South London and Maudsley NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

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.

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.

Overall summary

What we found

Overall trust

We carried out this announced comprehensive inspection of the acute wards for adults of working age and psychiatric intensive care unit (PICU) and community services for adults of working age services provided by this trust as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the provider as good.

We also inspected the well-led key question for the trust overall. We inspected two services, inspected and rated one as good (acute and PICU) and one as requires improvement (community mental health services for adults). Overall, we rated effective, caring, responsive, and well-led as 'good' but safe was rated as 'requires improvement'.

The trust serves a population of 1.3 million people across the London boroughs of Croydon, Lambeth, Lewisham and Southwark, and employs more than 5,000 staff. Staff provide services to around 41,000 patients in the community and in 716 inpatient beds across 52 inpatient wards. The trust has a turnover of £503 million and broke even in 2020/2021.

The trust 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

Wards for people with learning disabilities or autism

Mental health crisis services and health-based places of safety

Our findings

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

Specialist neuropsychiatric services

Substance misuse services

Other national specialist services

We did not inspect long stay/rehabilitation mental health wards for working age adults (previously rated requires improvement) because the services had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them when appropriate.

Our rating of services stayed the same. We rated them as **good** because:

We rated effective, caring and responsive as good and we rated safe as requires improvement. We rated well-led for the trust overall as good.

We rated acute wards for adults of working age and psychiatric intensive care unit as **good** and community-based mental health services for adults of working age as **requires improvement**. In rating the trust, we included the existing ratings of the fourteen previously inspected services.

Since the last inspection there had been significant changes to the executive leadership team at the trust and the new members had settled into their roles and were working together effectively. The trust had appointed a chief executive, chief operating officer, chief nurse, and director of communications, stakeholder engagement and public affairs. The trust had also appointed a new board level director of corporate affairs. The trust reviewed leadership capability and capacity on an ongoing basis. The new appointments had given them an opportunity to review how they carried out business and make further improvements.

Since the last inspection the board had a new chair and one new non-executive director. At this inspection we found the trust had an ambitious board, with a wide range of skills and experience who demonstrated dedication and commitment to improving the care delivered to patients by the trust. The non-executive directors all had experience as senior leaders in a range of organisations and brought skills such as a knowledge of finance and investment, strategic development, research, population health, working in partnership and transforming services. The non-executive directors were well supported and challenged effectively by the team of governors.

Our findings

Board members had completed board development days to better understand and further develop each person's roles and responsibilities in relation to the strategic direction of the trust. The board understood the plans for the development of the trust both internally and externally and recognised the complexity of achieving their strategic aims.

There was high quality, effective leadership at all levels of the organisation. There were regular board visits to services. Senior staff across the trust modelled open and transparent behaviour. Staff we spoke with during the core service inspections felt supported, valued and respected. Staff spoke about improvements in the culture and felt the trust leaders were more visible and present since we last inspected the trust in 2019.

The trust leadership demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. The trust leadership had demonstrated an ability to adapt at a fast-changing pace during the COVID-19 national pandemic. The trust had developed a very pro-active vaccination programme with a high uptake from staff and patients. At the time of the inspection over 85% of all staff had received their first vaccine. Staff provided information and advice to eligible patients regarding the COVID-19 vaccines to alleviate concerns and encourage uptake.

Since the last inspection the trust had embedded the divisional structures and borough-based working for local services. This had strengthened their multi-disciplinary working within each of the trust directorates. They had also further developed their ability to work in partnership with other stakeholders to meet the healthcare needs of the local populations and develop new responsive models of care.

The trust had also strengthened its input into the South London Mental Health and Community Partnership (SLP). The SLP focused on delivering mental health services across south London in partnership with two other NHS trusts. The three trusts collaborated effectively to improve the quality of services, learn from each other, and share functions to maximise the effective use of resources. The SLP had been successful in developing new models of care and ensuring patients were treated in services closer to their homes. The SLP was also involved in provider collaboratives for forensic services, CAMHS, and specialist eating disorder services in south London. The provider collaboratives were responsible for commissioning these services for the population of south London, including from the independent health sector.

The trust collaborated effectively with a range of external partners. The trust worked within a very complex landscape across four London boroughs, four clinical commissioning groups, local alliances, and two integrated care systems. The chief executive had recently led a London-wide project looking at emergency department admissions for children and young people in crisis.

Leaders spoke with insight about the need to work collaboratively to improve existing services. There was a high level of awareness of the need to improve access and flow for a number of its community and inpatient services. It recognised that while the trust could make changes within its own services, long term solutions would only be achieved through partnership working. Managers engaged actively with other local health and social care providers alongside other stakeholders to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. For example, the trust was supporting GPs to develop the skills to manage shared care arrangements. The trust was also working within boroughs to support partners in the development of housing, employment and other services to enable people with mental health needs to live successfully in the community.

The trust was committed to working with the local communities. The trust was leading a national piece of work to eliminate the unacceptable racial disparity for patients in terms of access to services, experience of service, and clinical

Our findings

outcomes through the development of the Patient and Carer Race Equality Framework (PCREF). Once developed this will be rolled out across all the mental health trusts. To address patients' social and digital exclusion during the pandemic, the trust had worked with the Maudsley Charity to provide digital support and equipment where possible and had set up a telephone befriending service provided by volunteers.

On 16 June 2021, following extensive consultation facilitated by voluntary organisations, the trust alongside the two other South London mental health and community trusts, and councillors from the 12 boroughs participated in the South London Listens Summit. They made pledges to help prevent and address a crisis in mental health services. These included support for young people's and perinatal mental health, better access to services, work and wages, and addressing social isolation. The trusts introduced mental health champions in every borough and forming mental health hubs to talk and share information. There were 350 community leaders trained as champions, and a social isolation, loneliness, and inclusion strategy was being developed.

The trust had begun the process of developing their five-year ambitions for 2021–2026 as their previous strategy was reaching its end. This included a 12-week engagement programme with staff, local communities, and external partners, to identify key ambitions. The engagement programme was also seeking feedback from service users, carers and governors. The trust had identified early strategic themes linked to the needs of the organisation, the local populations and the health and care system. The senior leadership team was confident in its capability to deliver on the development and implementation of the strategy.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. The board was operating well with quality being a key focus. Sub-committees were working well and governance throughout the services had improved.

Leaders understood the risks within their services and were able to report them and escalate them where required. The board assurance framework was used actively by the board. The risk registers and board assurance framework clearly described how risks would be mitigated and progress was closely monitored. The senior leadership recognised the need to clearly link the framework to the strategic ambitions of the trust. Risks identified in the inspections were already known by the trust and being addressed. The trust, through its audit committee and board development, reviewed its risk appetite annually, and undertook horizon scanning to identify new and emerging areas of risk. There was a balance between workforce, finance and service performance risks.

The standards of cleanliness and maintenance had improved since the last inspection in 2019. The quality of environmental risk assessments had improved. The trust was working hard to improve the quality of the buildings in which it provided care to patients. This included the development of a new centre for children and young people's mental health services which would bring together leading experts. The Douglas Bennett House development was due to complete in 2023 and will create eight new adult inpatient wards. The leadership team were aware that The Ladywell Centre was not fit for purpose and some estates work had taken place to improve facilities and safety for patients whilst it remains in use.

The trust had responded positively to the previous inspection and worked to make the necessary improvements. For example, we saw progress on physical health monitoring for inpatients and in the community. The trust continued to be part of the physical healthcare work with the Mind and Body Programme, which was committed to providing a programme of work to join up and deliver excellent mental and physical healthcare, research and education to treat the whole person. The Integrating our Mental and Physical Healthcare Systems project (IMPHS) launched in 2019 and was a three-year project focused on closing the mortality gap for people accessing services by improving the physical healthcare on offer to them. The IMPHS project team worked closely with physical health leads to support the trust's

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physical health strategy. We saw examples of where improvements had taken place in supporting patients to manage their physical health. Staff working in the clozapine clinic had access to point of care testing facilities. This ensured that patients could have physical health monitoring completed and medicines supplied within a 20-minute appointment. The trust continued to convey a clear message about ensuring the right physical health care in the right place at the right time delivered by the right person. There was still room for improvement in the recording of physical health monitoring on some inpatient wards.

The trust continued to focus on improving patient safety by reducing violence and aggression and the use of restrictive practices. The promoting safe and therapeutic services (PSTS) redesign was on-going and the trust envisioned this would have an impact in the future. This included community involvement in the development of the programme. Ward staff participated in the trust's restrictive interventions reduction programme including use of the safety huddles, monitoring of low-level incidents, and the use of the Dynamic Appraisal of Situational Aggression tool. The trust was aiming to eliminate prone restraint of patients by training relevant staff to administer rapid tranquilisation in the deltoid muscle (in the arm). The trust had a quality priority to reduce incidents of violence on all wards by 50% and stop prone restraint. Whilst achieving these targets was proving hard, the work was ongoing and closely monitored. There was also a quality improvement project focused on reducing restrictive practice.

The trust had focused on improving patient and carer involvement since the last inspection. The trust's 2019/2020 quality report said there had been an increase in the number of patients and carers attending the trust board and sub-committees. All quality improvement workstreams at the trust were coproduced, codesigned or had patient and/or carer involvement in projects. They were supported by the trust's patient and public involvement (PPI) leads. Patients and carers were able to join the trust's involvement register with support and opportunities in place to undertake paid tasks. Since the previous inspection, the scope of work undertaken by those on the register had significantly expanded. The trust had committed to improving identification of patient's carers, and membership of the Triangle of Care scheme (promoting partnership between patients, carers and staff). Patients, staff and carers were able to meet with members of the trust's leadership team to give feedback. Patient stories were routinely presented at board meetings.

The trust leadership had actively engaged with staff. The chief executive held regular open meetings with staff and during Covid-19. The chief executive and trust chair had held weekly broadcasts since March 2020, these had been twice weekly during the first national lockdown. These were used to share key messages with staff. In 2020, the trust had introduced the Listening into Action (LiA) programme with the aim of 'making [the trust] a GREAT place to work'. The LiA programme was focused on quick and positive improvements for staff. The trust had conducted a survey which over 60% of staff completed to identify areas for improvement. They had taken action to address issues raised including reviewing the disciplinary procedure and rewarding staff for their work during the pandemic with an extra annual leave day.

Quality improvement was well embedded across the trust and over 1,000 staff had been trained in the methodology. During the inspection staff spoke about the quality improvement projects taking place within their services. Monthly performance and quality meetings took place for both inpatient and community services and management systems were in place and reported through the various sub-committees to the trust board. However, some further work was needed to ensure learning from quality improvement projects was shared across the four boroughs.

Staff provided care that was personalised, holistic and recovery orientated. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Staff tried to proactively involve families and carers in patient care although this had proved challenging during the COVID-19 restrictions. Staff understood how to protect patients from abuse and the services worked with other agencies to do so.

Our findings

Processes for identifying and managing financial risk were well understood by the board. The board had a track record of ensuring financial control totals were delivered. The finance department was considered to have strength and was resilient. The trust had received bridging capital from the NHS, to funds its two large estate modernisation projects pending the sale of other trust assets. At the time of the inspection the trust told us that it had not yet finalised the terms and timing of the repayments. However, the formal loan agreement was signed following the inspection. In addition, the trust was planning to invest £12m capital in 2021- 2022 on digital and smaller estates maintenance and development projects.

At a national and international level there was a strong research base and system-leading research was taking place. Opportunities for research were explored and supported. Staff at the trust were heavily involved in innovative research and development work and were regularly published in clinical journals. The Pears Maudsley Centre for Children and Young Peoples was bringing together leading experts in care and research from the trust and another leading organisation in the field. The two organisations were working together to create a centre of care for young people. There was a focus on the potential of research to identify mental health difficulties early and transform treatment and care of children and young people in the UK and internationally.

However:

Due to the COVID-19 pandemic some face-to-face mandatory training had not been delivered. This resulted in trust-wide poor compliance for certain short courses which could impact on patient safety. The trust leadership were aware of this and had various mitigating actions in place to improve compliance by July 2021.

Whilst the trust had a workforce strategy and the executive team had succeeded in reducing the trust-wide vacancy rate, staff recruitment and retention was still an issue. There were a high number of nursing vacancies (21.3%) and staff turnover was also high (11%). Some staff on the acute wards told us escorted patients' leave was sometimes cancelled or postponed due to staff shortages although the frequency was not accurately monitored.

At the time of the inspection there were significant bed pressures across the trust. Patient flow remained a significant challenge for the trust and the trust had appointed a flow director and flow leads who had daily contact with the inpatient wards. The trust had significantly reduced out-of-area placements as part of the multi-year patient flow programme although these had started to increase again. Whilst male patients in the psychiatric intensive care units were now moving to an acute ward when this was clinically appropriate, there were still challenges for female patients. There was a quality improvement project in place to address this and these moves were being prioritised.

Within community services some teams reported high caseloads, waiting lists for non-urgent referrals and some long waits for some individual psychological therapies. However, the community services were implementing a redesign programme which aligned to the NHS Mental Health Implementation Plan. Staff were enthusiastic about the change programme and could see the value of the intended outcome and how this aligned with their work. The aim of this service redesign was to speed up patient access and flow through services, reduce staff vacancies, increase multidisciplinary teams (MDTs) and improve outcomes for patients and patient experience.

Within most teams, staff completed risk assessments for each patient using the trust's risk assessment tool and reviewed this regularly, including after any incident. Information was detailed and up-to-date and showed evidence of patient involvement. However, we found examples where patient records were not up-to-date and risk assessments were not reviewed. Team managers were aware of the issues with recording and updating risk assessments and providing support to improve the performance of staff and this was reported at the directorate's performance and quality meetings.

Our findings

The trust had improved waits for Mental Health Act assessments since 2019 and had built strong relationships with the police, ambulance services and approved mental health professionals. However, many services still reported long waits for assessment with an average of 12 days. The trust held regular forums with the associated police borough commanders where this issue was continually reviewed. Within the service redesign there was a crisis care programme which included a workstream focusing on improving the MHA assessment pathway. The trust was leading on a system-wide MHA assessment summit in summer 2021 with a goal to develop an action plan to further review and address MHA assessment delays.

The trust was working to improve its culture but recognised there was more work to do. Despite the trust's equalities strategy, the commitment from the trust leadership for the organisation to be anti-racist, a race equality conference taking place, the progress with staff networks and many other actions there still was considerable ongoing work required to improve the experience of some Black, Asian and Minority Ethnic (BAME) staff working for the trust. One of the trust's key actions from the Workforce and Organisational Development Strategy (2020 to 2023) was to establish a BAME Leadership Academy Programme specifically focusing on talent management, succession planning and career development for staff from a BAME background. The aim of the programme was to create greater levels of sustainable inclusion by addressing the social, organisational and psychological barriers restricting BAME staff from progressing. The trust had made improvements in the results of the Work Force Equality Standard (WRES) and NHS Staff Survey but there was more to do. In particular BAME staff were still overrepresented in comparison to white staff in formal disciplinary procedures.

Incidents and complaints were investigated, and lessons were shared with staff to minimise the risk of them happening again. However, the quality of the serious incident reports was variable; some were well written, others were less well written and lacked clear terms of reference.

The trust had a learning from deaths process in place and this was led by a member of the executive. Staff in services told us that learning from deaths and serious incidents was shared. The documented findings presented to the board were brief and it was not always clear whether learning had taken place. There were plans to strengthen this and share the learning more widely.

Compliance with the duty of candour could be improved, as the trust's own internal audit found that only 37% of letters to patients and families following incidents included a clear documented apology. In response to this the trust was planning an animated film regarding duty of candour with the communications team and a bulletin on the topic had been issued to staff in April 2020. There were plans for a re-audit to take place in October 2021. Staff told us they knew how to deliver duty of candour and were supported to do so when required.

Some staff experienced problems with IT equipment, such as mobile telephones and laptop computers, and significant delays in having these issues addressed. Staff also reported new starters had long waiting times for equipment and access to the trust's electronic systems.

How we carried out the inspection

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interviews by phone or online.

We visited 10 out of the trust's 47 community based mental health teams which included a mix of assessment and liaison, early intervention and promoting recovery teams. For adults of working age and psychiatric intensive care units (PICUs) we also used a sampling approach. We inspected 10 of the 22 wards operational at the time of the inspection.

Our findings

During the community services inspection, the inspection team:

- observed a handover meeting for one community-based team
- observed a zoning meeting for one community-based team
- observed a referral meeting for one community-based team
- observed a team meeting for one community-based team
- conducted a tour of the environment for seven community-based teams
- conducted a tour of the clinic rooms for three community-based teams
- spoke with one occupational therapist, five registered nurses and two social workers, three care coordinators, and four senior practitioners
- spoke with a psychotherapist and three clinical psychologists
- spoke with a senior clinical pharmacist and a pharmacy technician
- spoke with the four mental health advocates
- spoke with five consultant psychiatrists and one GP trainee
- spoke with five team managers, three team leaders, three modern matrons, three clinical service leads, one general manager of services and one deputy director
- spoke with 31 patients and 10 carers over the 10 teams
- looked at 55 patient care and treatment records
- reviewed documents relating to the running of the service
- carried out an anonymous staff survey for all staff in the teams inspected, for which we received 12 responses.

