Maudsley Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out an announced focused inspection of healthcare services provided by South London and Maudsley NHS Foundation Trust (SLAM) at HMP Wandsworth on 1 and 2 February 2022.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in September 2021, we found that the quality of healthcare provided did not meet the fundamental standards. We issued a Section 29A Warning Notice. We also issued a Requirement Notice in relation to Regulation 18, Staffing of the inpatient unit as well as the Assessment and Liaison Service (The Assessment and Liaison service forms part of the Outpatient Mental Health provision) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this focused inspection was to determine if SLAM was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008, and that patients were receiving safe care and treatment.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

This was a focussed inspection, we looked at a range of areas, for staffing, we concentrated on the Inpatient unit as well as the Assessment and Liaison Service which forms part of the outpatient provision for Mental Health, having identified concerns with these two distinct areas as part of our September 2021.

At this inspection we found:

- Patients waiting to be assessed by mental health professionals were reviewed and welfare checks made for most patients.
- Staff understood and applied the Mental Capacity Act.
- Referrals were reviewed thoroughly by a team of clinicians.
- Staff understood the needs of patients they supported and helped them manage their treatment or condition.
- The service continued to have high staffing vacancy rates for the inpatient unit, although there had been some improvement in covering unfilled shifts.
- There had been a slight improvement in staffing of the Assessment and Liaison Service, which supported an improved referral and waiting list management process, however, more staff were needed to ensure the full range of therapeutic services were available to patients.
- Therapy cover was inadequate and therapeutic interventions had been stopped for new patients and significantly reduced for existing patients. There were no short-term crisis interventions available to patients, although welfare checks were made as required.
- Governance systems needed strengthening, performance monitoring was not comprehensive and some information was not accurately reported. Incidents were not always reported in line with policy.
- Patients who required transfer to secure mental health inpatient services waited too long.

The areas where the provider **should** make improvements are:

- Deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff.
- Ensure all incidents are reported in line with its incident reporting policy.
- Produce accurate performance reports which contain meaningful information.
- Ensure all patients receive a welfare check and/or assessment as needed.
- Ensure therapeutic interventions are available for patients as needed.
- Ensure crisis intervention is available for patients as needed.

Overall summary

- Ensure all patients who require transfer to a secure mental health inpatient service are transferred in line with national timescales.

Our inspection team

Our inspection team was led by a CQC health and justice inspector, supported by a second health and justice inspector and a specialist advisor with a background in management and mental health services.

Before the inspection visit, we reviewed a range of information that we held about this service.

During the inspection visit, we:

- Spoke with four patients who were using the service
- Spoke with the service manager
- Spoke with 18 staff members across the multidisciplinary team in person and remotely
- Looked at 22 patients' care and treatment records
- Attended a referrals meeting and a multidisciplinary team meeting
- Looked at policies, procedures and other documents relating to the running of the service

Background to Maudsley Hospital

HMP Wandsworth is a local Category B prison in inner West London. It is a designated resettlement prison holding up to 1368 adult men and some young adults. The prison is operated by Her Majesty's Prison and Probation Service.

SLAM is contracted to provide mental health care for patients. SLAM is registered with CQC to provide the following regulated activities from its trust headquarters: Treatment of disease, disorder or injury, and Diagnostic and screening procedures.

Our last inspection of HMP Wandsworth was a joint inspection with HMIP in September 2021.

The reports from these inspections can be found here:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/01/Wandsworth-web-2021.pdf

Following the inspection in September 2021, SLAM have agreed to hand over the management of mental health services to another provider from 1 April 2022.

Inspected but not rated

Are services safe?

Safety systems and processes

At our last inspection, we found that the provider did not have adequate staffing for its inpatient and Assessment and Liaison service. During this focused inspection, we found that the inpatient service still had high vacancy rates, although there had been improvement in providing qualified nursing cover for unfilled shifts. The Assessment and Liaison service had high vacancy rates and was not able to provide a comprehensive service for patients.

