith leaders attended wards to support patients in spiritual observance. Religious texts were available on the wards.
- There were posters on the wards advertising the rainbow lanyards worn by staff. Patients could approach staff wearing these lanyards if they wanted to talk about any matters relating to their sexuality. On Lilacs Ward an ex-patient had provided training for staff on how to care for transgender patients.
- Almost all patients knew how to make a complaint. Staff understood the complaints procedure and complaints were discussed in team meetings to prevent repetition.

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- Ward managers were skilled, knowledgeable and very experienced. They were committed to improving safety and providing high quality care. The ward managers were accessible to patients and staff.

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

- Most staff described good morale and that they felt valued and supported. They described being happy in their role. Staff reported that equality and diversity was promoted in the trust. Staff came from diverse backgrounds.
- There was an effective system of governance and senior managers and clinical leaders had sight of areas of practice requiring improvement.
- There was a clear framework to structure ward business meetings and quality and governance meetings. This framework included a range of quality indicators and discussions regarding learning from incidents and complaints. Managers had good access to information about the performance of their ward.
- Staff were given the time and support to consider improvements. On Lilacs Ward, a peer support project had commenced and patients selected to take part. The project aimed to measure the impact of peer support on patients' recovery. Staff across the wards were taking part in a range of quality improvement initiatives including projects to reduce medicines waste; to improve the physical health and well-being of patients; implementing interventions designed to reduce violence and aggression, and improving the quality of handovers.

However:

- Very few staff were aware of the Freedom to Speak Up Guardian service.

## Outstanding practice

We found four examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found eleven areas for improvement in this service. See the Areas for improvement section above.

# Long stay or rehabilitation mental health wards for working age adults

Good  

## Key facts and figures

Since our previous inspection the trust had undertaken a consultation and had either transferred its rehabilitation services to a third sector provider or moved them to another service line. Phoenix Ward is now the only rehabilitation ward provided by the trust.

At the last inspection, the rehabilitation services were rated as requires improvement in four domains (safe, effective, responsive and well-led) and good in caring. We re-inspected all the key questions to see if improvements had been made.

The trust has one rehabilitation ward, which is Phoenix Ward. Phoenix Ward is a 16 bed, mixed sex, high dependency rehabilitation ward. Patients move from acute and secure services to Phoenix Ward for support and treatment before moving on to community based settings including community based rehabilitation units, longer term complex care rehabilitation units, supported accommodation and independent flats.

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection, the inspection team:

- looked at the quality of the ward
- observed how staff were caring for patients.
- spoke with six patients
- interviewed eight members of staff
- looked at care records for nine patients
- reviewed 13 medicine administration records
- checked Mental Health Act documentation
- looked at policies, procedures and other documents relating to the running of the service

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The trust had made improvements since the last inspection.
- Patients were involved in their care planning and staff supported them to give their views and develop objectives. Patient care plans were personalised and holistic.
- The ward planned for patients' discharge and worked well with both internal and external agencies. The ward did not experience delayed discharges and had reduced the average length of stay on the ward considerably in the previous year.
- Staff were caring and supportive of patients. Patients were allocated a care team and regularly met with named nurses for one-to-one sessions. Staff had a good understanding of the individual needs of patients, including their personal, cultural, social and religious needs.

# Long stay or rehabilitation mental health wards for working age adults

- Patients were supported to live healthier lives and had access to physiotherapists and dietitians to help improve fitness and diet.
- Staff followed good practice in medicines management. Medicines were stored safely. The implementation of electronic prescribing and medicine administration records had led to a significant reduction in omitted medicine doses. Ward areas and furnishings were visibly clean. Clinical equipment was checked, calibrated and kept clean and ready for use.
- At our previous inspection in March 2016, we identified that staff did not always address identified patient risks in risk management plans. At this inspection we saw improvement. Patients received a comprehensive assessment on admission with effective multi-disciplinary input. The ward assessed risk and physical health on an individualised basis. Plans were in place to address and mitigate risks.
- At the last inspection in March 2016, we found that the patients were not supported to access programmes of therapeutic activities to promote their rehabilitation. At this inspection, we found significant improvement. The ward supported patients to become more independent and prepare them for discharge into the community. The service provided a wide range of psychological interventions, occupational therapy, leisure and vocational activities. The ward adapted this on a regular basis to meet the needs of patients.
- At the last inspection in March 2016, we found that the trust had not supported managers to develop the leadership skills to implement a recovery orientated approach to care on all rehabilitation wards. At this inspection, we found the trust supported the ward manager for Phoenix Ward to ensure staff were aware of the aims and objectives for patients across the ward. The manager was attending a development course for black and minority ethnic staff.
- The ward had made considerable progress in ensuring that all staff received appropriate clinical and managerial supervision. Staff supervision rates had risen by 40% since the last inspection in March 2016. Eighty five per cent of planned supervision took place. All staff had received an annual appraisal.