For the adults of working age and PICUs inspection, the inspection team:

- visited 10 inpatient wards, and looked at the environment, medicines and observed interactions between staff and patients
- attended staff handover meetings on eight wards
- spoke with 23 patients by telephone and met with 6 patients in person
- spoke with nine relatives/carers of patients on the wards
- spoke with 46 members of staff in person or by telephone or video conference, including ward managers, registered and non-registered nurses, doctors, occupational therapists, psychologists, domestic staff, an activities coordinator, a psychotherapist and a pharmacist
- carried out an anonymous staff survey for all staff on the wards inspected, for which we received 36 responses
- looked at the care records of 69 patients
- looked at 53 medicines administration records for patients
- reviewed the recent incident reports for this service
- reviewed specific policies and documentation relevant to this core service

Our findings

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Patients told us that staff treated them with compassion and kindness. They said that staff respected patients' privacy and dignity. Patients said staff were attentive, non-judgemental and caring and tailored care to individual needs. Patients also reported staff provided help, emotional support and advice when they needed it. Patients said staff treated them well and were responsive to their needs.

Use of resources

NOT INSPECTED

Combined quality and resource

NOT INSPECTED

Outstanding practice

We found the following outstanding practice:

Trust-wide

The trust had developed a Listening into Action scheme where staff discussed issues and worked to find solutions, leading to improvements for patients and the organisation.

Community-based mental health services for adults of working age

Staff working in the clozapine clinic had access to point of care testing facilities. This ensured that patients could have physical health monitoring completed and have medicines supplied within a 20-minute appointment.

Patients and carers could access a one-to-one session with a specialist mental health pharmacist. Staff told us that they were proud of the patient feedback that they had received in relation to this service. Patients said they were able to discuss medication and staff listened to what they had to say.

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

On John Dickson Ward staff were piloting point of care testing, to measure clozapine levels at the bedside, with results taking seven minutes.

On LEO Ward staff arranged Diagnostic Interviews for ADHD in Adults (DIVA) assessments for relevant patients on the ward.

The clinical psychologist on Claire Ward had obtained funding for virtual reality headsets to work with patients on their known anxiety scenarios. This was due to begin in June 2021.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

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

Community-based mental health services for adults of working age

The trust must ensure that emergency equipment is managed in line with trust policy at the Croydon Central Assessment and Liaison team, the MAP Croydon East Treatment team and the Promoting Recovery East Croydon team (Regulation 12(2)(f)).

The trust must ensure that medicines are managed in line with trust policy at the Croydon Central Assessment and Liaison team, the MAP Croydon East Treatment team and the Promoting Recovery East Croydon team (Regulation 12(2)(g)).

The trust must ensure that controlled stationary is managed in line with trust policy at the Croydon Central Assessment and Liaison team, the MAP Croydon East Treatment team and the Promoting Recovery East Croydon team (Regulation 12(2)(g)).

The trust must ensure that staff meet its targets for compliance with mandatory training, in particular basic life support, immediate life support and promoting safe and therapeutic services disengagement training (Regulation 12(2)(c)).

The trust must ensure that patients who require a Mental Health Act assessment are assessed without undue delay to ensure their safety and that of others (Regulation 12(2)(b)).

The trust must ensure that all community mental health teams meet their target for assessing non-urgent referrals within 28 days (Regulation 12(2)(b)).

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

The trust must ensure that sufficient members of the staff team on each ward have current training in the use of physical restraint and disengagement, immediate life support and basic life support to provide lifesaving care and prevent harm to staff and patients in an emergency. (Regulation 12(2)(c))

Action the trust SHOULD take to improve:

Trust-wide

The trust should continue its engagement work and initiatives to improve the experience of BAME staff.

Our findings

The trust should develop a financial sustainability plan with integrated care system partners to demonstrate that it can live within its means going forward. This should draw on the outputs of a refreshed and updated workforce plan.

The trust should improve the consistency of the information and detail of their 72 hour report and serious incident investigations reports

The trust should ensure when there are cases in which patients have no known family / friends that the trust ensures advocacy for the patient to ensure objectivity and representation of the patients' perspective.

The trust should ensure all complaint responses are comprehensive and offer an apology.

The trust should ensure that they continue to address the issue of some staff being reluctant to speak up about their concerns, including bullying and harassment from colleagues and managers.

Community-based mental health services for adults of working age

The trust should ensure that information technology issues are addressed promptly for frontline staff.

The trust should ensure that work continues to recruit permanent staff to reduce vacancy levels.

The trust should ensure that work continues to address the high caseload numbers allocated to individual staff to ensure that all patients are appropriately monitored.

The trust should ensure that the Croydon Central Assessment and Liaison team complete up-to-date risk assessments for all patients and staff update these after any changes to patients' circumstances and risk events.

The trust should ensure that the Croydon Central Assessment and Liaison team complete and maintain up-to-date patient care plans and physical health assessments.

The trust should ensure that work continues to address patients' delayed discharges and transfers to other services.

The trust should take action to facilitate patients' access to psychological therapies without undue delay in line with best practice guidance.

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

The trust should continue to address the high number of nursing vacancies on some wards through active recruitment and retention strategies.

The trust should take action to improve monitoring of the impact of staffing shortages on patients agreed escorted leave.

The trust should continue to ensure that staff carry out physical observations of patients with specific physical health needs and that these are recorded consistently in line with trust guidance and ensure that all significant physical health issues are addressed in a care plan.

Our findings

The trust should ensure that the legal status of patients is accurately recorded on the front screen of the electronic patient record for each individual.

The trust should address concerns about IT equipment on the wards impacting on the time available for staff to spend with patients.

The trust should investigate and learn from the incident of a patient being placed on a mixed-gender ward when this was not recommended in their care plan.

The trust should continue to keep the number of clinical psychologists under review to ensure that patients' needs are met.

The trust should ensure that all prescribed medicines for the treatment of a mental disorder are included on the consent to treatment Mental Health Act documents.

The trust should ensure that patients' care plans include their views, once they are able to participate in discussions about them.

The trust should review systems to ensure that carers/relatives of patients on the ward are able to obtain information by telephone when appropriate, and that carer forums are resumed as far as possible (remotely if necessary).

The trust should ensure that patients are able to have regular individual meetings with their named nurse.

The trust should continue with the improvement project to address waiting times for discharge on ES1 PICU.

The trust should continue to address the bed management pressures and monitor earlier discharges against rates of readmission.

The trust should ensure that work is continued to make The Ladywell Centre as safe as possible until it is relocated.

Is this organisation well-led?

Leadership

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The trust board consisted of the chair, chief executive, seven non-executive directors (NED) and six executive directors. In addition, there was one non-voting executive director member of the trust board. The team had clear areas of responsibility including opportunities for individual development. The executive directors had the support needed to give them capacity to undertake their roles.

Since the last inspection published in July 2019 there had been significant changes to the trust board. The trust had appointed a new chair, chief executive, chief operating officer, chief nurse and director of communications, stakeholder engagement and public affairs, and a new board level director of corporate affairs. The trust reviewed leadership capability and capacity on an ongoing basis.

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The NEDs had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought skills such as a knowledge of finance and investment, strategic development, research, population health, working in partnership, and transforming services.

The executive board had nine members of which 33% were from Black, Asian and Minority Ethnic (BAME) backgrounds. The non-executive board had eight members of which 25% were from a BAME background. The non-executive directors were supported with their learning and development in line with a competency framework. Recently appointed non-executive directors were required to complete an induction process, which would be tailored to their individual development needs and incorporated meeting key people and visits to gain an understanding of the work of the trust. Each non-executive director had individual objectives and an annual appraisal.

All board members had lead areas including non-executive directors who chaired specific committees or were leads on areas of work. For example, one non-executive director led the finance and performance committee. Board members would attend each other's committees to understand their work and ensure issues that extended across more than one committee were considered in a joined-up matter.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The organisation had a clinical operational structure comprising of six divisions, each led by a service director, head of nursing and associate medical director reporting to the chief operating officer. These divisions were Child and Adolescent Mental Health Services; Croydon and Behavioural and Development Psychiatry; Lambeth; Lewisham; Psychological Medicine and Mental Health of Older Adults; and Southwark and Addictions.

Succession planning was in place throughout the trust and leadership development opportunities were available, including opportunities for staff below team manager level. There were training and education programmes available for staff, for example a Business Administration Masters and a Business and Management Masters. The trust had established the Nursing Development Programme and career pathway across the South London Partnership (SLP) which promoted development and movement through the career pathway and offered flexibility across the three NHS organisations for nursing staff to move into developmental roles.

One of the trusts key actions from the Workforce and Organisational development strategy (2020 to 2023) was to establish a BAME Leadership Academy Programme specifically focusing on talent management, succession planning and career development for staff from a BAME background. The aim of the programme was to create greater levels of sustainable inclusion by addressing the social, organisational and psychological barriers restricting BAME staff from progressing.

To support development among BAME staff the trust had initiatives in place to address inequalities such as Diversity in Recruitment, Reflect and Review, Listening into Action, Mentoring, and Reverse Mentoring. The trust had engaged BAME staff from across the organisation in the development, prioritisation and oversight of plans and actions to address inequalities. The senior leadership team has listened to and continued to provide opportunities for BAME staff to speak up about their experiences. The trust held a Race Equality conference which was received positively by staff.

Fit and Proper Person checks were in place. The trust had an appropriate process for carrying out their duties in respect of the Fit and Proper Person Regulation. Most files were fully compliant and there was a yearly check and update process in place. There were some areas for further improvement that we identified. Some executive files, for example, did not have formal proof of higher education qualifications and some Disclosure and Barring Service (DBS) checks for long standing executives had been completed many years ago without a more recent check.

Our findings

The trust board and senior leadership team displayed integrity on an ongoing basis. Trust directors were found to be professional and demonstrated a high level of commitment to ensuring people who use services and their families received the best care and treatment as possible.

The trust leadership demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. The trust leadership had demonstrated an ability to adapt at a fast-changing pace during the COVID-19 national pandemic. Leaders spoke with insight about the need to continue to work with external partners to meet the needs of the local population. For example, regional wide work with the police to improve joint working.

There were regular board visits to services. Most staff told us that leaders were approachable. Staff we spoke with on the core service inspections told us leaders were visible and approachable.

Directors and senior staff we met all said the board members were open and challenged each other professionally and openly, which we also observed when we attended the board. We also observed good challenge at committees below the board.

The director of pharmacy and pathology was line managed by the medical director. This ensured board level visibility of medicines optimisation themes. The deputy director of pharmacy was also the trust medication safety officer. The trust board looked to pharmacy as the leaders in medicines optimisation and supported them in advancing progress in this area. The director of pharmacy was one of the authors of the recently published 14th edition of the Maudsley Prescribing guidelines, a world-renowned reference text providing up to date expert guidance on prescribing in mental health. Staff were involved in writing this resource, which enabled the use and development of their skills. The resource formed the basis of the trust prescribing policies.

Vision and strategy

The trust had developed a clear vision and set of five commitments which were known by staff. The five commitments were displayed throughout the trust and on the trust's website. The five commitments were:

I will be caring, kind and polite.

I will be prompt and value your time.

I will take time to listen to you.

I will be honest and direct with you.

I will do what I say I am going to.

The trusts quality accounts report from 2019/2020 set out the vision for 'South London and Maudsley to offer each and every person outstanding treatment and support to enable their recovery and to live as fulfilling and socially rich as life as possible'.

Our findings

The trust leadership were aware that to achieve their vision it required excellent partnership working with service users and families, staff and the local communities. The trust had already developed joint working with other South London mental health trusts and Kings Health Partners. The trust collaborated with a range of external partners effectively. The trust worked within a very complex landscape across four London boroughs, four clinical commissioning groups and two integrated care systems (ICS).

The trust planned services to reflect the needs of the local population. The trust was part of the South London Mental Health and Community Partnership (SLP). The SLP focused on delivering mental health services across south London in partnership with two other NHS trusts. The SLP was driving work on delivering new models of care. The SLP managed the budget for child and adolescent mental health services (CAMHS) and forensic services in south London. The three trusts collaborated effectively to improve quality the quality of services, learn from each other and share functions to maximise the effective use of resources. The SLP had been successful in ensuring patients were treated in services closer to home. The SLP were the provider collaborative for forensic services, CAMHS, and specialist eating disorder services in south London. The provider collaboratives were responsible for the commissioning of these services across south London including the independent health sector.

An example of partnership working was where trust had recently agreed to signing the 'One Croydon Alliance Integrated Delivery Agreement' with a range of key stakeholders from Croydon. This ensured the trust remained a key partner in the health and social care partnership and was supported by a mental health transformation programme focusing on improving the outcomes for Croydon residents.

As well as serving the local community in four boroughs the trust also provided over 50 specialist services for patients from across the UK. The trust was also engaged in clinical and academic developments that had international reach.

The trust had a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care. The strategy was aligned to the national direction for the NHS as set out in the Five Year Forward View and being taken forward through local ICSs.

The Trust's 'Changing Lives' strategy was published in October 2018 and has five aims including: quality, partnership, a great place to work, innovation and value. The strategy was aligned with a wide range of partners including clinical commissioning groups, local authorities and ICSs. The strategy linked in with the trusts four clinical priorities.

The trust had set four quality priorities which were:

All patients will have access to the right care at the right time in the most appropriate setting.

To routinely involve service users and carers in all aspects of service design, improvement and governance; and all aspects of planning and delivery of each individual's care.

Enable staff to experience improved satisfaction and joy at work.

Reduce violence and aggression by 50% over three years with the aim of reducing all types of restrictive practice.

The trust was proactively working with other providers to facilitate the strategic development of mental health services within the integrated care systems (ICS). The trust board discussed the joint working with the ICSs regularly.

Our findings

The trust were in the process of drafting their five-year ambitions to 2026 and this was due to launch in September 2021. The developmental work and staff engagement on the trust ambitions had started in 2020. The trust was running a 12-week staff engagement programme 'Be the Change beyond Changing Lives' between April and June 2021. The trust had worked with leaders, stakeholders and governors across the trust as well as externally including local communities and partners, service users and carers to identify the key ambitions. The senior leadership team said their vision was to ensure they are always delivering outstanding mental health outcomes to meet the needs of service users and staff.

For the new five year ambitions the trust had identified early strategic themes linked to the needs of the organisation, the local populations, and the health and care system. There was capability to deliver on the development and implementation of the new five-year ambitions within the senior team. However, some risks had been identified and discussed associated with the major estates programme of work, workforce challenges, and future financial constraints. Further work was needed on how these emergent complexities and risks would be formally monitored or addressed. An example of this was how workforce challenges might be addressed through innovative thinking around local workforce opportunities and development to ensure the trust have a workforce for the future.

The trust had a five year forward ambition to deliver against suicide prevention plans and was aiming to work towards a national 10% reduction in suicide by 2021/2022. This included work to ensure plans were in place for a 'zero suicide' ambition for mental health patients.

Culture

The trust was open and transparent. The approach was modelled by the senior leadership and the trust board and continued down and across the rest of organisation.

Staff felt positive and proud to work for the organisation. Staff we spoke with during the core service inspection felt supported, valued and respected. Staff spoke about improvements in the culture and felt the trust leaders were more visible and present since we last inspected the trust in 2019.

The results of the NHS Staff Survey 2020 had a response rate of 52% and was completed by 2653 staff members. The response rate was slightly above the median response rate for NHS trusts which was 49%.

The trust compared themselves with other similar providers on ten key themes from the 2020 NHS Staff Survey. Possible scores ranged from zero to ten – a higher score indicates a better result. The trust had made improvements in comparison to the 2019 Staff Survey in eight areas themes. However, the trust still remained below average in eight areas including: equality, diversity and inclusion; health and wellbeing; morale; quality of care; safe environment – bullying and harassment; safe environment – violence; safety culture; and staff engagement.

The 2020 NHS Staff Survey results for equality, diversity and inclusion measures for the trust showed the trust was below the average for the following three measures: Does your organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?; In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public?; and In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?

As a result of the staff survey results the trust planned to focus on four themes to aid them in creating SLAM as a 'great place to work'. The four themes were: staff engagement; equality, diversity and inclusion; health and wellbeing; and

bullying and harassment. The trust ranked themselves against other mental health trusts both nationally and the SLP to assess performance against the four themes. The trust leadership had put in place a detailed action plan to improve staff engagement which included external engagement with other trusts' action plans to improve performance against the four themes.