There were appropriate arrangements for planning and monitoring the number and mix of staff needed on the inpatient unit:

- The service was staffed safely. Managers had calculated the number and grade of registered and non-registered staff required on each shift.
- The number of registered and non-registered staff on duty matched the core staffing level the provider had identified. At the last inspection we found that some shifts did not have the required qualified nursing staff working each shift, including some night shifts with no qualified nurse. During this inspection we found that contingency arrangements were in place to ensure the core staffing levels were always met.
- Managers used bank staff to ensure each shift had the required number of staff. The inpatient unit manager provided clinical support when needed and managers from other forensic units also provided cover. Staff described being busy at times but confirmed that patients were always cared for safely.
- At the time of inspection, 62.5% of registered nurse posts and 12.5% of non-registered staff posts were vacant on the inpatient unit. Managers told us that it had been difficult to fill vacancies; there had been some new starters since the last inspection but some staff had also resigned during this period.

For Assessment and Liaison Services, arrangements for planning and monitoring the number and mix of staff needed did not work well:

- The service was not adequately staffed to provide the required care. The number of registered and non-registered staff did not match the core staffing level the provider had assessed as required. At the last inspection we found that the Assessment and Liaison Service was not functioning as it should due to lack of staffing. During this inspection we found that staff numbers had increased. However, while some staff had been recruited, others had left the organisation. Managers told us they had increased onsite senior clinical leadership to mitigate staffing gaps including for clinical work in the Assessment and Liaison Service.
- Several staff told us that there were insufficient staff deployed to keep patients safe. To mitigate this risk, senior managers stepped in on a regular basis to provide clinical leadership and support and we saw evidence of this on the rota. We also found that the service regularly used therapy staff to support the nursing team as well as managers. This meant that therapy staff had less time to see their own patients.
- Staff worked hard to ensure patients referred into the service were seen and assessed promptly and to ensure those with more severe mental health needs were referred to the in-reach service. The Assessment and Liaison team conducted welfare checks for patients waiting to be seen by the in-reach team between 09:00-17:00. Outside of these hours staff from Addison ward undertake a welfare check.
- At the time of inspection, 80% of registered nurse posts were vacant, which was the same as during our last inspection, one of two recently introduced non-registered nursing posts were vacant.
- When necessary, managers deployed senior managers, therapy staff and ward staff to provide clinical support. There had been a high reliance on this additional support since the last inspection. For example, during the week of Monday 24 January 2022 cover was provided by managers, therapy staff and ward staff on 46% of sessions.

Inspected but not rated

Are services safe?

- The service had agreed a transitional period for recruitment and backfilling shifts for both the inpatient and Assessment and Liaison services, whereby the incoming provider would take on a shared responsibility before taking over the contract. However, legally SLAM remained accountable until the contract finished.

Risks to patients

During this focused inspection, we found that while the range of clinical interventions were limited, staff understood their responsibilities to manage emergencies and recognised patients in need of urgent medical attention:

- Staff knew how to identify and manage patients with mental health needs. However, due to a lack of staffing they were not able to provide a comprehensive Assessment and Liaison Service. This meant that while patients with mild to moderate mental health needs were assessed and welfare visits carried out as required, there were no short-term interventions available for these patients.
- Patients with severe and enduring mental health illness were prioritised appropriately for care and treatment, in line with their clinical need. Systems were in place to manage and support patients who experienced long waits.
- Staff completed a risk assessment for every patient on admission to the inpatient unit and for those patients receiving support from the in-reach team. Staff formally reviewed risk assessments at ward rounds and following appointments. Risk assessments were kept up to date.

Lessons learned and improvements made

During this focused inspection, we found that the service learned and made improvements when things went wrong, although staff had not reported all incidents:

- There was a system for recording and acting on significant events and incidents. Staff we spoke with understood their duty to raise concerns and report incidents and near misses. However, not all incidents were reported in line with the trust's policy. We found three incidents which had not been reported using the organisation's internal reporting system, although incidents had been appropriately reported externally. We discussed this with the provider who agreed that these incidents would be reported retrospectively. The service learned and shared lessons, identified themes and took action to improve safety in the service. Debriefs were held with staff and patients following an incident. Incidents were also discussed at daily staff handovers and team meetings, and a monthly email was produced by the provider to share learning from incidents across their sites.

Inspected but not rated

Are services effective?