However:

- Records of complaints and safeguarding referrals were not kept at a local level. Whilst staff had a good understanding of the trust processes for both, the ward did not have appropriate systems to monitor the progression of these concerns.
- Staff were unsure about the future of the service and felt this had not been communicated well by senior leaders in the trust. The morale of some staff was low as a consequence.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- At the last inspection in March 2016, we found that staff did not always address identified risks in risk management plans. At this inspection, we found that all patients had detailed, individualised and comprehensive risk assessments. Staff updated patient risk management plans on a regular basis to reflect current levels of risk.
- The ward was clean and well maintained. Clinic room equipment had been calibrated and maintained. The temperatures of fridges used to store medicines were monitored and within recommended limits.
- Staff identified and mitigated environmental risks through regular reviews of the environment.

# Long stay or rehabilitation mental health wards for working age adults

- There were sufficient staff on the ward to support patients to go outside the hospital, have one to one meetings with staff and develop their independent living skills.
- Staff followed good practice in medicines management in line with national guidance and had effective arrangements to support the safe prescribing and administration of medicines.

However:

- Whilst staff had a clear understanding of safeguarding processes within the trust, the ward did not have appropriate systems to monitor safeguarding concerns, which had been reported to the local authority and the outcomes of referrals at a local level.

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- All patients had a comprehensive assessment on admission with thorough multi-disciplinary input including occupational therapy assessments of all patients. Patient care plans were personalised, holistic and reflected the patient's view and voice.
- Staff provided a range of psychological interventions and treatments to support patients' recovery and rehabilitation. Patients had access to a range of support to improve independent living skills and the ward regularly adapted the occupational therapy programme to continuously engage and motivate patients.
- Patients had access to physiotherapists, dietitians and smoking cessation support to improve their physical health.
- The ward had made considerable progress in ensuring that all staff received appropriate clinical and managerial supervision. Staff supervision rates had risen by 40% since the last inspection in March 2016. At this inspection, we found that 85% of planned staff supervision took place. All staff had received an annual appraisal.
- The service worked well with other teams in the hospital and the community and with external agencies to ensure patients received the care, treatment and support they needed.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Patients were positive about staff and told us they treated them with a kind and caring attitude. Staff had a good understanding of patients' individual needs.
- Patients were involved in the development of care plans and were supported to give their views and opinions. Patients had the opportunity to give real time feedback that staff were able to respond in a timely manner.
- Carers received support from staff. The ward ran carers meetings on a monthly basis and gave relatives the chance to complete surveys. The ward clinical psychologist offered carers assessments and support.

# Long stay or rehabilitation mental health wards for working age adults

## Is the service responsive?

Good ● ↑

Our rating of responsive improved. We rated it as good because:

- At the last inspection in March 2016, we found that the patients were not supported to access programmes of therapeutic activities to promote their rehabilitation. At this inspection, we found considerable improvement. The ward had recruited an additional occupational therapist to offer a larger range of groups and individual sessions to support patients' recovery, improve their self-reliance and every-day living skills.
- The ward did not experience delays in discharging patients. The average length of stay for patients had significantly reduced over the previous year. Staff were clear about the aims of the service and supported patients to become independent enough to move to a less supported environment.
- Staff worked collaboratively with community mental health teams and external agencies to plan discharges.
- Patients were able to personalise bedrooms and had access to a wide range of facilities. Patients were positive about the standard of meals they received.
- Staff supported patients to use community resources, educational opportunities both within and outside the trust and maintain relationships with relatives.
- The service made adjustments for disabled patients, who had access to mobility friendly bedrooms and bathrooms.

However:

- The ward did not record and track complaints at a ward level and as a result staff were unable to easily access information regarding complaints about the service. This may have been a missed learning opportunity.

## Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- At the last inspection in March 2016, we found that the trust had not supported managers in the rehabilitation services to develop the leadership skills to implement a recovery orientated approach to care. At this inspection, we found improvements had been made. Staff were aware of the aims of the ward to support patients with recovery, overcome difficulties, achieve greater independence and had a better quality of life during their stay. The ward had a clear recovery oriented approach in all aspects of patient care and treatment.
- Staff had confidence in the ward manager and the leadership they provided. They were visible and led the ward well. The trust had supported the ward manager to develop their leadership skills and progress professionally.
- The trust had developed an effective dashboard that gave staff easy access to a range of performance indicators. This enabled the ward manager to understand how the ward was performing, address any emerging shortfalls and drive improvement.

However:

- Staff were unclear about the trust's strategy and vision in respect of the rehabilitation service and felt the recent changes had not been communicated well or early enough. The morale of some staff was low as a consequence.

# Long stay or rehabilitation mental health wards for working age adults

## Areas for improvement

We found two areas for improvement in this service. See the Areas for improvement section above.