In September 2020 we received some concerns regarding how staff felt equality and diversity were promoted in their day-to-day work and when looking at opportunities for career progression. Some Black, Asian and Minority Ethnic (BAME) staff we spoke with during engagement work before the inspection expressed concerns with how they were treated and their experience at work. We held various staff focus groups and concerns were raised regarding the treatment of BAME staff within the organisation. The trusts chief executive had made a public commitment to all staff that the trust would address the concerns raised. The trust engaged with BAME staff across the organisation to listen to feedback regarding inequalities and held a Race Equality Conference.

As a leadership team the trust had a defined aim for the organisation to be anti-racist. There were staff facing and patient facing strategies taking place to try and address the issues raised by staff and improve the situation. These included human resources strategies, changes to policies and procedures, leadership and development opportunities, and staff training all of which needed to continue to further improvement. There were opportunities to support under-represented staff to access senior roles, facilitated development, and reverse mentoring.

There was very positive work to support equality, diversity and inclusion for patients with the trusts involvement in the development of the Patient and Carer Race Equality Framework (PCREF) and how this was integrated into the strategy, trust measures, culture and experiences.

The trust recognised there was considerable ongoing work required to improve BAME staff experience of working for the trust. The trust had set up the BAME Leadership Academy Programme which was specifically for the development of BAME staff in band 5 and above roles. The programme is known as the 'Stepping Up Programme' and has been successfully implemented in a number of organisations. The programme had been beneficial in developing staff from BAME backgrounds as part of positive action.

Prior to the inspection we attended the Equality and Workforce Committee meeting. The committee were focused on improving the experience of BAME staff who worked in the trust.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. NHS England has published Workforce Race Equality Standard (WRES) 2020 results for NHS Trusts and Clinical Commissioning groups. Trusts have to show progress against nine measures of equality in the workforce.

As a trust, there was evidence of some sustained improvements. The WRES indicators five and six covering harassment and bullying from patients, relatives and staff had improved. WRES indicator seven measuring staff perception of career progression and promotion had seen the biggest positive improvement of 7.4 percentage points.

However, the trust still had work to do to address their poor performance for indicator three which was around the relative likelihood of BAME staff entering the formal disciplinary process compared to white staff. This was also one of the issues identified during our focus groups with BAME staff.

Our findings

The trust had measured itself against the Workforce Disability Equality Standard (WDES). The WDES was a new set of standards that aims to improve the experiences of Disabled staff in the NHS. From April 2019, all NHS trust had to measure themselves against ten data standards. The trust published its first report on this in July 2019. The 2019 report looked at the following:

Percentage of Disabled and non-disabled staff in Bands 1-9, Medical and VSM (Very Senior Managers) including Executive Board members and senior medical staff, compared to the percentage of staff in the overall workforce. Overall, there were 72.9% non-disabled staff compared to 4.3% disabled with 22.8% unknown. The results indicated that Band 7 was nearest to the overall Trust profile for disabled and non-disabled staff. Band 8D and VSM are the furthest from the Trust profile. Band 6 had proportionally the highest percentage of disabled staff overall with 5.8%.

The relative likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff was (0.16/0.14) and therefore non-disabled applicants were 1.10 times more likely to be appointed compared to disabled applicants (this excludes sickness).

Between 2017 and 2019 the relative likelihood of disabled staff entering formal capability process compared to non-disabled staff was 0.94. A score above 1.00 would indicate that disabled staff are more likely to enter formal capability processes. So in this case it is less likely.

Prior to our inspection we requested the most up to date WDES data and the most up to date WDES 2020 results are as follows:

Overall Band 4 had proportionally the highest percentage of disabled staff overall with 7.5% followed by Band 6 with 6.8%.

The relative likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff was (0.16/0.17) and therefore non-disabled staff were 1.06 times more likely to be appointed compared to disabled applicants.

The relative likelihood of a disabled staff entering formal capability process compared to non-disabled staff was 0.00. This means it is less likely.

The trust had put in the Staff Survey Joint Action Plan for Equality and Diversity to bring about improvements. For example, they were running a Diversity in Recruitment Campaign to increase the number of BAME staff sitting on interview panels, increased awareness of the BAME leadership programmes and were embedding the work of the BAME talent succession programme. The trust were also raising awareness of the trust's stance on patient/public harassment during the staff induction programme, held key equality events and had plans to support anti-bullying week in November 2021. There were plans to run 'harassment and bullying' workshops for managers and to implement the 'Beyond Bullying' action plan. There were also plans to work towards disability confident Level 2 learning and promoting a culture that is disability confident and to develop a disability passport initiative.

As part of the trust's commitment to equality, diversity, and inclusion they encouraged the establishment of staff network groups (SNGs) to promote diversity in the workplace. The trust discussed staff networks and how to promote them regularly. For example, the trust were running an awareness session for the LGBT+ network during pride month to try and increase the membership. The trust had five SNGs and each of these has an executive director champion:

BAME Network

Our findings

LGBT+ Network

Lived Experience Network

Diverseability (Disability Network)

Women's Network

The chairs of each of the networks were meeting up regularly to discuss each of the networks and understand the experience of those involved in them.

The trust had appointed Freedom to Speak up Guardians (FTSU). Most staff we spoke with during the inspection process were able to tell us how to use the whistle-blowing process and about the role of the Speak up Guardian. At the last inspection we found the trust had made improvements with regards to promoting FTSU and that staff were familiar with the role. The FTSU had participated in training by the National Guardians Office. The FTSU reported formally to the trust board and provided annual reports. The table below sets out the data submitted by quarter in 2020/21. It shows a steady decrease in numbers of cases/contacts throughout the year. However, the total number of cases this year is an increase over previous years. Between April 2020 and March 2021 there had been a total of 92 cases brought to the FTSU team within the trust. Of these 72 were related to behaviours of others, and 20 were in relation to behaviours including bullying and harassment.

The trust analysed the contacts and identified trends. The trust said the decrease in the number of cases and contacts was probably due to the COVID-19 pandemic. They also compared themselves with other local trusts although these results were very variable.

For 1920/21 Q3 and Q4, the top three themes were:

Issues with line manager

Other

Bullying

The trust had appointed a consultant psychiatrist as the Guardian of Safe Working Hours. The Guardian encouraged junior doctors to complete exception reports and had an overview of all reports. The Guardian met with other Guardians from across the South London trusts at a network meeting to promote shared learning. There was an awareness that junior doctors were still working excessive hours.

Organisations are required to report on the gender pay gap annually. In March 2020, the trust reported the gender pay gap at SLAM. Seventy per cent of the trust's 5028 staff were women. The trust reported that women's mean hourly rate was 10.7% lower than men and women's median hourly rate was 12.18% lower than men.

Trust Gender Profile (based on headcount) March 2020

South London and Maudsley NHS Foundation Trust has a higher proportion of females to males in its workforce. Of the 5,028 staff counted as part of the gender pay gap reporting, 3,497 were female compared to 1,531 male.

Our findings

The mean hourly pay for male staff was £2.52 higher than that of female staff, which was a gap of 10.71%. Male staff median pay was £2.59 higher than that of female staff, which was a gap of 12.18%. For mean pay there has been a reduction in the gap in pay between male and female staff from the previous year (11.5%) however the gap in median pay has increased (10.2%). The trust had a gender pay gap action plan which included encouraging transparency in pay and grading decisions and establishing a women's staff network and programme of activities and events.

Staff had access to support for their own physical and emotional health needs through occupational health. As a result of the COVID-19 pandemic the trust had put in place many initiatives to support staff well-being. The trust planned to continue these activities in 2021/22. This included the utilisation of the Health and Wellbeing Project Manager, focusing on retention by reviewing exit and stay interview results, reviewing and rolling out stress assessment work, and running health and well-being campaigns throughout the year.

The trust had been working towards complying with the requirements of the Accessible Information Standard, 2016. This was identified as a 'should do' by CQC at the last inspection. In March 2021 the trusts compliance was 80.3% and most services had mainstreamed Accessible Information Standards within their referral, administration and clinical processes. Compliance was reported into the monthly Performance and Quality meetings which were led by the Chief Operating Officer. The trust had taken steps to improve compliance since the last inspection including monthly service-level monitoring of progress and the provision of advice and support on request. They had developed a 'Your Information Your Way poster' and advocacy service posters for teams to raise awareness to staff, service users, carers and family members. The trusts Accessible Information Standard intranet page was kept up to date with information for staff to access. However, the trust recognised there was still work to do on this and had a new equality objective which will focus on meeting the communication needs of service users with Learning Disabilities (LD) and Autism. The trust had also recently subscribed to a service that produces easy read and translated medication information. This will go live in the next month and will be promoted to staff, patients, carers and family members.

Staffing

Vacancies

Non-registered nurses

As of February 2021, the trust was reporting a vacancy rate of 17.6% for non-registered nurses. Although this has fallen since the start of the year, it was still higher than at the middle of 2020.

Registered nurses

The most recent figure for registered nurse vacancies reported by the trust was higher than that for non-registered nurses. However, there appeared to have been some improvement in this vacancy rate in the latter part of 2020.

The trust had more challenges in recruiting registered nurses than non-registered nurses which was something that was noted in the last inspection report in July 2019.

All staff groups

The overall vacancy rate (for all staff groups) was below that of the registered and non-registered nurses groups.

Our findings

The trust was conducting further work looking at vacancies and plans were in place to recruit across the directorates. The non-registered nurses vacancy rate had dropped from 20.6% to 17.6% as a result of the work the trust had done as part of the National Healthcare Support Worker programme.

Staff sickness

The trust had reported staff sickness for all staff groups and this was reported as 2.7% in February, after a steady increase and a one-month fall.

However, more up-to-date staff sickness data from NHS England/NHS Improvement shows the latest staff sickness broken down by staff groups for April, May and June 2021. There had been a decrease in the number of staff sickness as a result of COVID-19 between April and June 2021.

Overall, staff sickness at South London and Maudsley has come down over the period, particularly the Covid-19 sickness.

Mandatory training compliance

The trust set a target of 85% for completion of mandatory and statutory training. For the two core services we inspected was compliance variable. For the Croydon Adult COAST team compliance was poor at 62%.

Mandatory and statutory training overall has been reasonably steady over the period that the trust had published it. However, the Lambeth directorate and Clinical Support Services were below the other areas in terms of meeting the 85% target.

The trust also published areas of training that were currently of concern in their board meeting minutes. There were four mandatory trainings that were not meeting the trust target as of March 2021. These were Basic Life Support (46%), Immediate Life Support (58%), Promoting Safe and Therapeutic Services Awareness/Disengagement (55%) and Promoting Safe and Therapeutic Services Teamwork (66%).

The trust highlighted that these were face to face trainings that had been impacted due to COVID-19. There were weekly meetings set up between the chief operating officer and service leads to focus on improving compliance. To improve the Basic Life Support (BLS) compliance the trust was reviewing the eLearning module and key actions were in place to achieve compliance by July 2021. For Promoting Safe and Therapeutic Services (PSTS) there had been issues with the availability of venues and tutors for the course. The trust had sourced external trainers for both PSTS and resuscitation training and new venues, and were in the process of allocating places to priority groups.

All staff had the opportunity to discuss their learning and career development needs at an annual appraisal. The trust target rate for annual appraisal compliance was 95%.

At the time of the inspection the trust was undertaking medical appraisals with a target for the majority of appraisals to be completed by the end of June 2021 and final sign off to be completed by July 2021. The trust had 347 medics in their appraisal system and 136 were signed off, 70 had taken place but were awaiting sign off and 43 were still waiting to be completed. The 2020/2021 appraisal cycle had been cancelled in agreement with NHS England during the COVID-19 pandemic.

Our findings

The trust were in the current appraisal cycle for non-medical staff appraisals. However, the trust provided the data from the last cycle which was reported in December 2020. The appraisal rates for non-medical staff were overall at 88.5%.

Managers across the trust addressed poor staff performance where needed. The trust had policies and procedures in place for managing staff capability and performance concerns.

The trust had worked hard to ensure staff received the flu vaccination. By June 2021, 74% of staff had been vaccinated against the flu. The trust monitored the total staff and frontline staff (including substantive, sub-contracted and partner organisations) for first and second vaccination uptake of the COVID-19 vaccination programme. Overall 85.4% of frontline staff had received their first vaccine and 61.8% their second vaccine.

The trust recognised staff success through feedback and staff awards. The trust held an annual staff awards event and had an employee of the month.

Duty of Candour was being applied across the trust and guidance was in place although there was a recognition that the trust could improve how they apologised to the person harmed and/or their families and carers. A review of 15 randomly selected root cause analysis reports following a serious incident showed the trust applied the Duty of Candour guidance. The Trust's 2019 audit of Duty of Candour identified some areas of high compliance such as an 'offer of support to the person harmed or their family/carer' (90%) and Duty of Candour was fulfilled in 87% of cases'. However, there was poor compliance for 'apology offered to the person harmed or their family carer' at 37%. In response to this the trust were planning an animated film regarding duty of candour with the communications team and a bulletin had been issued in April 2020. There were plans for a re-audit to take place in October 2021.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. Leaders regularly reviewed these structures.

The board was supported by eight sub-committees: partnership committees in common, quality committee, equalities and workforce committee, business development and investment committee, finance and performance committee, audit committee, mental health law committee, and remuneration committee. There had been an increased focus on patient safety risks and the trust had introduced a new patient safety committee.

When we last inspected the trust the borough operating structure system had been implemented and the associated systems and processes were being embedded. The change had taken place to provide closer working with partners in boroughs and provide more visibility for local services. At this inspection we found the systems and processes were fully embedded and the trust had improved working with key stakeholders and partners in the different areas.

The board was organised well. They met every two months. The topics discussed in the confidential part of the board meeting were appropriate. The papers for the board had a clear summary and agenda. The papers reviewing performance and risk were detailed. Narrative analysis of the data was provided and where possible benchmarked against the performance of other similar trusts. The presentation of performance information at board was detailed and informative. There was evidence that the trust had become much more externally focused when it comes to learning and improvement. The narrative analysis was effective in communicating key messages from the data. The data was presented over time which made it easier for the board to identify and interpret real changes in performance and ensure

early intervention where needed. The trust board had a good understanding of the areas for improvement and the actions in place to address performance. At the last inspection it was found the agenda was tightly packed and discussions were brief. The trust had improved this and we observed that there was appropriate time for discussion of specific topics, and non-executive directors had the opportunity to ask questions.

The non-executive directors were clear about their areas of responsibility. They chaired the board sub-committees. They worked to ensure there was appropriate level of communication between the sub-committees and the trust board. For example, we observed the trust Finance and Performance Committee and observed them discussing the importance of continuously linking in with the quality committee. The committees produced summaries for the board and understood the issues that needed to be escalated. The trust board requested various deep dives during the year. The most recent request was for the quality committee deep dive to look at the different elements of health and safety work to feed into the patient safety committee.

The executive directors had defined areas of responsibility. The trust held combined directorate performance and quality meetings to provide oversight of work. The clinical directors had operational responsibility for the service lines. At a ward and team level, front line managers were clear about responsibilities. Each ward and team manager had access to a range of information containing essential performance information for their team. This helped inform the management of their service.

The trust board were working with an external consultancy firm to improve management processes and deliver better outcomes for those who use services.

The medicines safety committee was chaired by the medical director. This ensured it received priority within the trust and contributed to board level visibility for medicines optimisation overall. Systems and processes monitored and ensured progress on the trust medicines optimisation strategy. Medicines safety was a trust priority and was well-integrated into the governance structure. For example, the medicines issues that were picked up during the recent core service inspection were included in the annual report to the trust board.

The director of pharmacy and pathology was line managed by the medical director, who was also the controlled drugs accountable officer. The deputy director of pharmacy was the trust medication safety officer and in addition worked as a clinical pharmacist. Staff were heavily involved in innovative research and development work and were regularly published in clinical journals. Whilst electronic prescribing had not yet been implemented, this remained a priority.

The medical director was the executive lead for the annual medication report produced by the pharmacy leadership team for approval at the trust quality committee. There was a controlled drugs accountable officer for the trust who was in constant communication with pharmacy leaders. The trust had a medicines safety committee for review of medicines incidents and the identification of themes. Quality improvement programmes were generated through these themes and passed to the relevant forum for completion. For example, there was a ‘depot medication’ forum. All workstreams were overseen by pharmacy.

There were robust arrangements to make sure that hospital managers discharged their specific powers and duties according to provisions of the Mental Health Act 1983 (MHA). The use of the MHA and Mental Capacity Act (MCA) was overseen by the Mental Health Law committee that met quarterly.

Our findings

It had been recognised that there was very high use of section 136 of the Mental Health Act 1983 in SLAM. Learning had been taken from the programme developed by North Tyne and Wear trust to improve police knowledge of mental health issues, awareness of alternatives to hospital detention and access to information about the care plans or advanced decisions for individual service users. A 'Respond' simulation training programme was being adopted as well as the digitalisation of police 136 forms which will be sent in advance. A directory of services for police use is to be developed.