Effective needs assessment, care and treatment

We saw evidence that clinicians assessed needs and delivered care within the staffing capacity available. However, a comprehensive service was not offered to patients (there was an in-reach team which was not reviewed as part of the inspection. The inspection focused on referrals into the service as well as care and treatment for patients on the inpatient unit and those in crisis who did not necessarily meet the criteria of having a diagnosed mental health illness:

- Patients' with a severe and enduring mental health illness were fully assessed. This included their clinical needs and their mental wellbeing.
- Patients referred into the service were assessed by the multidisciplinary team during a daily meeting from Monday to Saturday. On Sundays, a registered mental health nurse from the inpatient unit assessed referrals in case of emergency, and the referral was reviewed at the Monday morning meeting. Patients were either signposted to another service or reviewed by the in-reach team if they potentially had a severe and enduring mental health illness.
- Crisis management for patients who might benefit from a brief intervention was not available. Managers had planned for a fully functioning Assessment and Liaison Service which was not available due to recruitment difficulties. The service had an operational policy which set out criteria for those who required treatment. However, staff who worked in the Assessment and Liaison Service did not currently hold a caseload. This meant that patients without a serious mental illness but who were in a state of emotional crisis were not receiving short-term interventions. Patients' could be seen for welfare checks by the team, referred back to their GP or in some cases referred to the in-reach team.
- The service did not have access to the full range of specialists required to meet the needs of patients. The service had good psychiatric cover but there were high vacancy rates for both nursing and therapy staff.
- The service provided few care and treatment interventions for patients. The service did not have a psychologist, with two posts vacant. There was an assistant psychologist in post with a second position also vacant. One occupational therapist of three whole time equivalent posts was also vacant. Due to the low number of therapy and outreach staff in post, therapists had stopped taking on any new patients from mid-January 2022 and were reviewing patients to see who could be discharged. Frequency of sessions were also reduced for patients where it was safe. This meant that some patients who required therapeutic intervention did not receive the support they needed.
- Therapeutic intervention for patients on the inpatient unit was significantly reduced due to the lack of therapy staff available. We were provided with a timetable and the trust informed us that therapeutic activities were undertaken by the nursing team. Patients told us that on occasion, they undertook some activities with nursing staff and orderlies (a prisoner from the main prison who worked on the unit).

Coordinating care and treatment

During this inspection, we found that staff worked well together, but did not always work well with other organisations to deliver effective care and treatment:

- Staff held daily referrals meetings and regular and effective weekly multidisciplinary meetings. During this inspection, we attended a referrals meeting and a multidisciplinary meeting. We noted that there was input from each discipline, but due to the high vacancy rate for therapy staff, the focus was mainly on treatment for patients who required support from the in-reach team as well as those who required a welfare check and/or assessment. Staff within the mental health service told us that they worked well together in planning patient care and treatment. They told us the hierarchy was flat which meant they could present different points of view and felt listened to by colleagues.
- Some staff reported that they did not have effective working relationships with all external partners within the prison, there was evidence of regular partnership working, however, some staff told us that relationships were tense."
- Staff communicated regularly with NHS England and NHS Improvement (NHSEI), who commissioned services. NHSEI were closely monitoring the service including transitional arrangements while the service prepared to hand over to another provider.

Inspected but not rated

Are services effective?

Consent to care and treatment

During this inspection, we found that staff understood and appropriately recorded issues around consent and capacity:

- Staff understood the requirements of legislation and guidance when considering consent and decision making. Training for staff in the Mental Capacity Act (MCA) was mandatory and 84% of staff had completed the training. Staff understood how the MCA related to their professional practice and understood the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care.
- The provider monitored the process for seeking consent appropriately. They audited the application of the MCA and took action on any resulting learning.

Inspected but not rated

Are services caring?

Kindness, respect and compassion

During this inspection, we found that staff treated patients with kindness, respect and compassion:

- Staff understood patients' personal and mental health needs. They displayed an understanding and non-judgmental attitude to all patients. Patients told us that the team were exceptional, friendly, responsive and sensitive. We observed good interactions between staff and patients and found that staff were discreet, respectful and responsive, providing patients with help, emotional support and advice when they needed it.
- Staff went the extra mile to build relationships with patients and care records showed that staff took the time to provide a good service for their patients.
- Staff said they always put patients first and maintained a positive and hopeful attitude when working with patients. Staff showed a deep interest in patients and were alert to signs of progress, however small, and celebrated these.
- There was a strong and visible person-centred culture among the staff. They were highly motivated and inspired to offer care that was kind and promoted patients as individuals. Staff had an excellent understanding of what it meant for a patient to suffer from mental health illness? while in prison.
- Staff were patient in their approach, persistent and worked with patients over long periods of time to effect change. Staff were highly committed to each patient and put in the necessary time and effort on an individualised basis to try to achieve positive outcomes were reached.