# Community-based mental health services of adults of working age

Good  

## Key facts and figures

The trust's community-based mental health services for adults of working age provide services throughout the boroughs of Wandsworth, Sutton, Merton, Richmond and Kingston. They use a recovery model to support patients and carers.

- The Merton Assessment Team takes referrals from GPs for adults aged 18-65 years and acts as the single point of access in Merton for patients. The service is for the assessment of anyone who has a serious mental health need.
- The Merton, Sutton and Wandsworth early intervention services (EIS) provide a service for patients presenting to specialist mental health services with a first episode of psychosis. The team support young people and adults aged between 17 and 65 years experiencing early signs of psychosis and their families and carers.
- The Kingston South, Kingston North, East Wandsworth, and Central Wandsworth and West Battersea community mental health teams (CMHT) provide care coordination and recovery focused interventions for adults aged 18-65 years. The teams provide treatment for adults suffering severe and enduring mental health conditions.
- The Richmond, Twickenham, Morden, Mitcham, Putney and Roehampton recovery and support teams (RST) provide care coordination, recovery focussed interventions, and psychological, practical and emotional support for adults aged 18-75 years who are experiencing severe and enduring mental health conditions. The team aims to encourage recovery through offering evidence-based treatments and support interventions.
- Wandsworth rehabilitation and recovery team (RRT) provides community mental health services to adults with severe and enduring mental illness living in supported accommodation at ten properties within the borough.

During the inspection, we visited 14 of the 33 teams.

At the last inspection, community-based mental health services for adults of working age had four key questions (safe, effective, responsive and well-led) rated as requires improvement and the other key question (caring) rated as good. We re-inspected all of the key questions to see if they had made improvements.

Our inspection between 5 March and 7 March 2018 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection, the inspection team:

- spoke with 56 patients who used the service and seven relatives or carers
- spoke with 14 managers, including the lead clinical psychologist, a clinical manager and the clinical director
- spoke with 80 other staff members, including consultant psychiatrists, social workers, clinical psychologists, occupational therapists, nurses, healthcare practitioners, assistant practitioners, administrators and employment workers
- observed three hand over meetings
- observed one clinical appointment
- observed four multidisciplinary team meetings

# Community-based mental health services of adults of working age

- observed seven risk management or 'zoning' meetings
- reviewed 73 patient records
- reviewed 15 medicine administration records
- looked at a range of policies, procedures and documents related to the services we visited.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- During this inspection, we found that services had addressed the issues that caused us to rate it as requires improvement following the March 2016 inspection.
- The services had embedded systems to support staff to remain safe whilst carrying out their work. Staff assessed risks for patients and worked with them to manage these risks. Staff knew when to report incidents and when to make vulnerable adult and children safeguarding referrals. Medicines management within the teams had improved since our last inspection, in March 2016. Staff safely transported, stored and administered medicines to patients.
- The trust continually worked towards recruiting sufficient staff to support patients, but this proved more difficult in some boroughs. Staff were skilled in their roles and received specialist training, especially in caring for patients with a personality disorder, from the psychology teams. Staff supervision within the teams had improved since our last inspection, in March 2016. Staff received regular management and clinical supervision to develop their skills and check their wellbeing.
- Staff demonstrated excellent working relationships with teams, both internal and external to the trust, to ensure a smooth, holistic pathway of care for patients. Staff offered interventions aimed at improving patients' social networks, education and employment. Patients attended the recovery college provided by the trust to complete courses such as mindfulness and understanding self-harm. Patients also attended the recovery cafés in Merton and Wandsworth to meet with their peers in the evenings and weekends.
- Staff worked with some patients to develop care plans that were holistic, person-centred and recovery focused. The teams provided care and treatments based on national guidance that promoted patients' holistic care and included receiving psychological therapies. Staff worked to improve the physical health of patients and actively monitored the effects of medicines.
- Patients praised clinical psychologists, psychiatrists and care coordinators within the teams. For example, patients said that they would not be able to cope without the staff in the teams. Staff spoke with patients in a meaningful way and could calm patients down when in distress. Staff involved patients and, when appropriate, carers in decisions about care.
- The services had clear acceptance and referral criteria for who they would offer a service to and clear care pathways for patients depending on their mental health needs. Most teams met waiting time standards. When patients did not attend their appointments, staff actively followed them up.
- Staff described the trust's vision and strategy and understood how this applied in their work. Most staff were positive about the teams that they worked for. They felt confident in the leadership of the community teams. Managers could easily access information about their teams and use this to drive improvement. Senior management regularly monitored the safety and quality of services.