There was a lead for MHA legislation who managed the MHA administration function in the trust, supervising the MHA administration team leaders and overseeing the MHA administration teams. There was a clinical lead for the MHA and a lead for the MCA who sat on the Mental Health Law Committee which also had service user representatives. The trust had developed an MHA dashboard, which enabled scrutiny and analysis of trends and performance.

The MHA administration team completed a register which detailed all the timeframes in relation to detention under the Act. Reminder notices were sent to each ward or community team, followed up by phone calls. Regular audits were undertaken including section 132 rights and assessment of capacity to consent to treatment and admission.

The trust had made some improvements to reduce delays in Mental Health Act (MHA) assessments, However, there were still some delays with a risk that the service may be unable to ensure patients' safety due to a delay in support and treatment. Trust data has showed the average MHA assessment wait dropped from 14 days in 2019 to 12 days in 2021. Senior leaders had good oversight of the issue and were regularly monitoring delays and cancellations. The trust held regular forums with the associated police borough commanders where this issue was continually reviewed. Within the service redesign there is a crisis care programme which included a workstream focusing on improving the MHA assessment pathway. The trust was leading a system MHA assessment summit in the summer of 2021 and wanted to develop an action plan to further review and address MHA assessment delays.

NHS guidance in response to the COVID-19 pandemic saw changes in how the trust managed the complaints process. This was due to NHS England pausing the formal complaints process for three months. This resulted in some delays in responding formally to concerns as staff faced significant challenges relating to COVID-19. However, the complaints office ensured that all complainants received acknowledgements and an explanation that difficulties in releasing frontline staff/investigators from clinical duties might adversely impact the ability of the trust to provide a response to concerns within their desired timescales.

The trust continued to accept complaints raised during this period and introduced a triaging process for complaints to ensure prompt risk assessment and responsiveness to immediate issues and assurance. Complaints were reviewed to determine whether the matters raised could be addressed informally with the support of the PALS team; whether aspects could be dealt with through the support of the directorate governance team, with other aspects addressed formally at a later date; or complaints which required a full and formal response to all aspects. The trust's average response time to formal complaints in 20/21 was 50 working days at the conclusion of the complaint, the final calculation of time taken to respond did not take into account the pausing of the complaints process or clinical pressures during subsequent lockdowns. The trust's usual target was 25 days. In 2020/21 the trust had received 435 complaints and 652 compliments. There had been eight referrals to the Ombudsmen service.

We found a variation in the quality of some complaint responses. Some were comprehensive and apologetic and within agreed timescales; however, some did not fully address the issues identified and could be perceived as defensive. Complaints are reviewed to identify if any serious incident or incidents can be identified and lessons learnt. Themes were identified from the complaints and reviewed at the Performance and Quality meeting.

Management of risk, issues and performance

Our findings

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. The trust had a risk management process in place which set out the key responsibilities and accountabilities to ensure that risk was identified, evaluated and controlled. Risk was considered from the perspectives of clinical risk, organisational risk, and financial risk.

The trust maintained an electronic risk register. All staff had access to the risk register and were able to effectively escalate concerns as needed. Service risks fed into operational risks, which fed into divisional risk, which in turn fed into the strategic risks. The trust board had sight of most risks and mitigating actions were clear. Staff concerns matched those on the risk register.

The most significant risks to delivering the strategic aims of the trust were placed on the Board Assurance Framework (BAF). The BAF detailed risks and gaps in the risk controls which could impact upon strategic ambitions. The trust outlined 10 strategic risks. Following review by the executive leadership team, the Board Assurance Framework (BAF) was considered by both the audit committee and trust board. The main strategic risks were identified as workforce, estates strategy, finance and ongoing sustainability and the right care for inpatient services. The BAF, alongside the trust and service line risk registers were regularly reviewed by the board, executive leadership team, audit committee and individual risks were owned by sub-Committees of the Board and are subject to review bi-annually at those Committees. The BAF was used as an active document. The trust had completed work to define the trust's risk appetite and map this to current risks. The trust board had agreed the principles of risk that the trust were willing to tolerate in pursuit of its objectives. The trust actively encouraged well-managed and defined risk management in line with the risk strategy, however recognised that service development, innovation and quality improvement required a certain amount of risk taking. The May 2020 risk appetite statement identified that they would minimise risks in relation to compliance with all regulatory, legislative and statutory duties. However, the trust would seek opportunities around service development, innovation and improvement. The Board last reviewed risk appetite and undertook a horizon scanning exercise in June 2021, although the updates had not yet been published.

The trust had identified workforce and the estates strategy as its top two risks in its BAF. The top risk was workforce. The BAF notes that 'if the trust cannot attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services'. The second top risk was the estates strategy. The BAF notes that 'there are risks to quality outcomes and staff recruitment and retention from an aging estate that is not fit for purpose in many areas. The trust has developed and are successfully executing an estates modernisation strategy, but risks remain due to major projects being delayed or going over budget... Additional, capital constraints could stop or delay the execution of the modernisation strategy.' In relation to workforce, the trust had developed a Workforce and Organisational Development Strategy 2020 to 2023 to reflect the strategic aims. The priorities included reducing time to hire, targeted action to improve staff engagement and career development and targeted recruitment programmes to address hard to fill vacancies. The trust was also aiming to improve the experiences of those from BAME backgrounds by focusing on fair recruitment practices and a review of disciplinary process. In relations to the estates strategy, the trust had identified the growth in the management team's strength and experience as a mitigation.

The trust identified 'Right Care – Community Redesign' and 'Right Care – Inpatient Services' as a risk on their BAF. For inpatient services, due to increasing levels of demand during wave 2 of the pandemic there had been an increased number of emergency department 12-hour breaches and extended waits in the place of safety. The trust had ongoing capacity issues due to increased demand and external factors leading to delayed discharges. During the core service inspection, concerns were raised with regards to delayed discharges from the Psychiatric Intensive Care Units (PICU). This was identified during the last inspection and the trust had taken various actions to try to address this. This included patients ready to be discharged from the PICU being added to the daily bed demand lists, escalation to the directorates

twice daily bed call meetings and monitoring via the daily flow dashboard. Staff were also required to complete incident reports where delays occurred so this could be monitored via the right care director. The trust were currently in the middle of the community transformation programme which was seen as key to improving patient flow along the adult care pathway and the effective use of beds, allowing the trust to be responsive to the local population needs.

The trust executive team had good oversight of the risks associated with patient flow. For example, the trust had completed a piece of work focusing on reducing out of area placements.

The trust recognised the importance of having a strong programme of quality assurance. The quality committee received on-going feedback on several areas for example infection control, workforce, safeguarding, incidents, performance, restrictive practice reduction programme, patient experience and compliance with national guidelines and best practice. The assurance work fed into the quality and performance report at the trust board.

The trust continued to focus on improving patient safety by reducing violence and aggression and the use of restrictive practices. The promoting safe and therapeutic services (PSTS) redesign was on-going and the trust envisioned this would have an impact in the future. Ward staff participated in the trust's restrictive interventions reduction programme including use of the safety huddles, monitoring of low-level incidents, and the use of the Dynamic Appraisal of Situational Aggression tool. The trust was aiming to eliminate prone restraint of patients by training relevant staff to administer rapid tranquilisation in the deltoid muscle (in the arm). The trust had a quality priority to reduce incidents of violence on all wards by 50% and stop prone restraint. Whilst achieving these targets was proving hard, the work was ongoing and closely monitored.

The trust had capital funding in two different workstreams for ligature reduction work. The first was the annual general maintenance budget which factored in anti-ligature maintenance and replacement (for damage etc.) as part of the normal running of the organisation. The second was when specific trust wide issues were identified funding was made available as part of the trusts planning processes. For example, there was specific funding for anti-ligature windows for Ladywell in the trust's current capital and revenue plans. In addition, where new ligature requirements were identified these were escalated into other major programmes. For example, the window specification for the new Douglas Bennett House had been updated following the project findings in Ladywell.

The trust continued to focus on improving physical health monitoring which including ensuring physical health observations were completed and documented. As a trust, they continued to deliver on the Covid-19 physical health strategy. The previous trust physical health strategy was now due for review. The aim was to build upon previous work and the learning from the Covid-19 Strategy. The trust continued to convey a clear message of ensuring the right physical health care in the right place at the right time delivered by the right person. From a physical health perspective, this emphasised the importance of early screening, identification and escalation of physical health needs. The trust had also established a physical health strategy implementation committee. This fed into the quality committee which ensured the trust maintained strategic oversight of operational implementation of the trust physical health care policy and strategy. The committee aimed to ensure the trust clinical services were working to reduce the mortality gap associated with patients with a severe mental illness and physical health needs and promote and advocate for parity of esteem between mental and physical health.

The trust continued to host the physical healthcare work by the Mind & Body Programme as part of King's Health Partners, which was committed to providing a programme of work to join up and deliver excellent mental and physical healthcare, research and education treating the whole person. At the trust, the Mind and Body programme were involved in a range of initiatives and projects to support and strengthen the physical healthcare offering for its service users.

Our findings

The Integrating our Mental and Physical Healthcare Systems project (IMPHS) launched in 2019 and was a three-year project focused on closing the mortality gap for people accessing trust services by improving the physical healthcare on offer to them. The IMPHS project team worked closely with physical health leads to support the trusts physical health strategy, as well as supporting related projects across other King's Health Partners organisations. The IMPHS project activity was being evaluated by a group of researchers led by the Centre for Implementation Science at King's College London. The aim was that any learning and success will be reported to the trust so that work can be translated into sustainable improvements and initiatives for physical healthcare beyond the timeline of the project.

The trust participated in national audits and there was an annual programme of clinical audits. The trust Perfect Ward audit tool was in place and any service area which scored red received feedback from the relevant clinical lead as a learning tool. The trust had seen an increase in the number of community services using the audit tool and had planned to include audit results in the community performance and quality report. The tool replaced local paper audits to provide a systematic local clinical audit programme.

The trust had implemented the use of a quality improvement application to enable nursing staff to complete ward level medicines audits. Pharmacy staff also completed quarterly medicines audits and maintained oversight of any issues. They also published medicines bulletins to ensure that learning from incidents was shared.

Many clinicians at the trust were actively involved in research and development and the trust were a core partner for the Quality Centre in collaboration with Institute of Psychiatry, Psychology and Neuroscience (IoPPN) at Kings College London (KCL) and Kings Health Partners (KHP).

Systems were in place to ensure medical revalidation was taking place. A trust revalidation advisory group was formed in 2017, chaired by the medical director. Revalidations were being completed as planned unless the doctor was on prolonged leave or a new starter.

The trust had appropriate measures for safeguarding in place. The work was monitored through the trust safeguarding committee which met quarterly. Reports were submitted to the quality committee through to the trust board. The director of social care managed the safeguarding adult and children leads. There were safeguarding champions in each directorate.

Although there were estate development plans underway the trust was also aware of the need to maintain existing facilities. This was monitored through a capital estates and facilities dashboard brought to the trust board.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. There was a clear procedure for managing serious incidents and the board received a report on serious incidents on a quarterly basis, together with lessons learned from those incidents, following root cause analysis and compliance with the trust's 'being open' policy.

The tables below show the number of incidents reported between April 2020 and March 2021. The trust reported 123 serious incidents which was an increase from the previously financial year of 95. The most common type of incident was 'death' with 71 followed by violence and aggression with 24. The trust reported no never events during the reporting period. Of the incidents reported 1878 (11.4%) were no harm, 4167 (25.3%) were low harm, 9675 (58.7%) were moderate harm, 117 (0.7%) were severe harm and 647 (3.9%) were death.

Our findings

The Chief Coroner's Office published the local coroner's Report to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by local coroners with the intention of learning lessons from the cause of death and preventing deaths. In the last 12 months there had been no 'prevention of future death' reports sent to the trust. However, the trust had been informed in June that a report was on the way.

The trust had a process in place to manage the investigations of serious incidents. The quality of the serious incident reports were variable, some appeared to be well written, detailed with clear terms of reference, contact with family, clear lessons and recommendations supported by a factual chronology of events. Others were less well written and lacked clear terms of reference. In a number of cases there were no family/friends and it was not clear who in these cases acts an advocate for the patient to ensure objectivity and representation of the patient's perspective.

From the 15 serious incidents reviewed there were clearly some themes regarding moving to a virtual platform in response to Covid-19 and whilst they had a risk stratification process, in some instances this had not worked. What was not clear was how they had taken the learning from this and applied to improvements needed going forward. Other themes were risk assessment and care planning.

The NHSE timeframe for investigating serious incidents (60 days) was suspended by NHSE due to the pandemic. As such, there was currently no timeframe. Pre-pandemic, all extensions in timeframes were agreed by CCGs. The trust told us that many reports are completed within this timeframe. However, investigations could be delayed for several reasons. For example, the police asking the trust not to commence an investigation where it could compromise a criminal investigation. In 2019 the reports were submitted to the CCGs on average 106.5 days in excess of the 60-day timeframe. From January 2020 onwards, the trusts delay had dropped to an average of 100.8 days. There were also delays with the CCG signing off reports due to COVID-19.

A learning from deaths process took place and was led by a member of the executive team. The documented findings to board were brief and it was not always clear whether learning from deaths had taken place. There were plans to strengthen this and share the learning more widely.

There were plans in place for emergencies. The trust had a business continuity plan and major incident plan in order to deal with disruption to staff and facilities. This covered all the areas of the trust's resilience arrangements.

The following feedback was received from NHS England / Improvement about the trust's financial sustainability:

In 2020-21, the Trust received income of around £500m, receiving around £30m of top-up funding from NHS London, and meeting the financial targets expected. For 2021-22, it was budgeting to spend £249m for the first half-year. Prior to Covid-19n the trust had an underlying annual financial deficit assessed at around £14m, which is understood to have now increased to around £25m per annum. It received commercial income through Maudsley Learning; and from its management fees for providing services in Gulf States. It benefits from close links with the Maudsley Charity; and its relationships external partners including Kings Healthcare Partners.

The trust was implementing two large capital schemes: Douglas Bennett House; and The Pears Maudsley Centre for Children and Young People. Both these buildings will be completed in 2022-23. The trust has received bridging capital from the NHS, pending the sale of other trust assets. At the time of the inspection the trust told us that it had not yet finalised the terms and timing of the repayments. However, the formal loan agreement was signed following the inspection. In addition, it was planning to invest £12m capital in 2021-22 on digital and smaller estates maintenance and development projects.

Our findings

At the time of the inspection, the trust was re-evaluating its strategy to ensure that it could continue to provide services that meet the needs of its population in south London. As part of this re-evaluation it had started two new large capital build projects after carefully balancing costs, risks and benefits. It was important that the costs of these projects were controlled, and the NHS got good value for money. The trust had programme management arrangements to ensure tight control of costs.

To pay for these projects the trust recognised that it needed to realise value from buildings and land that it currently owned. The details of how and when this repayment would be made remained a risk that the trust had not fully resolved at the time of the inspection.

The trust's running costs had risen over the period of the pandemic, owing to higher levels of demand for services and workforce costs. The financial position of the trust was such that it would be able to meet its financial targets in 2021-22 through one-off measures; but it recognised that it needed to take steps to improve its financial sustainability. It was actively scoping opportunities such as:

Increasing commercial and non-NHS income;

Extending the scope of its role in local communities, including its role as an anchor institution;

Working more closely and efficiently with partners to streamline services and reduce duplication;

Increasing use of community services and reducing length of stay in inpatient beds.

The finance department was led by an experienced chief finance officer (CFO) who understood the need to balance clinical care with financial control and delivery. In terms of the control of capital expenditure, he exercised tight control of variations through his chairmanship of the programme boards. The finance department was considered to have strength in depth and was resilient. There were good professional relations with system finance colleagues. The finances of the trust were sufficiently strong for the CFO to be confident that he could manage 2021-22 financial risk through non-recurrent / one off methods. The Director of Estates told the inspection team that he had "shelf-ready" schemes that could be activated quickly should additional capital funding become available.

The trust undertook overall horizon- scanning via board development annually, ensuring a broad view was taken of trust risk, including financial risks. The trust reviewed its risk appetite annually. The trust had a track record of delivering its annual financial control total. The trust board had kept under close review the risks to the financing of its two large capital schemes as bridging finance was negotiated. The inspection team was told that the board had recognised that it might have to abort the projects had finance not been made available. The responsibility for fire safety and health and safety compliance rested with the Chief Operating Officer and service managers rather than with the estates' teams.

The trust had satisfactory arrangements for financial governance. At the time of the inspection the trust focus was on delivering a break-even position at the end of the financial year. The draft Annual Report and Accounts were presented at the May finance and performance committee and trust board. The reports were being scrutinised further by the audit committee before final approval and finalisation by 15 June 2021.