Inspected but not rated

Are services responsive to people's needs?

Timely access to care and treatment

At our last inspection, we found that patients waiting to be seen by the mental health services were not and assessed and managed safely. Patients who required transfer to a secure mental health inpatient service waited too long.

During this focused inspection, we found that patients awaiting assessment were mostly reviewed and welfare checks made. We found that patients who waited for a secure mental health inpatient service continued to wait too long, although staff did everything they could to progress transfers. We also found that performance reporting did not always contain accurate or sufficient information:

- Patients could access care and treatment via referral from a professional or self-referral. The mental health service accepted referrals from several sources. Once a referral was received, clinicians attended a referrals meeting to decide whether the referral was appropriate and if so where the patient would be best placed within its current capacity. Patients who were severely unwell could be assessed and admitted as an inpatient. There were 12 beds funded by NHSEI, although all beds were not always available. Patients frequently damaged the cells which meant there were frequently two or more out of commission at any one time.
- Referrals were categorised according to urgency, and although data gathered was not always accurate, most patients were seen within the required timescales. Patients discussed at the referrals meeting were assessed as priority 1 or 2. Priority 1 patients were expected to be seen within 48 hours and priority 2 patients within five days. Data provided by the trust for December 2021 and January 2022 indicated two patients had breached the timescales each month, two for each priority. We found that there was also a delay in recording the date and time of referral which impacted on the accuracy of reporting.
- Waiting lists were managed appropriately for most patients. Where patients were waiting a long time for an assessment or treatment, there were arrangements in place to monitor the waiting list and welfare checks were carried out. to support them while they waited. We found one example where a patient had been overlooked and not been assessed in line with the services' operational policy. We raised this with the provider who took prompt action.
- Some patients who required transfer to secure mental health inpatient services still waited too long for a bed. Since the last inspection, of 13 patients had waited for a bed, two had waited 31 days before a decision was made. Three patients had waited between 37 and 91 days, with two still waiting at the time of inspection. All other patients waiting were within acceptable timeframes. The appropriate escalation procedures to the relevant providers had been followed.

Inspected but not rated

Are services well-led?

Culture

During this focused inspection, we found that the service had a mixed culture. Staff were committed to their role and to patients but did not always feel supported by senior managers:

- Staff felt very proud to be working in the service, although working relationships with other health providers did not always work well. SLAM worked in partnership with other health providers delivering elements of healthcare for prisoners at HMP Wandsworth. Staff had mixed perceptions of how well this worked and some described the situation as very tense with both parties not always communicating well together.
- Some of the staff did not feel respected, supported and valued. Staff had recently been informed that another service would be taking over the provision of mental health services from 1 April 2022. There was evidence some communication had taken place, however, staff felt this was not sufficient and that they did not feel they had been consulted about the changes which were happening.
- Staff felt well supported by the service manager and the rest of the multidisciplinary team at a local level. They felt able to speak up if they had any concerns and were confident they would be listened to.

Governance arrangements

During this inspection, we found that there were not clear systems of accountability to support good governance and management:

- Structures, processes and systems to support good governance and management were not clearly set out, understood or effective. Assurance over new systems was not well managed. For example, There had been a cluster of deaths during the previous 12 months with some learning established. An action plan had been established to monitor actions from identified learning. This was under scrutiny from NHS EI.
- We identified three incidents which had not been reported using the trust's internal incident reporting system.
- The provider's monthly Performance Quality Improvement Meeting had not taken place since November 2021, and performance monitoring reports were not accurate and lacked information. The forensic directorate held monthly meetings, although, the December 2021 and January 2022 meetings had been cancelled due to Omicron. A performance report had been prepared for the planned meeting in February 2022. We found that data on timescales for referrals into the service was not accurate. Data was gathered on referral timescales of 48 hours and five days. However, the way this was calculated meant patients may have been waiting longer than reported. The report also included data on waiting list numbers for the in-reach team. Data included within the report was insufficient and did not include information on non-attendance at appointments, no access visits or sessions cancelled due to lack of staffing. This meant the provider was not monitoring service provision effectively and did not have a full understanding of where improvements could be made.