However:

# Community-based mental health services of adults of working age

- At the last inspection in March 2016, we found that the trust did not ensure staff updated patient risk assessments regularly and after incidents. At this inspection, although we found that this had improved, staff did not always fully review and update risk assessments after a transfer from another team or after an incident in 19% of records we reviewed.
- Patients reported that when they rang the trust's contact centre to speak to their care coordinator they often struggled to get through. This was especially an issue in Kingston, Richmond and Merton. As a result, patients may not have been able to get hold of their care coordinator quickly.
- Caseloads in the Wandsworth early intervention service were higher than nationally recommended levels.
- Staff did not always keep records of when they had explained to patients their rights and conditions in respect of Community Treatment Orders.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as outstanding because:

- Staff knew when to report incidents and when to make vulnerable adult and children safeguarding referrals. Managers provided support to staff after incidents and acted on the findings of investigations.
- The teams had good medicines management arrangements. At the last inspection in March 2016, staff did not safely transport medicines whilst out on home visits. At this inspection, the trust had made improvements. Staff safely transported, administered and stored medicines for patients.
- Staff assessed risk for patients and worked with patients to keep them safe. Staff worked with other teams within the trust to respond when patients' health deteriorated. Risk or 'zoning' meetings were held regularly and were an effective way of managing risk. Patients had crisis plans and knew who they could contact in a mental health crisis.
- The services had embedded personal safety protocols for staff working alone. Staff followed the trust's lone working guidance and teams had robust systems in place to monitor staff movements in the community.
- Staff received training in most topics considered essential for their area of practice. The trust provided training to staff in protecting adults and children from abuse, fire safety and conflict resolution to carry out their role safely.
- Teams reported incidents, trust staff investigated these incidents and shared any lessons learned with staff that would benefit from knowing. Teams made improvements to practice and changes that would minimise the risk of incidents happening again.

However:

- At the last inspection in March 2016, we found that the trust did not ensure staff updated patient risk assessments regularly and after incidents. At this inspection, we found that, although this had improved, staff did not always update risk assessments in a timely manner, particularly when they transferred from another team. Managers recognised that the risk assessment tool needed more improvement for staff to be able to use effectively.
- Caseloads in the Wandsworth early intervention service were higher than nationally recommended levels. The average caseload ranged from 23 to 25 patients, higher than the recommended maximum of 20 patients.

# Community-based mental health services of adults of working age

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff provided patients with good quality care based on evidence-based, best practice guidelines produced by the National Institute for Health and Care Excellence. Staff completed comprehensive assessments of patients and allocated a care coordinator to manage their care and treatment promptly.
- Staff demonstrated effective collaborative working within the multidisciplinary teams they worked in and with other teams in the trust and external organisations. This included close work with GPs, the local authorities, acute hospitals and other services such as substance misuse teams and third sector organisations. This helped to ensure clear and effective pathways of care.
- Staff completed personalised, holistic and recovery-focused care plans for most patients. Patients had recovery goals to support them in their care and treatment.
- Staff planned and delivered services to improve the physical health of patients using the services. Staff actively monitored patients' physical health and the effects of medicines. In Central Wandsworth and West Battersea community mental health team staff participated in a physical health quality improvement project.
- Staff valued that they had access to clinical and management supervision. At the last inspection, in March 2016, staff did not have access to regular supervision. At this inspection, we found that all staff received regular supervision from their line manager. This ensured staff could discuss complex cases, their health and wellbeing, and areas for skill and professional development. The trust provided new staff with an induction and specific training to work in the community teams.

However:

- Staff across the teams did not always record when they had explained to patients on a Community Treatment Order, their rights and the conditions of the order.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients using the services with kindness, dignity and respect. Staff spoke to patients in a meaningful way and could calm patients down when in distress.
- Patients consistently reported that staff cared for them and provided them with emotional support. Patients praised clinical psychologists, psychiatrists and care coordinators within the team. For example, patients said that they would not be able to cope without the staff in the teams.
- Staff understood the needs of patients they supported, including their age, religion and disability. Staff in the East Wandsworth CMHT worked closely with the local mosques.
- Teams engaged with patients, families and carers to ensure they had all the information they needed to make a decision about their care and treatment. Some services, including early intervention services, had specific carers groups.

# Community-based mental health services of adults of working age

- Staff treated information about patients confidentially.
- The teams engaged with patients to involve them in their care and treatment. While staff did not consistently record in care plans that they had offered patients a copy of their care plan, patients reported that staff had offered them a copy and that they felt involved in their care and treatment.

## Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- The service had clear criteria for patients needing care and support from a care coordinator. Staff engaged with commissioners, social care and third sector organisations to create clear admission and discharge pathways for patients.
- Staff had a target to assess routine patients within 28 days after referral. The majority of staff met this target across the teams. Managers had clear oversight of their waiting list and knew why certain patients waited over 28 days.
- The clinical psychology team kept a list of all the patients waiting for psychological therapies. Senior clinical psychologists monitored this and had a good oversight of how long people had been waiting. At the time of the inspection, the longest wait for patients to access psychological therapies was four to five months.
- Staff actively followed up patients who did not attend their appointments and followed the trust's protocol. For example, staff visited patients at home to encourage engagement with the service. Staff ensured appointments with patients could be flexible and rarely cancelled them unless in an emergency.
- At the last inspection in March 2016, the trust did not ensure effective administrative processes were in place for patients to receive appointment letters on time, especially in Kingston. At this inspection, we found that improvements had been made with a new centralised hub. Kingston now had a dedicated administrative team. Patients reported receiving their letters on time.
- Patients knew how to complain. Staff were open and transparent in respect of complaints raised by patients.
- Staff offered interventions aimed at improving patients' social networks, education and employment. Patients attended the recovery college provided by the trust to complete courses such as mindfulness and understanding self-harm. Patients attended the recovery cafes to meet with their peers in the evenings and weekends.

However:

- Patients reported that they often struggled to get through to staff when they telephoned the trust's contact centre. This was especially an issue in Kingston, Richmond and Merton. As a result, patients may not have been able to get hold of their care coordinator quickly.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

# Community-based mental health services of adults of working age

- Managers had made improvements to the service since the last inspection. At the last inspection in March 2016, we found that the trust did not support managers to access performance indicators for their teams. At this inspection, we found improvements had been made. The trust had implemented a system that managers could easily access to see how their teams performed. This included access to information on staffing levels, supervision records and audits.
- Staff could raise concerns and felt positive about their teams despite the pressures of caseloads and the demands on their service. Staff felt well supported by their team managers and the clinical managers for each borough. The clinical director still provided clinical sessions in the Sutton and Merton community teams and had a good understanding of the issues faced within the community service.
- Senior staff met regularly to share information and concerns with other teams.
- Managers could raise local risks onto the trust risk register and senior managers reviewed these risks. Staff worked towards resolving these risks by finding new ways of working.
- The trust had a clear plan for the community service and staff followed this. Staff knew the trusts' visions and values. The community teams had changed into service lines since the last inspection in March 2016. This had improved the way the community teams operated.

## Outstanding practice

We found one example of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found four areas for improvement in this service. See the Areas for improvement section above.

# Substance misuse services

Good 

## Key facts and figures

Inspire is the trust's only substance misuse service. The service provides support to adults with drug and alcohol problems in the London borough of Sutton. This service is run in partnership with two other providers. The trust provides the clinical input for the service, which includes substitute prescribing and community based alcohol detoxification. The other two providers support and provide treatment to patients around other aspects of their substance misuse. The trust was not the lead provider. The three partners provide a comprehensive treatment service to patients and carers who live in the borough of Sutton.

The service is commissioned by the local authority. The service moved to their current location in March 2017. Prior to that, the three providers were located at different office bases.

The service had not been inspected before.

We visited the service on 26 February and 9 March 2018. The visit was announced. The inspection of the service was part of a larger inspection of core services operated by the trust, in addition to inspecting how well-led the trust was. Our inspection activity focused on the work undertaken by the trust, rather than the work of the other providers in the partnership. This was the first time that this service had been inspected. Before the inspection visit, we reviewed information that we held about this service and requested additional information from the trust regarding the work undertaken by the trust employees as part of the clinical team.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff communicated with patients
- spoke with three patients
- spoke with the two part time managers for the clinical team
- spoke with the borough manager who worked for the lead provider to get a better understanding of the partnership arrangements
- spoke with the community clinical manager who was employed by the trust
- spoke with five other members of staff, four nurses and a doctor
- looked at 14 care and treatment records
- attended and observed the handover meetings
- undertook a specific check of the medicines management at the service
- looked at policies, procedures and other documents relating to the running of the services

## Summary of this service

We had not inspected or rated this service before. We rated it as good because:

# Substance misuse services

- The clinical team were knowledgeable and skilled. They had a wealth of experience. The team was led by managers who were committed to ensuring that high quality care was delivered. The clinical team worked closely with their partner providers to ensure that patients received the care and treatment they required.
- The service recognised the importance of ensuring that patients were supported to remain in good health. The clinical team had a nurse that specialised in physical health. The service had good links with the local acute hospital's accident and emergency department. The service ran physical health clinics and the clinical team ensured that they referred patients to these clinics. Patients received a comprehensive physical health assessment.
- The clinical team monitored patients who were prescribed high dose methadone. The guidance suggests that all patients who are prescribed 100mg or above should have regular cardiac monitoring. The clinical team monitored all patients who were prescribed 70mg or above. Where cardiac abnormalities were detected staff escalated this to colleagues in the acute hospital.
- Patients were provided with crisis cards, which outlined what they should do if they became concerned that they may relapse.
- Patients stated that the staff were kind and compassionate. The clinical team had a good understanding of the needs of their patient group.
- The service had undertaken a needs analysis of the patient group. As a result, the service had made links with the local lesbian, gay, bisexual and transgender (LGBT+) forum. This was to ensure that LGBT+ patients were offered the support when needed.