The trust had set out the finance principles initially in March 2020 and continued to operate on these via the revised planning processes which were implemented on the 1 October 2020. This involved:

Additional funding for Coronavirus costs to deliver a break-even position through the period

Our findings

Suspending the Operational Planning Processes for 2020/2021

Moving to block contract payments determined at system (Integrated Care System and regional) level.

At month 12 (March 2021) the 2020/2021 targets had been exceeded and breakeven was achieved against a £2.9 million deficit plan. The improvement was due to a combination of factors which included reducing risk around central funding such as research and development income and changes in the agreed system response method to mental health patients in the emergency department.

Bank and agency run rates and ward costs were being looked at each month with directorates. Ward costs in 2020/2021 were below the previous financial year run rates due to reduced ward numbers. The trust were aware that once the activity level increases the bank and agency spend in inpatient areas remains a significant challenge for the trust. The trust ongoing actions and initiatives to address this included the launch of the agency transfer process in July 2020 and various reviews of operational models.

The average monthly COVID-19 costs in quarter 4 were 1.7 million per month. The trusts reported COVID -19 expenditure for 2020/2021 was £19.4 million.

Capital expenditure plans are required to be managed within the South East London Integrated Care System capital control total (CDEL). SLaM submitted revised CDEL plans for £30.4 in May 2020. The outturn position was £28.2 million. The total slippage of £2.2m was made up of a deferral of £8.3 million grant income into 2021/2022 less £10.5 million slippage on capital expenditure in year.

However, there had been a significant deterioration in the underlying position as a result of suspending Cost Improvement Plans (CIPS) which would impact sustainability in future years from the second half of 2021/2022.

Information Management

The trust was aware of its performance through the use of key performance indicators and other metrics. Information was in an accessible format, timely, accurate and identified areas for improvement. The integrated performance and quality report, which included metrics on both operational performance and quality, provided information to the board every month.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Systems were in place to collect data from wards and teams and this was not over burdensome for front line staff. The trust had a clear process for the management and monitoring of data quality. Most records were held on a core clinical operating system with clear requirements for data entry, that drive activity reporting and Key Performance Indicator management.

Leaders submitted notifications to external bodies as required. The trust reported serious incidents to the Information Commissioner's Office (ICO). Incidents with a severity level of two or above are classed as serious incidents and are required to be externally reported to the ICO. The trust also regularly updated CQC where serious incidents occurred.

The information governance team was supported by the Caldicott Guardian. The quality committee received an annual report from the Caldicott Guardian, including issues raised / reported to the ICO.

Our findings

Staff experienced problems with IT equipment such as mobile telephones and laptop computers not working and significant delays in having these issues addressed. Staff reported that replacement equipment could take several months to arrive. Staff also reported new starters had long waiting times for equipment and access to the trust's electronic systems. Staff understood the trust had significant challenges in increasing staff access to IT equipment during the COVID-19 pandemic, however, delays in having their IT issues addressed reduced staff efficiency.

The trust has a team reviewing how information technology systems can be integrated to allow staff to access relevant information held by primary care.

Engagement

The trust had focused on improving service user and carer involvement since the last inspection. The trust's 2019/2020 quality report reported there had been an increase in the number of service users and carers attending the trust board and sub-committees. All quality centre workstreams at the trust were coproduced, codesigned or had service user and/or carer involvement in projects. They were supported by the trusts Patient and Public Involvement (PPI) leads.

The previous Patient and Public Involvement (PPI) Policy was replaced in early 2020 by the Family and Carer Strategy and a new Service User Strategy. This change idea was instigated and led by the chairs of the Family and Carer and Service User committees and was presented by them at a board development day on the 25th February 2020 The Service User Strategy remains under development in order to facilitate maximum involvement with service users in its design during the pandemic, but in the meantime the trust had a strong governance framework with regard to service user and carer involvement through the Service Users Committee, Quality Committee and Board oversight. The trust identified that the area of least service user involvement was from inpatient services and was looking at ways to improve this. This will continue going forward and the strategy will inform the reporting and measurement of engagement.

Patients who use services were actively involved in quality improvement projects and were part of the central team.

The trust was still committed to improving the care experience of service users with protected characteristics, considering ways to make services more accessible and relevant and to support staff to provide person centred care to all.

The trust had launched a new patient experience survey patient in September 2020 which included the new national Friends and Family Test (FFT) question. The FFT asks patients whether they would recommend the services they have used based on their experiences of care and treatment. One of the trust's quality priorities was to increases the trusts performance to 90%. The trust's FFT was at 88%, however some services had reached the 90% target in March 2021 including Child and Adolescent Services and Lewisham services. The trust had continued collected FFT feedback throughout the COVID-19 pandemic which demonstrated their dedication to patient engagement and experience.

Patients, staff and carers were able to meet with members of the trust's leadership team to give feedback. Patient stories were routinely presented at board meetings and patients presented their stories in person or via teleconference.

The chief executive held regular open meetings with staff and during Covid-19 the trust CEO and Chair Person held twice weekly broadcasts. We attended one of these broadcasts during the core service inspection and it provided key updates around actions the trust were taking to improve.

Our findings

In 2020, the trust had introduced the Listening into Action (LiA) with the aim of 'making SLaM a GREAT place to work'. The LiA programme was focused on quick and positive improvements for staff. The trust had conducted a survey which over 60% staff response rate to identify areas for improvement.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

Governors were actively involved in the operation of the trust. They fed back that members of the board were very open and engaging. They were able to perform their role of appointing and holding non-executive directors to account. There were 30 governors in post plus the Chair and this was made up of public, staff, service user and appointed governors. They met on a quarterly basis for its full Council of Governors meeting and on a quarterly basis looking at quality, planning and strategy, bids, nominations, membership and involvement. These were attended by the relevant non-executive directors, so they could be asked about their work in the area to afford the opportunity to be held to account for the Board's performance. Non-Executive Directors also met with Governors before every Board meeting and attended site visits with them. Governors observed the board and participated in sub-committees. All new governors had access to an induction designed for governors and formal training for governors. Governors felt well engaged with the work of the trust.

The trust had over 14,000 members who were kept in touch with the work of the trust through a monthly newsletter. Governors also ran a seminar programme to engage with members and had a Membership and Engagement Strategy to facilitate their role in representing the membership.

External stakeholders such as clinical commissioning groups fed back about the trusts engagement. They felt the trust engaged excellently with stakeholders, was open and transparent and demonstrated high levels of collaborative working. For example, the trust supported local workstreams on medicines optimisation in care homes for older people, people with learning disabilities or those living with mental health problems. Work was ongoing to engage with Croydon GPs in the management of shared care.

Learning, continuous improvement and innovation

The trust quality centre had been established to develop and commission quality standards for operational directorates to implement as part of their pathways with clear outcomes. The quality centre aimed to define, test, implement and continuously improve the Maudsley Model of clinical care. The strategic direction of the quality centre aligned with the trusts overarching Changing Lives strategy. For 2020/2021 the quality center's areas of work were focused on care process models, staffing, population health and outcomes. For example, staffing was around work force initiatives for staff support.

Quality Improvement was established with further staff being trained. The outputs from the QI approach were starting to be seen throughout some services. Staff we spoke to on the core service inspections said learning was shared in a better way and they were supported to develop the skills in QI.

The trust had invested in its quality improvement (QI) programme across the organisation. At the inspection there were multiple QI projects ongoing including within the two core services we inspected. Over 1000 staff had received a range of QI training. The QI model encouraged staff to make small tests of change overtime, using data to inform improvements and measure variation over time. The trusts QI team were available to support and coach staff.

Our findings

A variety of quality improvement projects have been completed or were ongoing. For example, a review of the accuracy of information held by GPs in relation to clozapine prescriptions was completed. The trust was committed to improving information sharing, for example, communication of medicines information to community pharmacies. The trust learnt from working with local acute trust partners in the delivery of the COVID-19 vaccination programme. Another example, was a QI project looking at improving junior doctors' core training experience to increase recruitment and retention.

NHS trusts can take part in accreditation schemes that recognise services compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed. The trust had 15 services who were either currently or previously accredited, for example Croydon Forensic and Offender Health services were accredited by the Quality Network for Prison Mental Health Services in June 2021.

At a national and international level there was a strong research base and system-leading research was taking place. Opportunities for research were explored and supported. The trust had a research and development strategy, which set out research priorities. The research and development committee met quarterly. The trust aimed to increase research capacity across all professional groups and promoted research as part of career development for staff. Staff at the trust were heavily involved in innovative research and development work and were regularly published in clinical journals.

The Pears Maudsley Centre for Children and Young People was currently under development and would bring together the world’s leading experts in care and research from SLAM and Kings College London Institute of Psychiatry, Psychology and Neuroscience (IoPPN). The two organisations were working together to create an exceptional centre of care for young people with a focus on the potential of research to identify mental health difficulties early and transform treatment and care of children and young people in the UK and internationally.

The trust's Alcohol Assertive Outreach team won the Mental Health Team of the Year award at the British Medical Journal (BMJ) Awards. The addiction services meet people in their own homes or local communities rather than at clinic appointments, improving the outcomes for alcohol dependent patients.

The trust was a joint winner of partnership of the year at the Health Innovation Network South London Recognition Awards for implementing the Serenity Integrated Monitoring (SIM) with two other south London NHS trusts and the police. SIM is a new way of working with mental health service users who experience a high number of mental health crisis.

The trust was shortlisted in the Health Service Journal (HSJ) Awards for a System Leadership award.

The trust, KCH and Mind and Body had won the HSJ award collectively for staff support during Covid-19.

The CEO had led a project across London auditing emergency departments where children and young people had presented. The purpose of this was to identify learning and look for solutions to reduce attendances as a system.

The trust had effective systems in place to identify and learn from unanticipated deaths. The medical director was the executive lead for learning from deaths. The documented findings to board were brief and it was not always clear whether learning had taken place. There were plans to strengthen this and share the learning more widely. There was a suicide prevention strategy in place from 2019.

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
Requires Improvement ➔➔ Aug 2021	Good ➔➔ Aug 2021	Good ➔➔ Aug 2021	Good ➔➔ Aug 2021	Good ➔➔ Aug 2021	Good ➔➔ Aug 2021

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 a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Adult social	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Requires Improvement	Good	Good	Good	Good	Good
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement →← Aug 2021	Good →← Aug 2021	Good →← Aug 2021	Good →← Aug 2021	Good →← Aug 2021	Good →← Aug 2021

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating 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 ↔ Aug 2021	Good ↑ Aug 2021	Good ↔ Aug 2021	Good ↑ Aug 2021	Good ↔ Aug 2021	Good ↑ Aug 2021
Wards for older people with mental health problems	Requires improvement Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Community-based mental health services for older people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018
Forensic inpatient or secure wards	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Long stay or rehabilitation mental health wards for working age adults	Good Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Wards for people with a learning disability or autism	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016
Child and adolescent mental health wards	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Mental health crisis services and health-based places of safety	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community-based mental health services of adults of working age	Requires Improvement ↔ Aug 2021	Good ↔ Aug 2021	Good ↔ Aug 2021	Requires Improvement ↔ Aug 2021	Good ↔ Aug 2021	Requires Improvement ↔ Aug 2021
Specialist community mental health services for children and young people	Good Jan 2016	Good Jan 2016	Good Dec 2020	Requires improvement Dec 2020	Good Dec 2020	Good Dec 2020
Community mental health services for people with a learning disability or autism	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016
Services for people with acquired brain injury	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Perinatal services	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Overall	Requires Improvement	Good	Good	Good	Good	Good

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.

Community-based mental health services of adults of working age

Requires Improvement ● →←

Is the service safe?

Requires Improvement ● →←

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well furnished, and fit for purpose. However, equipment used in emergencies were not always checked to ensure suitability for use. Staff experienced problems with IT equipment and significant delays in having these issues addressed.

Staff at all sites completed health and safety checks of all areas and removed or reduced any risks they identified. Managers or team leads conducted weekly environmental audits. Where any risks were identified these were reported and followed up. Ongoing maintenance issues where escalated and addressed at performance and quality meetings.

All interview rooms had alarms and staff available to respond. Staff made checks to ensure the alarms were working and practised how to respond to an alarm.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Patients and carers said they found the premises to be well maintained.

Staff followed infection control guidelines, including social distancing. Hand gel, face masks and disinfectant wipes were readily available for staff and visitors. Adequate signage and posters were displayed reinforcing infection control measures. Staff demonstrated good practice and use of personal protective equipment in all areas we inspected.

Staff made sure equipment was well maintained, clean and in working order. Staff had access to emergency equipment, including anaphylaxis kits. However, in Jeannette Wallace House, where the Croydon Central Assessment and Liaison team, the MAP Croydon East Treatment team and the Promoting Recovery East Croydon team were based, there were gaps in the emergency equipment checks that should have taken place daily.

Staff experienced problems with IT equipment such as mobile telephones and laptop computers not working and significant delays in having these issues addressed. Staff reported that replacement equipment could take several months to arrive. Staff also reported new starters had long waiting times for equipment and access to the trust's electronic systems. Staff understood the trust had significant challenges in increasing staff access to IT equipment during the COVID-19 pandemic, however, delays in having their IT issues addressed reduced staff efficiency.

Safe staffing

Not all teams were compliant with the trust's mandatory training targets. The number of patients on the caseload of some teams exceeded national guidance recommendations. However, the service had enough staff, who knew the patients and their individual needs to keep them safe from avoidable harm.

Community-based mental health services of adults of working age

Nursing staff

The service had enough nursing and support staff to keep patients safe. Patients said staff were available when they needed them, and they felt supported.

The service's vacancy rates had improved since the last inspection. However, teams in the Croydon directorate had the most vacancies. The vacancy rate across the service was 15% at 2 June 2021. This totalled 26 vacancies across the service, with 19 care coordinator and four registered nurse vacancies. The Croydon Adult COAST team had seven care coordinator vacancies. The Promoting Recovery East Croydon team had four and a half care coordinator vacancies. The MAP Croydon East Treatment team had three care coordinators vacancies. Staff said that this led to increased patient caseloads for established team members. Managers filled vacancies with locum staff who were familiar with the service. However, carers said that temporary staff were not always as caring and supportive as permanent staff. Managers told us that that the Croydon directorate service had a rolling recruitment process in place for care coordinators and registered nurses. For the Croydon Adult COAST team six of the vacant care coordinator posts had been recently filled but the individuals were set to confirm start dates. Staffing was on the service risk registers for the Croydon, Lewisham and Lambeth teams and all of the directorates had a recruitment strategy which formed part of the trust's long-term joint workforce and organisational development strategy. Actions the trust were taking as part of strategy included recruitment drives, considering over-recruitment in teams with higher staff turnover, regular approaches to agency workers to attract them to convert to trust employment, creating nursing associates roles in the community teams and establishing new roles as part of the community wide service redesign. The redesign of community services started in January 2020 and was due for completion in March 2024. The aim of this service redesign was to speed up patient access and flow through services, reduce staff vacancies and increase multidisciplinary (MDT) teams and improve outcomes for patients and patient experience. The trust secured £10.4 million in total to fund this service redesign.

The number of patients on the caseload of some teams exceeded national guidance recommendations. Care coordinators in the Croydon Adult COAST and the Lambeth Leo Community Service early intervention teams had caseloads which were much higher than the 15 recommended in national guidance. Care coordinators in the Croydon Central Assessment and Liaison team, and the Lambeth North Short-Term Support team had caseloads which were higher than the trust's target of 28. Staff said that although they felt they could manage their workload, at times they felt pressured and this impacted on activities, for example monitoring patients and updating and auditing patient care records. In all teams, managers had good oversight of staff caseloads and were supporting those staff with a larger than average caseload to reduce it. Mangers actively monitored caseloads identifying any patient who had not had contact within the last four weeks and supported staff to make contact. This was also reviewed every month at the directorates' performance and quality meetings. Staff said there was support in place to help them manage their caseloads, such as clinical supervision, complex case MDT discussions, one to one sessions with managers and team psychologists and caseload reviews. Senior leaders were aware of the caseload numbers and caseloads reduction was part of the community wide service redesign.

Managers made arrangements to cover staff sickness and absence. Where there were unfilled vacancies for registered nurses and other staff, such as care coordinators and psychologists, vacancies were filled by agency staff. Managers limited their use of bank and agency staff. Staff said the majority of bank and agency staff requested were familiar with the service and bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. Staff said their managers were understanding and supportive when managing ill health.

The average sickness rate across the four service directorates was 3.2% as of March 2021.

Community-based mental health services of adults of working age

Medical staff

The service had enough medical staff. Records showed no medical vacancies across the teams inspected as of May 2021. Staff and patients said they could access support from a psychiatrist quickly when they needed to.

Mandatory training

The Croydon Adult COAST team's mandatory training compliance rate of 62% did not meet with the trust's mandatory training targets. Face to face training courses were postponed during the COVID-19 pandemic which resulted in low mandatory training rates. Managers were aware of the this and were supporting staff to book and attend training. All other teams were compliant with the trust's training compliance targets. The service had rolled out online training during the COVID-19 pandemic and was now returning to face to face training sessions. Staff said online training was easy to attend and worked well. The service was exploring which online training sessions could be kept while returning to face to face training. Managers monitored mandatory training and alerted and supported staff when they needed to update their training.