However:

- Staff stored clinical information, particularly in relation to patients' physical health, in different places on the electronic patient record, which meant that it could be difficult for staff to find it when they needed to. This was brought to the attention of the trust who took immediate steps to provide staff with guidance regarding the recording of information on the electronic patient record.
- It was not clear how recently staff had cleaned the physical health monitoring equipment as this was not recorded. Staff had not labelled the yellow sharps disposal bins correctly. There was a risk that equipment might not have been clean and safe to use.
- The trust had not reviewed prescribing protocols since the publication of new UK clinical guidance in July 2017. There was no assurance that the prescribing protocols were still in line with best practice.
- The clinical team did not have mechanisms to monitor informal or local complaints. This was a missed opportunity for learning.
- The soundproofing in the therapy rooms was poor. Conversations could be heard outside. This had been brought to the attention of the lead provider who was addressing this issue.

## Is the service safe?

**Good** ●

We rated it as good because:

- The clinical team completed risk assessments for all patients. The team updated these risk assessments regularly. The risk assessments were comprehensive and covered the range of risks relevant to this patient group.

# Substance misuse services

- Staff monitored patients' physical health well. If there were concerns regarding a patient's physical health the staff escalated this quickly.
- Medicines were stored securely and at the correct temperature. The clinical team had robust procedures to minimise medicine errors.
- The managers of the clinical team ensured that the service was safely staffed. There was an active programme of recruitment. Vacancies were covered by long term experienced agency staff.
- Staff had received training in safeguarding, knew how to recognise potential abuse and made appropriate referrals to the local authority safeguarding team.
- Staff reported incidents appropriately. They were aware of the reporting processes of the lead provider of the service and the trust. Incidents were escalated appropriately. Lessons learned from incidents that occurred within the service were identified and shared. The clinical team had made improvements in their practice as a result of incidents.

However:

- Staff did not store clinical information, particularly in relation to patients' physical health, consistently in the electronic patient record. The system was difficult to navigate, which meant that it could be difficult for staff to find specific information when they needed to. This was brought to the attention of the trust during our inspection visit who promptly issued staff with more detailed procedural guidance.
- Although visibly clean it was not clear how recently staff had cleaned the physical health monitoring equipment as this was not recorded. Staff had not labelled the yellow sharps disposal bins correctly. There was a risk that equipment might not have been clean and safe to use.

## Is the service effective?

### Good

We rated it as good because:

- The clinical team carried out comprehensive physical health assessments of patients. The clinical team encouraged and supported patients to have blood tests at the services to check for blood borne viruses (BBV). Staff administered BBV immunisations.
- Medicines were prescribed in line with guidance from the National Institute for Health and Care Excellence. There was good monitoring of patients who were prescribed high dose methadone.
- The clinical team provided patients with a range of information regarding their treatment, which meant that patients were able to make informed decisions.
- Staff provided patients with crisis cards, which outlined what they should do in an emergency. The clinical team trained each patient on how to use naloxone injections to prevent drug related deaths.
- Staff supported patients with their housing, benefits and sexual health.
- Staff had a good understanding of the Mental Capacity Act. They were able to provide examples of how this related to their practice with patients.

However:

- The trust's prescribing protocols had not been updated since the publication of new UK clinical guidance in July 2017.

# Substance misuse services

## Is the service caring?

**Good** ●

We rated it as good because:

- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. There were strong working relationships between the clinical team and patients. The clinical teams were very caring and understood the needs of patients and their families.
- Patients were very positive about the service, they said they received excellent care and that staff were kind and supportive.
- Patients were supported to express their views and realise their potential. Patients were encouraged to contribute their ideas regarding how to improve the service. For example, patients had suggested that the service have an art and poetry competition. The work created as part of this was on display throughout the communal areas of the service. The work was inspirational and included quotes aimed at motivating others.

## Is the service responsive?

**Good** ●

We rated it as good because:

- All new referrals were screened to ensure that they were allocated to the correct team. The majority of patients were offered appointments within five working days. Staff were able to respond promptly to emergencies. They could offer urgent appointments to patients who needed them. The team had effective handover procedures. Staff recorded handover discussions in patients' progress notes.
- The clinical team could offer patients late night appointments. This meant that it was easier for people to attend at a time that was convenient to them.
- The team did not discharge patients before they were ready. Length of treatment was determined by client need.
- The clinical team made an effort to understand and respect the diversity of the patients who accessed the service. They had undertaken a needs analysis and had made links with the local LGBT forum in order to address an identified gap in the service.
- The service was accessible for patients with limited mobility or who used wheelchairs. If a patient was unable to attend their appointment due to poor health or a disability, staff were able to visit them at home.