At the directorate level none of the directorates were compliant with the trust's full compliance target rate of between 86% and 100% for basic life support, immediate life support and promoting safe and therapeutic services disengagement mandatory training. In March 2021 compliance for basic life support training ranged between 38% for Lambeth to 52% for Lewisham. Compliance for immediate life support training ranged between 54% for Lambeth to 66% for Lewisham. Compliance for promoting safe and therapeutic services disengagement training ranged between 44% for Lambeth to 63% in Lewisham and Croydon. Staff were compliant with training in other mandatory courses. Senior leaders were aware of this issue and an action plan was in place to improve performance.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols. However, staff did not always update risk in patient care records and the trust was experiencing delays in Mental Health Act assessments

Assessment of patient risk

Assessing patients' risk had slightly improved since the last inspection. We reviewed 52 patient care records. All patients were risk assessed at point of referral and followed up for further risk screening within 24 hours for urgent referrals and within 28 days for routine referrals. Teams risk assessed all patients before they are allocated to staff caseloads.

Within most teams, staff completed risk assessments for each patient using the trust's risk assessment tool, and reviewed this regularly, including after any incident. Information was detailed and up to date and showed evidence of patient involvement. However, seven care records in the Croydon Central Assessment and Liaison team did not have comprehensive risk information recorded. These records did not demonstrate they were regularly reviewed with up to date risk assessments. One record showed a delay of four months in the recorded follow up contact after reports of increased patient risk. This posed a risk that staff may not recognise or respond appropriately to signs of deteriorating health or medical emergencies. However, managers were aware of the issues with recording and updating risk assessments and this was reported in the directorate's performance and quality meetings. A matron was monitoring the

team's care records on a fortnightly basis and mangers were supporting staff with individual risk planning and formulation training. Staff we spoke to in the Croydon Central Assessment and Liaison team were able to demonstrate an understanding of their patients' risk levels and risk factors and told us they discussed each patient's risk in weekly zoning meetings.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Care records were updates where patients' risk changed. Patients said they were involved in the management of their risk and discussed this with staff. We observed two handover meetings, one zoning meeting and one cluster meeting which all include comprehensive discussions of risk with full MDT input. Where patients did not attend appointments and/or disengaged the service had clear follow up protocols in place. Staff arranged welfare checks for patients that missed appointments and liaised with external services such as housing providers as part of this process. Staff made use of the zoning meetings to indicate where patients might have disengaged and took suitable actions to attempt further contact and support.

Crisis plans were in place which were tailored to individual needs. Patients, and where requested family members and carers, were involved in crisis and prevention planning.

Staff followed trust personal safety protocols, including for lone working.

The trust had now made some improvements to reduce delays in Mental Health Act (MHA) assessments, however, there were still delays in MHA assessments. There was a risk that the service may be unable to ensure patients' safety due to a delay in support and treatment.

Trust data had showed the average MHA assessment wait dropped from 14 days in 2019 to 12 days in 2021. The trust reported that no serious incidents had resulted from MHA assessment delays between the 1 December 2020 and 28 May 2021.

Staff said the waiting times for MHA assessments had improved as they had built strong relationships with police and ambulance services and approved mental health professionals. This helped coordinate and manage MHA assessments. Where MHA assessments were delayed staff said they were able to escalate this to senior leaders who then supported staff in ensuring the assessment happened promptly. Staff reported that in urgent cases MHA assessments would take place quickly and they actively supported patients and their families and carers while they were waiting for an assessment.

The data over the last two years shows that around 50% cancellations were due to inpatient bed availability with the rest coming from the patient not being available at the planned address, the process for provision of evidence for a warrant being delayed, police availability on the planned date and availability of other key attendees. Senior leaders had good oversight of the issue and were regularly monitoring delays and cancellations. The trust held regular forums with the associated police borough commanders where this issue was continually reviewed. The community wide service redesign had bed occupancy as one of the key outputs and the long-term aim was to operate at 85% bed occupancy in order to facilitate timely access to inpatient beds whenever they are required. Within the service redesign there was a crisis care programme which includes a workstream focusing on improving the MHA assessment pathway. The trust was leading on a system MHA assessment summit in summer 2021 with the output to be an action plan to further review and address MHA assessment delays.

Safeguarding

Community-based mental health services of adults of working age

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Directorate records showed that staff were fully compliant with trust safeguarding training targets of 86% to 100%, with competition rates between 85% and 98% for all required courses. Staff said they received alerts so they knew when to renew their training. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff said they felt confident in reporting safeguarding alerts and knew how to make a safeguarding referral and who to inform if they had concerns. Staff said they regularly discussed safeguarding concerns within MDT and zoning meetings and could raise concerns with the service safeguarding leads and team leaders if needed.

Staff access to essential information

Records were available to all staff providing care.

All staff, including agency staff could access patient records. Information about patients' previous contact with trust services was readily available. Staff used the trust's electronic patient records system to record and securely store information.

Medicines management

The service used systems and processes to safely prescribe and administer medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. However, there were some gaps in the record keeping and controlled stationary was not always stored in line with the trust policy.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were dispensed from another trust site and sent to each teams' base. Staff used paper prescription charts alongside an electronic system for patients notes which supported them to prescribe, administer and record the use of medicines. A senior pharmacist was accessible on weekdays and was able to provide clinical advice. Access to medicines was appropriately restricted. Medicines were stored appropriately so that they would remain safe and effective for use. However, there were some gaps in the record keeping which included temperature checks and emergency medicines. Clinical rooms were clean, spacious and equipped with handwashing facilities. Physical health monitoring was completed at the clozapine clinics. Staff had access to medicines disposal facilities.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff could access a clinical pharmacist on weekdays for advice and support. Staff working out of hours could access the trust on-call pharmacy service for medicines advice. Patients and carers could access a one to one session with a specialist mental health pharmacist. Staff told us that they were proud of the patient feedback that they had received in relation to this service. Patients said they were able to discuss medication and staff listened to what they had to say.

Staff stored and managed medicines in line with the provider's policy. Medicines charts were stored in areas that were only accessible to trust staff. However, controlled stationary was not always stored in line with the trust policy at Jeanette Wallace House. Access was not restricted to one designated person. From the records it was not clear how many prescriptions should have been in stock.

Community-based mental health services of adults of working age

Staff followed current national practice to check patients had the correct medicines. Staff had access to summary care records (SCR) for local GP practices. This means that on admission, they could carry out medicines' reconciliation (the process of accurately listing a patient's current medicines).

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed blue light bulletin updates during team meetings. Staff used an electronic incident reporting system to manage medicines incidents. As a result of an incident, training had been delivered to nursing teams and teams consisting of those without a clinical background.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. Staff working in the clozapine clinic had access to point of care testing facilities. This ensured that patients could have physical health monitoring completed and have medicines supplied within a 20-minute appointment. A mental health nurse and pharmacist technician managed the clozapine clinic and could access assistance from a senior pharmacist if this was required. Staff were able to use the electronic system to ensure that all patients on lithium had the appropriate blood monitoring. They were able to access SCR to check that appropriate monitoring had been done by the GP. If it had not been done, staff contacted GPs to ask them to do it.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns and report incidents and near misses and felt confident and supported when doing so. Staff said they were debriefed after incidents and ensured patients, families, carers and other providers such as supported housing staff were updated. Staff also ensured care records were updated. Incidents were reported on their datix system and reflected on within the team. Most teams had a dedicated weekly slot to discuss incidents. Staff said they discussed learning and looked at improvements to patient care such as strengthening joint working and communication with external service providers. The staff survey (of 12 staff members) showed that 91% heard about incidents that happen across the service and learnt from them. Incidents were also discussed at each directorate's performance and quality monthly meetings.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, and recovery oriented. However, some care plans did not include comprehensive physical health care planning.

Community-based mental health services of adults of working age

Since the last inspection the trust had made some slight improvements. Now most patients had a comprehensive mental health assessment and a holistic care plan that demonstrated input from the patient. Patients said they were involved in developing and updating their care plans and received copies. Staff regularly reviewed and updated care plans when patients' needs changed. However, three patient care records in the Croydon Central Assessment and Liaison team in did not have updated care plans even though patients had been supported by the team for more than eight months.

Staff made sure that most patients had a full annual physical health assessment and knew about any physical health problems. Physical health issues were recorded in their electronic patient records and updates were added to patients' progress notes. Staff had updated care plans and recorded correspondence after liaising with specialist health teams. However, seven care records in the Croydon Central Assessment and Liaison team did not have comprehensive physical health care planning. Patients in this team had their immediate physical health needs met by their GPs but physical health care planning should have been in place in order to provide holistic care and support and meet national recommended guidance.

Most care plans were personalised, holistic and recovery-orientated. Care plans showed that patients' views were recorded and addressed a range of issues such as medication, safety, social inclusion, psychological needs and participation with community services.

Best practice in treatment and care

Staff provided a range of treatment and care for patients. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. However, some patients experienced significant waits for individual psychological therapy.

Staff provided a range of care and treatment suitable for the patients in the service. These were delivered in line with best practice and national guidance from relevant bodies such as NICE. For example, the early intervention teams provided a wide range of evidence-based individual and group inventions such as high and low intensity psychological support, psychosocial support, housing and finance support and families and carer support.

Waiting times for individual psychological therapy remained significant. The COVID-19 pandemic had a significant impact on this with most therapy moving to telephone or video calls. The trust waiting times were in line with national waiting time targets with 91% of patients starting some type of treatment within six weeks, and 99% of patients starting some type of treatment within 18 weeks. However, the longest waiting time for individual psychological therapy varied between 31 weeks in the Lewisham directorate to 138 weeks in the Southwark directorate. In December 2020 a recovery plan was put in place for the Southwark directorate which consisted a staffing increase to recruit additional therapists to increase the directorate's capacity to provide therapy and reduce the waiting list. By March 2021 five psychological wellbeing practitioner trainees and three high intensity CBT trainees had been recruited. Alongside this, by March 2021 everyone on the waiting list for individual therapy was contacted and offered additional group therapy. Care coordinators, with support from psychology staff, monitored patients while they were on the waiting list for individual therapy and offered additional support if their needs changed.

Senior leaders were aware of this issue and waiting times were monitored and reported at monthly performance and quality meetings. The trust's community wide service redesign included improving waiting times for psychological therapy as a key outcome. The trust was aiming to increase access to psychological therapy by increasing the number of therapists, increasing the range and level of therapeutic interventions and embedding more psychology therapists within community teams.

Teams were liaising with internal psychology staff and being supported to provide low intensity interventions while patients were on waiting lists for individual psychological therapy. Care coordinators offered face-to-face support and group sessions for patients waiting for individual therapy, which could be accessed in most cases immediately. Patients and carers said that this support worked well while waiting for therapy. Psychology staff within teams helped staff liaise with external providers such as improving access to psychological therapy services and provided one to one sessions for staff to discuss cases and develop their low intensity support skills. Some teams are also operating with a triage system. For example, staff in the Lambeth Leo Community Service team could reassess their patients as patient needs changed and reprioritised them for individual therapy if their need increased.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Care records showed staff liaised with patients GPs and other specialist medical teams where patients required regular physical health monitoring.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. For example, the Croydon Adult COAST team held a weekly physical health clinic addressing patients' health concerns and supporting them to develop and maintain a healthy lifestyle.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Teams used health of the nation outcomes and the mental health clustering tool scales to measure patient progress.

Staff used technology to support patients. Staff used telephone calls and text messaging to update patients. During the high of the COVID-19 pandemic staff were using telephone and video calls to see patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service was using perfect wards audits. Senior staff supported managers and matrons in auditing care records. Staff were proactive in developing their own internal quality improvement initiatives, for example staff from the Lambeth Leo Community Service and the Croydon Adult COAST team developed their own local staff forums to support staff and engage patients around race and inequality issues.

Managers used results from audits to identify improvement areas. Managers were supporting staff where audits highlighted development areas such as completing care plans, and risk physical health assessments.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Staff had the range of skills needed to provide high quality care. Managers supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Community-based mental health services of adults of working age

The service had access to a full range of specialists to meet the needs of each patient. All the teams were multidisciplinary. Staffing establishments varied from team to team, but included psychiatrists, trainee doctors, registered nurses, support workers, occupational therapists and psychologists.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff found their colleagues to be skilled and experienced.

Managers gave most new member of staff a full induction to the service before they started work. Staff said induction processes were thorough for agency staff although some permanent staff felt their induction could have been more comprehensive.

Managers supported staff through regular, constructive clinical supervision and appraisal of their work. Staff said they were able to discuss their wellbeing, case management, personal and professional development and to reflect on and learn from practice.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Staff attended regular business and governance meetings.

Managers made sure staff received any specialist training for their role. Staff said there was an extensive range of mandatory and specialist training on offer to develop their professional competence. For example, staff in the Lambeth Leo Community Service were accessing cognitive behavioural therapy for psychosis training.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed strong communication and team working across four team meetings attended by a variety of clinical and non-clinical staff. Staff valued these meetings. Staff felt they supported learning across their teams and encouraged holistic care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfers of care. Most teams had opportunities to share learning across their teams. For example, the Croydon Central Assessment and Liaison team held weekly learning sets within the team that covered a range of topics such as post-traumatic stress disorder, emotionally unstable personality disorder and autism.

Staff had effective working relationships with other teams in the organisation. Care records showed communications and updates on patient care with other teams. Staff said they regularly liaised with other teams such as integrated psychological therapy, mental health wards and home treatment teams

Staff had effective working relationships with most external teams and organisations. Staff developed positive relationships with GP services and approved mental health professionals. For example, teams in the Croydon directorate had started to work with GPs to support patients approaching discharge and teams in the Southwark directorate were providing GPs with teaching sessions. Advocacy staff said that when they supported patients, they found the working relationships with the service to be positive. However, advocacy staff stated that outside of the direct patient work communication on service updates could be slow at times.

Community-based mental health services of adults of working age

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. They received training on the Mental Health Act and knew how to access support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had access to information about independent mental health advocacy. Advocacy details were on clear display at team premises. Independent mental health advocates said that Mental Health Act tribunal system for the patients worked well. Patients felt listened to and were able to voice their views.

Staff now explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Records showed staff explained patients' rights and documented in line with Mental Health Act (MHA) Code of Practice. Staff now kept accurate records of consent to treatment.

For patients subject to a Community Treatment Order (CTO), staff completed all statutory records correctly and ensured patients' rights where explained and documented it. The electronic patient records system indicated if a patient was under a CTO. Teams used CTO tracking documents to monitor CTOs and this was included in the service's monthly audits. Records showed patients were involved in reviews of CTO and tribunals.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They received training on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received training in the Mental Capacity Act and knew where to get accurate advice on Mental Capacity Act. The Mental Capacity Act was included in mandatory training. There was a policy on the Mental Capacity Act, which staff knew how to access.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff told us that they assumed that patients had capacity, and a capacity assessment would only be arranged after the initial assessment if evidence suggested that a patient's capacity was lacking. Records showed assessments of patients' capacity in line with the underlying principles of the Mental Capacity Act.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Community-based mental health services of adults of working age

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Patients said staff were respectful, attentive, non-judgemental and caring, and tailored care to individual needs. Patient also reported staff provided help, emotional support and advice when they needed it. Patients said staff treated them well, behaved kindly and were responsive to patient needs.

Staff supported patients to understand and manage their own care treatment or condition. Care records showed discussions that had taken place with patients with various members of their team.

Staff directed patients to other services and supported them to access those services if they needed help. Patient said staff made them aware of what other services were available to support their care, such as wellbeing hubs and crisis prevention support.

Staff felt comfortable and supported by their colleagues to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential. Patients felt staff were suitably discrete when communicating.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Involvement of patients

Staff involved patients and gave them access to their care plans. This had improved since the last inspection. Patients said they felt involved in their care planning and were now offered a copy of their care plans.

Staff made sure patients understood their care and treatment. Patients reported they received clear information and explanations of their care and treatment. They said they were able to discuss their care with their care coordinators and psychiatrist at regular meetings. Patients also said they felt fully supported and validated throughout the whole process.

Patients were aware of the complaints procedure and could give feedback on the service and their treatment and staff supported them to do this. For example, a patient found their care coordinator's tone a bit patronising but experienced a positive change in the care coordinator when this was fed back.

Involvement of families and carers

Staff supported, informed and involved families or carers. Staff gave carers information on how to find the carer's assessment and supported carers to access the carer support groups. Carers said they found the support groups, enjoyable, empowering and gained useful advice and learning. Staff updated carers when required, for example providing copies of relapse prevention plans.

Community-based mental health services of adults of working age

Staff informed and involved families and carers appropriately. Care records showed some patients had carer engagement and support plans in place. Records also documented clear involvement of families and carers with correspondence and text updates.

Carers felt staff were supportive and non-judgemental. Carers said staff provided good communication particularly around changes to the service through the COVID-19 pandemic.

Staff helped families to give feedback on the service. Carers said they were aware of the services complaints process and were confident in raising feedback directly with care coordinators and managers.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and staff followed up patients who missed appointments patients. However, some patients who did not require urgent care had a significant wait for their referral to be assessed. Some patients experienced delays in discharge.

The service had clear criteria to describe which patients they would offer services did not exclude people who would have benefitted from care. Patients said the service was easy to access.

The service had not met trust target waiting times for seeing non-urgent patients from referral to assessment for all teams. The trust's target wating time for seeing non-urgent referrals was 28 days. From April 2020 to March 2021 the average waiting time for Southwark South Promoting Recovery team was 59 days, for the Promoting Recovery East Croydon team it was 50 days, for the Lewisham Promoting Recovery Neighbourhood 3 team it was 37 days and for the Croydon Central Assessment and Liaison team it was 32 days. Other teams we inspected were all within the 28 days target.

However, managers and senior leaders had oversight of the referral issues and actions were in place to address them. In the Southwark South Promoting Recovery and Promoting Recovery East Croydon teams, dedicated care coordinators had been appointed to manage all referrals. Staff said this had sped up the referral process. The Promoting Recovery East Croydon team also had a clinical service lead leading on referral screenings and allocation to reduce referral waiting times. The Lewisham Promoting Recovery Neighbourhood 3 team introduced a weekly meeting dedicated to patient flow into and out of the team which was led by the team psychiatrist, service manager and team leaders. Staff said this provided a forum to oversee and coordinate incoming referrals and set clear actions that were shared within the team. The Croydon Central Assessment and Liaison had made process on reducing its referral waiting time since the last inspection. Staff said the service had been realigned with GP services in the borough and had introduced a new triage

tool in April 2021 to help process referrals. The team adopted weekend working to ensure all referrals had been through the triage tool and their risk assessments updated. All patients on their referral list were transferred to staff caseloads after patients were risk assessed by the multidisciplinary team at point of referral. Senior leaders were monitoring this and were planning for an evaluation of the new triage tool.

As part of the community wide service redesign each team was also taking action to improve their referral waiting times. The Southwark South Promoting Recovery team and Promoting Recovery East Croydon team were involved in a step-down pilots. These pilots included dedicated 'front door' triage and assessment team to manage all referrals. These teams could assess all referrals and could offer short term inventions and psychological interventions via wellbeing hubs and increase access to psychological therapy services. This aimed to speed up the referral process and start treatment quickly for patients who would benefit from short term and/or psychological interventions. The aim was to reduce the number of referred patients going on to the promoting recovery teams and allow those patients to be seen quicker.

Staff saw urgent referrals quickly. Staff said urgent referrals were reviewed and followed up within 24hrs to 48hrs with face to face contact within five days.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff discussed patients who were reluctant to seek support within team meetings and with managers to generate actions to further support patients. Staff tried to contact people who did not attend appointments and offer support through text messages, phone calls, letters, unannounced visits and welfare checks.

Patients had some flexibility and choice in the appointment times available. Patients said they were able to arrange appointment times that suited them. Where staff cancelling appointments and they gave patients clear explanations and offered new appointments as soon as possible. Patient said most appointments ran on time.

The service monitored waiting lists data and review this in monthly performance and quality meetings.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Care records showed arrangements for a safe and well-supported transfer between service that included planning and assessments details, letters to GPs and other service providers and discharge documents. However, staff were experiencing delays in discharging patients to other services where other services did not have capacity to support discharged patients. This led to patients who were ready for discharge remaining of staff caseloads for extended periods of time. Records showed between December 2020 and May 2021 the service had 122 patients on staff caseloads ready for discharge to primary care services. Senior leaders were aware of this issue and actions were in place to support staff with discharging patients to other services. For example, the Promoting Recovery East Croydon team had appointed a discharge coordinator to facilitate patient discharges and reduce staff caseloads. This team had also appointed a temporary occupational therapist and a temporary support time and recovery worker to support care coordinators giving them more time for focus on discharges. In addition to this, the team was piloting a caseload weighting tool to support decision making around discharges. Across all the teams, managers and team leads were working with individual care coordinators to support patient discharge. Delayed discharges were discussed in multidisciplinary meetings, complex case discussions and supervision sessions. Teams were also working with GP services to strengthen relationships and provide guidance to support discharge. There was a focus on this in the Croydon directorate where GPs did not prescribe anti-psychotic medicines. The community wide service redesign included improving transfer and

discharge to step-down service and primary care services as part of the outcomes. The step-down pilots in the Southwark South Promoting Recovery team and Promoting Recovery East Croydon team had a formalised step-down process with medicine and physical health support, patient and carer led group programmes and peer support, and discharge and support planning with primary care services.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Patients and carers said premises were suitable and provided privacy and confidentiality.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Premise were wheelchair accessible and there was suitable lift access.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This information was clearly displayed at team premises.

The service provided information in a variety of languages and accessible formats so the patients could understand more easily. Leaflets at team premises were available in different languages and format. Staff had a good understanding of the make-up of the local population.

Managers made sure staff and patients could get hold of interpreters or signers when needed. For example, staff could access interpreter services when this was required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers said staff provided information on how to complain.

Staff understood the policy on complaints and knew how to handle them. Staff were aware of the complaints policy and provided patients and carers with information on how to complain.

Managers investigated complaints and shared learning with their teams to improve the service. Staff said that learning was shared through team meetings, supervision, one to one sessions and discussed within the multidisciplinary teams. Significant issues that were identified through complaints were escalated to senior leaders.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Community-based mental health services of adults of working age

Patients received feedback from managers after the investigation into their complaint. Patients said after complaining they still felt fully supported.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff spoke highly of the senior leaders and mangers in the service. Leaders in the service could describe how staff were working to provide safe, high quality care and were striving for excellence. They were aware of the key risks and challenges and were open in sharing them.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Most staff understood the provider's vision and rational for the community wide service redesign. Staff were enthusiastic about the change programme and could see the value of the intended outcomes and how this aligned with their work. Staff displayed the provider's values. Patients said staff were caring, kind and polite and listened to what they had to say.

Culture

Most staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear of retribution.

Most staff felt positive and proud about working for the provider and their team. The staff survey (of 12 staff members) showed that 75% of respondents felt that trust actively promoted equality and diversity for all staff.

Career development was supported. Staff supervision included conversations about career development. Staff said managers supported them in identifying professional development opportunities.

Staff felt able to raise concerns without fear of retribution. Staff said they would feel comfortable in raising any concerns with their colleagues and managers. They felt their views and options would be listened to and acted on. Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian. Posters detailing who to contact if staff needed to speak up were on display in staff areas.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Teams were aware of their performance. Managers and staff knew the issues they were facing and where teams were missing targets and were working to make improvements and mitigate risk. There were effective forums in place to discuss and improve care covering areas such as complex cases, risk, referrals, discharges and clinical audits findings.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The electronic patient records system was effective for documenting patients' needs, planning and monitoring care, monitoring mental and physical wellbeing and recording and updating risk. Patient records were kept confidential.

Service level risks were identified and had corresponding actions to mitigate those risks. Risk registers reflected the issues and challenges face by the service. Risks noted included staffing levels, low compliance in basic life support, immediate life support and promoting safe and therapeutic services disengagement training, referrals waiting times and delays in Mental Health Act assessments. It was notable that there were significant differences between the formats and contents of the different directorate risk registers.

Leaders had oversight of risk and demonstrated an understanding of how to improve performance. Concerns highlighted during this inspection in relation to staffing vacancies, staff caseload numbers, delays in MHS assessments and long waiting times for individual psychological therapy were discussed at multiple levels throughout the service from the frontline staff to senior leadership. There was clear evidence of action to resolve concerns at different levels across the service as well as being included as key outcomes within the community wide service redesign.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers had access to the information on their team's performance collected through clinical audits. This included information on completion of patient risk assessments, care plans and community physical health assessments.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Meeting papers show staff participating in system wide meetings highlighting how the community wide service redesign met the needs of population and improved care and support. partnership.

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

Good ↑

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, and well maintained.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We found significant improvement in the completion and quality of environmental risk assessments, as recommended at our previous inspection published in July 2019. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients as safe as possible.

Staff were knowledgeable about the risks on their wards, and environmental risk assessments had timescales for actions identified as appropriate. We found a plastic bin liner of potential concern on one of the ten wards that we inspected, and fed this back to the trust, who took action to address this, and ensure consistent application of risk management processes across all wards.

Staff could observe patients in all parts of the wards, with parabolic mirrors in place to improve lines of sight. On one ward (being used temporarily in the Ladywell Unit whilst each ward was refurbished), there was an area of poor sight. However, staff were aware of this and had systems in place to reduce the risk.

The ward complied with guidance and there was no mixed sex accommodation. Only one of the wards we inspected was mixed gender at the time of the inspection, with separate areas available for male and female patient's bathrooms, and a separate female only lounge.

Staff had easy access to alarms and patients had access to nurse call systems. As recommended at the last inspection published in July 2019, we found that staff and patients on all wards had access to sufficient alarms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, and well furnished. There was an improvement in the cleanliness and maintenance of the wards since the previous inspection. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing, and carried out regular audits to ensure that appropriate standards were maintained. Ongoing maintenance issues where escalated and addressed at performance and quality meetings. Patients told us that the wards were generally kept clean, and any issues they raised were addressed.

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

Staff followed infection control guidelines, including social distancing. We observed appropriate use of PPE throughout the inspection. Hand gel, face masks and disinfectant wipes were readily available for staff and visitors. Adequate signage and posters were displayed reinforcing infection control measures.

The only seclusion room on ES1 Ward allowed clear observation and two-way communication. It had a monitoring system in place to monitor vital signs whilst patients were asleep, in addition to a camera to monitor patients. It included safe bedding, toilet and washing facilities and a clock for patients to see, and two-way communication system. It also had some artwork visible to patients using it. However, its location in the middle of the ward, was problematic, and staff had to be creative in ensuring the privacy and dignity of patients using it and enabling them to access garden space. This was recorded on the Southwark directorate risk register.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment regularly. Staff recorded checks of emergency equipment bags each week. Physical health examinations, such as electrocardiogram monitoring were carried out in treatment rooms. There were appropriate arrangements in place for disposal of clinical waste.

Safe staffing

The service was taking action to address vacancies in nursing staff, which were impacting on patients' experience on some wards. There were also low rates of staff training in some mandatory areas. Appropriate medical staff support was in place on each ward.

Nursing staff

The service had enough nursing and support staff to keep patients safe, but a significant number of staff vacancies across the wards, which were mostly covered by bank staff. Managers attempted to limit bank staff use as far as possible to those staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

In the inspection report published in July 2019 we found that the trust must continue to address the high number of n he cleanliness and maintenance of the wards since the previous inspection. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing, and carried out regular audits to ensure that appropriate standards were maintained. Ongoing maintenance issues where escalated and addressed at performance and quality meetings. Patients told us that the wards were generally kept cleans, and any issues they raised were addressed.

Staff followed infection control guidelines, including social distancing. We observed appropriate use of PPE throughout the inspection. Hand gel, face masks and disinfectant wipes were readily available for staff and visitors. Adequate signage and posters were displayed reinforcing infection control measures.

Seclusion room

Nursing vacancies on some wards through active recruitment and retention strategies. We saw evidence that the trust had prioritised recruitment of frontline staff. However, staff and patients on some wards told us that when short staffed

it was not always possible to support patients with escorted leave. The trust provided details of 32 incidents recorded when a ward was short staffed in the last six months until 30 April 2021. The majority were on Clare Ward with 15 incidents of short staffing, followed by Ruskin Ward with six incidents. Only one of these incidents included details of the impact on patients' escorted leave.

Due to staffing issues during the pandemic, patients were not always able to have individual meetings with their named-nurse as frequently as they wanted.

Vacancies, and staff absence from sickness across the wards, had been gradually reducing in recent months. In March 2021 the highest vacancies were in the Lewisham and Croydon Directorates (18.8% and 18.7% respectively) and the highest sickness absence rates were in Lewisham with 3.6%. Turnover was largely staying the same averaging around 12%. Staff on most wards told us that staffing vacancies were one of their biggest challenges. For example, on LEO unit, although vacancies were covered by regular bank staff, staff told us that it was not unusual to be one nurse down on a shift. This was mitigated by the ward manager or other senior staff supporting when needed.

The service had enough staff on each shift to carry out any physical interventions safely. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Ward managers told us that they could adjust staffing levels according to the needs of the patients. Staff shared key information to keep patients safe when handing over their care to others. We observed detailed handover meetings between staff shifts, to ensure that all necessary information was passed on.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had completed and kept up to date with most of their mandatory training. However, there were gaps in face-to-face training following courses being postponed during the COVID-19 pandemic.

At our focussed inspection of an acute ward published in March 2021 we found low rates of training in basic and immediate first aid training. Mandatory training rates for face-to-face training remained low as these courses were postponed during the pandemic. The trust was aware of this issue and had an action plan in place working to improve performance. They also had systems in place to ensure that there was a trained staff member with immediate life support training on each shift. In March 2021 basic life support training levels ranged between 37% in the Lewisham directorate to 52% in Croydon. Immediate life support training levels ranged between 54% in Lambeth to 66% in Lewisham, and PSTS (promoting safe and therapeutic services) disengagement training ranged from 44% in Lambeth to 63% in Croydon and Lewisham.

Staff were generally compliant with training in other mandatory courses which could be undertaken remotely. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

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

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after incidents. Staff used a recognised risk assessment tool. Risk assessments were in place for every patient, and these were reviewed on a regular basis. Information was clear, detailed and showed some level of patient involvement in detailing triggers. We found a small number of risk assessments that were not fully up to date, for example a patient had absconded while on section17 leave, but the risk assessment did not reflect this. In another case a recent incident of violence and aggression had not been updated on a patient's risk assessment (indicating only a historical risk of violence). However, by attending handover meetings and speaking with staff it was clear that staff were knowledgeable about patients' current needs and risks.

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to or posed by patients. Staff followed procedures to minimise risks where they could not easily observe patients. Staff were aware of trust policies and procedures to follow when they needed to search patients or their bedrooms to keep them safe from harm.

As noted at the inspection published in March 2021, we still found variable recording of patients' physical health checks across the wards including food and fluid charts not totalled. The trust provided an action plan since that inspection, with timescales for completion not yet reached. Actions taken included training being provided to relevant staff in Electronic Observation (E-Obs) and National Early Warning Score (NEWS). Staff were attending medical devices training and physical health training, and regular audits were being undertaken.

We were concerned to learn of a patient placed on a mixed gender ward despite this being against their care plan. The trust was in the process of investigating this incident, to ensure that learning could be taken forward appropriately.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme. However, reductions in restrictions had not taken place within the last year as planned. Staff told us that they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We observed skilled de-escalation techniques being used by staff across the wards we visited.

Ward staff participated in the trust's restrictive interventions reduction programme including use of the safety huddles, monitoring of low-level incidents, and the Dynamic Appraisal of Situational Aggression (DASA) tool. The trust was aiming to eliminate prone restraint of patients, by training relevant staff to administer rapid tranquilisation in the deltoid

muscle (in the arm). Staff followed NICE guidance when using rapid tranquilisation, ensuring that appropriate physical health monitoring took place afterwards. The trust monitored staff practices in carrying out physical health checks on patients after they receive rapid tranquilisation in line with trust policy and maintained records of patient restraints as appropriate.

The trust had a quality priority to reduce incidents of violence on all wards by 50% and stop prone restraint. However, data indicated that there had not been an overall trend in reduction in the last six months, possibly due to the added pressures experienced during the pandemic. Staff understood the Mental Capacity Act definition of restraint and worked within it and followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was placed in long-term segregation. The trust made us aware of one patient who was frequently in segregation and provided assurance that this took place in line with the guidance in the Mental Health Act code of practice.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role, and kept up to date with their safeguarding training. Directorate records showed that staff were fully compliant with trust safeguarding training targets with competition rates between 85% and 98% for all required courses. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, we saw that staff had spoken out against discrimination against a transgender patient on one ward.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers took part in serious case reviews and made changes based on the outcomes.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. As recommended at the previous inspection the trust had ensured that staff had a clear understanding of safeguarding policies and were making appropriate referrals to local authorities as necessary.

Staff access to essential information

Staff had access to clinical information and had paper and electronic systems in place to maintain high quality clinical records. Patient notes were comprehensive and all staff including bank staff could access them. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

However, we noted that the legal status recorded on the front screen of each patient's case notes was not always accurate. For example, some patients were recorded as informal, despite their progress notes making it clear that they were detained under a section of the Mental Health Act (MHA). This was due to the MHA team alone being able to change the status on the electronic records, which could often lead to delay. It was clear, however, that staff were aware of the correct status of each patient, and this was also recorded on the patient whiteboard on each ward.