However:

- The clinical team did not monitor informal or local complaints. This made it more difficult to identify any patterns or trends in complaints and was a missed opportunity for learning.
- The soundproofing of some therapy rooms was poor and conversations could be heard outside the rooms. This had been brought to the attention of the lead provider, who was responsible for the building. It was addressing the issue.

# Substance misuse services

## Is the service well-led?

**Good** ●

We rated it as good because:

- Local leadership was strong. Leaders strove to deliver and motivate staff to succeed.
- The clinical managers were highly visible in the teams. Managers undertook patient work when required to ensure that they kept their skills up to date.
- The clinical managers were skilled, knowledgeable and very experienced. They were committed to improving safety and providing high quality care. The managers were accessible to patients and staff.
- The clinical team were supportive of each other and modelled the trust's visions and values. They knew the goals for the service and were committed to ensuring that these were implemented to a high standard.
- Staff morale was high. Staff said that they felt valued and supported.
- Governance and performance management arrangements were robust and underpinned the delivery of high quality services that aimed to continuously improve. It was clear who was accountable for the different parts of the service. The three partners worked collaboratively and information was shared appropriately.
- There was a focus on working closely with stakeholders and using their feedback to improve the service.

## Areas for improvement

We found five areas for improvement in this service. See the Areas for improvement section above.

# Specialist community mental health services for children and young people

Good   

## Key facts and figures

We inspected five child and adolescent mental health service (CAMHS) teams delivered by the trust across several London boroughs. Four of the services we visited provide specialist assessment, diagnosis, treatment and support to young people aged five to 18 years experiencing significant mental health issues. These are:

- Richmond CAMHS
- Kingston CAMHS/Woodroffe Family, Adolescent and Child Team (FACT)
- Sutton CAMHS
- Wandsworth CAMHS

We also visited:

- The child and adolescent neurodevelopmental service, which provides assessment and diagnosis for people aged up to 18, where there is an identified need for assessment for possible Autistic Spectrum Disorder and/or Attention Deficit with Hyperactivity Disorder.

During the inspection visit, the inspection team:

- visited all five teams and looked at the quality of the service environment and observed how staff were caring for patients
- spoke with 12 young people or parents/carers who had accessed the services
- spoke with the managers or acting managers for each of the services
- spoke with 22 other staff members; including clinical psychologists, doctors, nurses, family therapists and administrative staff
- attended and observed two multidisciplinary meetings
- looked at 20 treatment records of patients.
- carried out a specific check of the management of prescription pads
- looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Young people and families said that the services had been helpful to them and this was reflected in feedback surveys that services collected each month. They said that staff provided them with information about what to expect when first using the service and were kind and patient.
- Services had a range of experienced and qualified staff who were able to deliver interventions in line with national guidance. Staff were trained in safeguarding and followed appropriate steps to keep young people safe. Services had embedded a protocol for assessing and managing people of different risks, including supporting those on the waiting list.

# Specialist community mental health services for children and young people

- Teams worked well with other services both within the trust and externally to provide a consistent and seamless service to children, young people and their families. Teams had taken a proactive approach to providing information to young people. For example, staff identified that several young people had presented at emergency departments having misused a particular substance during a short period of time. The service worked with external organisations, to notify them and also to put together information packs for young people about the dangers of the substance.
- Since the last inspection in March 2016, the trust had successfully addressed five areas of improvement. These included, the management of low risk patients, working with commissioners to highlight the need for additional resources to address long waiting times, particularly for psychological therapies and the completion of staff safeguarding training.
- Staff enquired about, considered and acted on the diverse needs of young people and their families. One team had an LGBT champion and signposted LGBT+ young people to local LGBT+ groups and useful websites. Staff worked closely with a specialist local authority team to support young people from the local South Korean community referred to CAMHS. Premises were accessible to people with physical disabilities.
- Governance systems supported service managers to access the information they needed to run services effectively and identify areas of development. All services had good systems to report and learn from incidents. Staff met regularly and learning from incidents and complaints was evident.
- Staff were very positive about their teams, said that they felt supported by colleagues and managers and that everyone was dedicated to supporting young people who accessed their services.
- The trust had set up a CAMHS emergency care team in response to the level of acuity and pattern of young people presenting to emergency departments in a crisis. Staff were able to offer assessments and appropriate onward referrals to suitable services promptly.

However:

- Although the recording of patient information by staff had improved since the last inspection in 2016, staff did not always save and record information about patient care in a consistent way in electronic records.
- Staff had begun implementing the use of crisis information sheets and 'what if' plans in order to provide young people and families with information about what to do in a crisis or when their health deteriorated. These were not yet fully developed or embedded in practice.
- The electronic records system and IT infrastructure did not support staff to carry out their roles as effectively as possible. Staff reported that access to emails and the patient records system was often interrupted and the records system itself did not allow for information to be stored and re-accessed in a clear way.
- Staff did not always record the wishes and views of young people in care records, so could not demonstrate that young people and families were involved in care as much as they could be.
- Kingston CAMHS did not have robust systems for recording who was on the premises at any particular time, which had fire safety implications.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

# Specialist community mental health services for children and young people

- Staff ensured environments were safe and clean for young people and staff. All equipment for physical health assessment was calibrated to ensure correct readings.
- Staff understood their responsibilities in relation to safeguarding and keeping people safe and acted appropriately in response to this.
- Services had embedded a protocol for assessing and managing people of different risks, including supporting those on the waiting list.
- Since the last inspection, the trust had updated the lone working protocol and policy and staff were aware of this and their responsibilities in terms of safe practice.
- All services had good systems to report and learn from incidents.

However:

- Staff did not use and share crisis information with young people and families as well as they could have as the resources were still in development. Services had developed 'what if' plans to use for young people who might need support if their mental health deteriorated, but staff said these were not user friendly, so they did not often use them.
- Connection to the trust IT server was regularly interrupted, meaning there were periods of time staff could not access emails and patient records, which was a risk.
- The electronic patient record system used by staff did not support them to store and retrieve information effectively. During the inspection, we were unable to open documents relating to care for three separate patients.
- At Kingston CAMHS, staff did not keep a record of who was entering and leaving the building, which was a fire safety risk.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Services were made up of experienced and qualified staff who delivered interventions in line with national guidance and used outcome measures to demonstrate effectiveness.
- Staff were supported through clinical and line management supervision and appraisal. They carried out clinical audits to identify where service improvements were needed. Staff met regularly as a team to discuss case management and share knowledge.
- Most young people and families we spoke with said the service had made a positive impact on their lives and had helped them with their mental health issues.
- The teams had effective working relationships with other teams and services both within the trust and externally. A CAMHS emergency liaison team supported patients presenting to emergency departments in local acute hospitals.

However:

- Care records sometimes lacked details about how young people were involved in their care and what their wishes, preferences and goals were.
- Although the recording of patient information by staff had improved since the last inspection in 2016, staff did not always save and record information about patient care in a consistent way in electronic records.

# Specialist community mental health services for children and young people

## Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Feedback from young people and families was that staff were patient, kind and listened attentively to young people and families. We observed several positive and supportive interactions during our inspection.
- Staff supported young people and families to give feedback about services. Response rates to questionnaires were very high and were shared with managers and staff who could take actions to address any areas of concern and drive improvements.
- Staff discussed confidentiality with young people and families to make it clear what could and could not be shared, depending on a young person's age and the situation.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Services had set targets for waiting times and could see urgent and emergency referrals quickly. There were specialist teams in the trust to respond to young people who presented at an emergency department in a local acute hospital and who needed more intensive support than the specialist tier three services could provide.
- Staff worked actively to engage young people who were reluctant to take part in treatment.
- Staff enquired about, considered and acted on the diverse needs of young people and their families. One team had an LGBT champion and signposted LGBT+ young people to local LGBT+ groups and useful websites. Staff worked closely with a specialist local authority team to support young people from the local South Korean community referred to CAMHS. Premises were accessible to people with physical disabilities.
- There was a clear process for young people and families to make complaints about the service and managers acted on these quickly.
- Services received half of all total compliments for the trust in the 12 months before the inspection.

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- Leaders were visible and approachable. Staff said they felt supported by their colleagues and line managers. There had been some changes in management staff in the six months before the inspection, but this had not caused disruption to the running of services and new managers demonstrated they had the skills to perform their roles.
- Systems and processes supported management staff to access the information they needed to run the service.
- There were effective and well embedded processes for staff to discuss incidents and any learning from them.

# Specialist community mental health services for children and young people

- Young people were involved in making improvements to the waiting area in Wandsworth CAMHS.

## Outstanding practice

We found three examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found five areas for improvement in this service. See the Areas for improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

#### Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Treatment of disease, disorder or injury

# Our inspection team

## Our inspection team

This inspection was chaired by Jane Ray, Head of Hospital Inspections, Care Quality Commission. An executive reviewer, Anna Morgan, Director of Nursing and Quality, Norfolk Community Health and Care NHS Trust, supported our inspection of well-led for the trust overall.

The team included two inspection managers, 14 inspectors, two Mental Health Act reviewers, three assistant inspectors, one pharmacist inspector, an inspection planning coordinator, three observers, 16 specialist advisers, nine experts by experience and a British Sign Language Interpreter.

Executive reviewers are senior healthcare managers who support our inspections of the leaderships of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have developed expertise in health services by using them or through contact with those using them – for example, as a carer.