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

On approximately half of the wards we visited staff complained of computer/equipment issues causing delay in their work, and therefore impacting on patient care. It was clear that the trust had had to make significant adaptations in increasing staff access to equipment during the COVID-pandemic. However, this remained an issue for many staff on the wards.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy and followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. The trust provided an action plan in response to our inspection published in March 2021, including staff training from the ward pharmacist on Jim Birley Unit, medicines competencies, and audits, monitored on a monthly basis.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff were open and transparent and gave suitable support.

Staff were clear about which incidents needed to be reported including near misses, in line with trust policy. The service had no never events on any wards within the last 12 months.

The wards had experienced an increase in serious incidents during the COVID-19 pandemic period. There were three deaths in this core service in May 2021. Managers investigated incidents and shared lessons learned with the whole team and the wider service. There was evidence that changes had been made as a result of feedback. Staff gave examples of learning from serious incidents including night observations of respiration, and improved searching of items brought in by visitors, following a patient becoming unwell after receiving a visit. Learning from incidents was part of each ward's business meeting, and blue-light bulletins sent to all staff also provided important safety information to all relevant staff.

Staff understood the duty of candour, the need to be open and transparent and give patients and families a full explanation if things went wrong. Managers debriefed and supported staff after any serious incident with a dedicated trust team providing support to wards involved.

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

Is the service effective?

Good  

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were generally personalised and holistic although would benefit from being more recovery orientated.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff developed individual care plans with patients, which they reviewed regularly through multidisciplinary discussion and updated as needed. In the previous inspection report published in July 2019 we noted that some patients did not have care plans to meet all their physical and mental health needs. There had been an improvement in the quality of care plans across the wards. Most care plans reflected the assessed needs of patients, and were personalised, and holistic.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. For example, one patient had a care plan for support with over-eating, with support from a dietitian. A patient needing support with incontinence, had a plan in place to support them including pelvic floor exercises and support to maintain skin integrity. Staff regularly reviewed and updated care plans when patients' needs changed.

However, many of the care plans we reviewed were not recovery-oriented. For example, some care plans did not mention discharge matters even when it was apparent from the rest of the record that discharge planning was advanced. It was also not clearly recorded if all patients had been offered/given a copy of their care plan, and some care plans had little in the way of patient views recorded, despite improvements in the patient's insight.

We found some gaps in patients' physical health monitoring records. Although some patients identified as at risk of dehydration were monitored with a food and fluid chart, these frequently did not include targets or have totals calculated. We raised these individually with staff and were assured that the patients involved were not at risk. We also found that some patients did not have care plans for risk areas identified, such as HIV, or very low body weight.

There were regular audits in place to check on the quality of physical health records. Most wards scored highly with the highest scores on ES1 ward (98%) and John Dickson ward (94%). In March 2021 the lowest scores for physical health recording were on Virginia Woolf Ward and Jim Birley Unit, scoring 76% and 77% respectively. There were action plans in place to address areas of improvement needed.

Best practice in treatment and care

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

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. At the previous inspection published in July 2019 we recommended that the trust should continue to improve the monitoring of patients with specific physical health needs, including blood glucose monitoring for patients with diabetes, and food and fluid intake monitoring. We also made a requirement on this issue in the inspection report of Jim Birley Unit published in March 2021. Significant improvements had been made in physical health care provision across the wards with regular physical health monitoring taking place on the wards. This included electrocardiograms (ECGs), baseline blood testing and diabetic monitoring.

Staff identified patients' physical health needs and recorded them in their care plans and made sure patients had access to physical health care, including specialists as required. Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

When people were prescribed medicines with additional monitoring requirements these were completed and reviewed in line with best practice requirements. For example, patients with constipation as a side effect of medicines, had a bowel chart in place as appropriate. A new physical health recording tool, the Physical Health Hub was being rolled out on some wards including Virginia Woolf and LEO wards.

Patients had access to smoking cessation workers. Care records showed that staff supported patients to be seen by a chiropodist and attend dentist appointments. On ES1 Ward a sexual health consultant visited regularly to provide a sexual health clinic for patients and to answer their queries and questions. One ward held a weekly cannabis group to support patients with substance misuse.

Staff provided information and advice to eligible patients regarding the COVID-19 vaccines to alleviate concerns and encourage uptake. The trust had a very pro-active vaccination programme with a high uptake from staff and patients. Considerable work had gone into challenging common vaccination myths and helping staff and patients think through the advantages of vaccination.

On Leo Ward, staff held a well-attended weekly healthy living group discussing different topics such as nutrition, exercise, and sleep hygiene. They encouraged patients to use an outside and (most recently) an indoor gym.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. They also participated in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Rating scales used included Health of the Nation Outcome Scales and core clusters were used for all patients. We also saw examples of CIWA-Ra (alcohol withdrawal scale) and CGI (substance misuse) improvement scale being used when relevant.

Staff used technology to support patients. On John Dickson Ward staff were piloting Point of Care testing, to measure clozapine levels at the bedside, with results taking seven minutes. On LEO the multidisciplinary team discussed arranging Diagnostic Interview for ADHD in Adults (DIVA) assessments for patients on the ward. One patient was due to

have an assessment during our visit. The clinical psychologist on Clare Ward had published a paper in the British psychosocial journal demonstrating better outcomes and less cancellations when appointments were made by video conferencing. They had also obtained funding for virtual reality headsets to work with patients on known anxiety scenarios. The plan was to begin using these in June 2021.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The ward teams included or had access to a full range of specialists to meet the needs of the patients on the ward. Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. However, at the previous inspection published in July 2019 we recommended that the trust keep the number of clinical psychologists under review to ensure that patients' needs were met. Staff told us that on several wards, particularly at the Ladywell Unit, there was not enough individual psychology support for patients. Some group support was provided by associate practitioners.

All new staff including bank staff and gave each new member of staff a full induction to the service before they started work. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Despite the pandemic, most staff were receiving regular supervision sessions. In our anonymous staff survey of 36 staff across the wards, 89% reported regular clinical supervision, and 78% reported regular management supervision. Managers made sure staff attended regular team meetings or gave them information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. As recommended in the inspection report of July 2019, the trust provided autism training for staff on all acute and PICU wards. However, staff told us that it was not always possible to find time to undertake this and other additional training due to the pressures of the pandemic.

Managers recognised poor performance, could identify the reasons and address them as needed.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. There were named consultant psychiatrists appointed for each ward, and ward doctors told us that they were supported appropriately.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We attended staff handover meetings on eight wards and found that there was a strong multi-disciplinary approach to discussion of each patient, including inhouse pharmacists attending regularly.

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

Ward teams had effective working relationships with other teams in the organisation and external teams and organisations. At one meeting staff discussed support for a carer and considered offering a referral to a family therapy service. One ward with a high number of patients diagnosed with personality disorders had access to a psychotherapist visiting the ward regularly.

Staff had reflective practice sessions available to them following incidents on the ward and told us they found these helpful. Staff including ward managers felt well supported following serious incidents on their wards, with psychology support provided to staff and patients, and counselling available to staff involved. Staff were also able to take compassionate leave if they needed this.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice in line with the trust target.

Detention paperwork was in good order with a small number of exceptions which were addressed without delay.

Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice and requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and could access them when needed. Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Overall we looked at the medicines records of over 40 detained patients. We found one medicine being administered to a detained patient which was missing from a patient's consent to treatment form. We reported this to the relevant consultant psychiatrist who corrected this without delay.

At the start of the pandemic, staff reported some difficulties in carrying out mental health tribunals remotely, due to technical difficulties, but had received improved IT equipment to address this.

Good practice in applying the Mental Capacity Act

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

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles in line with the trust target.

There was a clear policy on Mental Capacity Act (MCA) and deprivation of liberty safeguards, which staff could describe. Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. They assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff reviewed mental capacity regularly for each patient. However, the embedded MCA form on the electronic patient records system were generally not used, with the assessments noted in the ward round templates offering no explanation for the decisions.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Most patients told us that staff treated them with compassion and kindness. Staff were discreet, respectful, and responsive when caring for patients. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff gave patients help, emotional support and advice when they needed it. We saw numerous examples of staff using skilled, and compassionate interactions with patients to prevent them from becoming increasingly distressed. This was very evident during medicines administration.

Where possible, staff took time to find out what was important to patients on the wards. We observed staff ordering a cake for a patient's birthday. Staff were also seen arranging extra support for a patient to attend a relative's funeral.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. We saw an example of staff addressing the issue of trans-phobic comments being made by patients on a ward in a community meeting.

Staff followed trust policy to keep patient information confidential, with information about patients stored securely.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. However, there was some variability in the recording of patients' views across the wards. Some care plans had little in the way of patient views recorded, even when insight and the ability to express views had improved over the course of their admission.

Patients were able to attend ward rounds and their views were recorded when they did so. We saw some evidence of carers/relatives being involved in ward rounds remotely with the permission of the patient involved. On Claire Ward the consultant psychiatrist had changed the format of the ward round so that it now lasted 30 minutes per patient. Junior doctors spoke with the patients and relatives before the ward round with increased preparation time leading to much more engagement with patients and their families.

Staff made sure patients understood their care and treatment and found ways to communicate with patients effectively including use of interpreters where appropriate.

Staff made sure patients could access advocacy services. Following some initial delays during the COVID-19 pandemic they adapted to new ways of ensuring that patients had access to independent advocates. Wards in Croydon had managed to maintain a high level of referrals to the advocates, so that the Croydon advocacy team met its target for contacts despite the pandemic.

Staff enabled patients to give feedback on the service they received, for example, by completing surveys, and attending community meetings on each ward. Community meeting records indicated that patients spoke up about issues of concern to them, ranging from food, hygiene, staff support and activities.

Peer support workers provided extra support to patients on some wards, assisting them with activities and leave, with the benefit of having experience of using similar services themselves.

Due to staffing issues during the pandemic, patients were not always able to have individual meetings with their named-nurse as frequently as they wanted.

Several patients told us that they would like to have more activities available to them on the wards but were aware of the pressure on staff during the pandemic. Staff told us that the range of activities available were improving as pandemic restrictions were lifted.

Involvement of families and carers

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

Staff supported, informed and involved families or carers. However, there was some variability in the way in which staff informed and involved families and carers during the COVID-19 pandemic. Some relatives/carers found it very difficult to get through to the wards and get information or be involved and found this very upsetting. Some wards continued with regular weekly carer forums remotely during the pandemic, but others did not.

Restrictions on family or friends visiting the wards and leave away from the hospital sites, were experienced as very difficult for patients and carers. However, these were implemented based on risk for IPC reasons. Exceptions were made for patients whose visitors provided care and support essential to their wellbeing, or when not permitting visits would cause significant distress to the individual. For example, on one ward an exception was made when a patient restricted their food and fluid intake.

LEO ward was implementing the 'trusted friend principle' to increase family/friend involvement. This involved patients nominating a relative/friend who would be asked to agree to help staff communicate with them if they were feeling distressed while on the ward. This person would then be contacted to listen to the patient and explain how the patient was feeling on their behalf. Wards had tablets and a laptop provided for patients to communicate with relatives/friends.

Is the service responsive?

Good 

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

Access and discharge

Staff managed beds well but due to the significant pressures experienced during the COVID-19 pandemic, there were significant bed pressures across the wards.

Bed management

Although staff worked hard to ensure that beds were available when needed, the significant pressures experienced during the COVID-19 pandemic meant there were significant bed pressures across the wards. In the previous inspection report published in July 2019, we found that there were improvements needed in the patient flow between acute and PICU wards, leading to patients remaining on wards with higher levels of security than they needed. During the current inspection we found that there remained significant delays in patients being discharged from ES1 Ward (a PICU unit). Data provided by the trust indicated that while there had been an improvement in the time taken for patients waiting once referred out of the three male PICU units over the last two years, this had deteriorated for the female PICU (ES1) increasing by 4.7% in the last year. The Southwark directorate had an improvement project in place to address this issue including escalation of patients ready to be discharged, prioritising transfers, and ensuring least restrictive practice while patients referred out remain on the PICU ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The trust had taken action to address patient flow since the 2019 inspection, including appointing a flow director, and flow leads who contacted wards twice daily. With the onset of the pandemic they had added a further two extra bed escalation meetings daily attended by the service directors. The original flow plan of 2019 achieved a significant reduction in out of area placements. However, this had since risen to 98 in March 2021 during the pandemic. Staff fed back that there

remained considerable pressure put on the wards to discharge and to admit patients. Some staff also mentioned concerns about earlier discharges of patients leading to a higher rate of re-admissions of patients within 30 days of discharge. We noted that on Southwark wards re-admission rates had increased from five to 17 between February and March 2021, whilst average length of stay reduced from 30.78 to 29.6 during this period. Correlations were less obvious within the other directorates. In Croydon it was noted that there had been five readmissions on Fitzmary 1 Ward during this period. The trust target was for 85% bed occupancy but this had not been achieved within the last 12 months. They were working to achieve this as soon as possible.

The pandemic had led to a significant increase in patients being moved ward at night to facilitate timely out of hours admissions to COVID-19 isolation wards. However, the trust stepped down the COVID-19 isolation ward pathways as soon as it was deemed safe to do so in March 2021. Staff on Fitzmary 1 and Virginia Wolf wards (the trust designated female and male COVID 'cold' isolation wards) spoke of the immense pressures they had faced at the height of the pandemic, noting that bed pressures had eased since they returned to being acute wards.

Discharge and transfers of care

The service was working hard with local partners to reduce the numbers of delayed discharges and managers monitored the number of delayed discharges. They had taken steps to address issues of delays caused by lack of appropriate accommodation. The trust had identified some step-down accommodation sites for patients who had no other address available for discharge.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Gresham 1 Ward was piloting a barriers to discharge Quality Improvement project known as the Right Care project. The project aimed to ensure that discharge and any potential barriers to discharge were discussed for each patient upon their admission, with set actions for staff to complete in reducing barriers. They were also working to ensure that discharge summaries were being sent to GPs and community teams within 48 hours of discharge. Following adjustments, they looked at 10 random samples, and found that they were being sent out within 24 hours of discharge.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of most wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Significant improvements had been carried out in the Ladywell Unit, providing a more comfortable environment despite the building not being fit for purpose. There was a plan in place for the long-term relocation of this service, but the trust was investing in significant improvements to the unit in the interim period, to make it as safe as possible. Despite significant improvements at the Ladywell Unit, the design and layout of the wards was not therapeutic to support patients' treatment. The trust had made the decision to relocate this unit in the coming years.

On all wards across the trust each patient had their own bedroom, which they could personalise. As recommended at the previous inspection, patients on LEO Ward were provided with adjustable vision panels on their bedroom doors, to ensure their privacy and dignity.

Patients had a secure place to store personal possessions. Staff used a full range of rooms and equipment to support treatment and care. Each ward had quiet areas and a room where patients could meet with visitors in private. Patients told us that they could make phone calls in private.

Wards had access to an outside space that patients could access with staff support. Patients could make their own hot drinks and snacks and were not dependent on staff except on ES1 PICU where staff supported them when they wanted hot drinks/snacks. The service offered a variety of good quality food, and most patients told us that they were satisfied with the quality and quantity meals provided.

On ES1 Ward, patients had access to a sensory room, with soft padding and bean bags including a sensory touch wall and projector for patients to watch movies, and sensory lighting. This room was particularly helpful for patients with a diagnosis of autism, learning disability or emotionally unstable personality disorder. It was also useful as a low stimulus area for patients to get away from the noise of patients in the communal areas. Gresham 1 Ward also had a sensory room available to patients.

Wards had a range of activities available for patients to engage in including a computer room, and books. On Ruskin Ward there was a Netflix account so that patients could access programmes. There were a number of fitness and relaxation groups. Patients on one ward particularly enjoyed a yoga group in the garden. Other groups included grooming sessions, art groups, mental health support and coping mechanisms, smoothies' groups, and healthy eating groups.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff attempted to support patients with access to opportunities outside of the wards. However, due to restrictions placed on patients during the COVID-19 pandemic this was largely by virtual means.

Staff helped patients to stay in contact with families and carers, although carers indicated that support was variable between wards.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service was able to arrange interpreters and signers if they were required, and we observed an interpreter attending a ward round on LEO Ward during the inspection.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Managers provided teaching for staff to be sensitive to the needs of transgender patients and ensure that they respected how each patient wanted to be addressed. Staff held events during Ramadan and during Black History month. One staff member described how they supported a patient observing Ramadan to have a hot meal each time when they broke their fast. Staff also told us that they had a rainbow lead champion and had recently celebrated LGBT+ month.

The service had information leaflets available in languages spoken by patients in the local community. The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients had access to spiritual, religious and cultural support provided within each hospital.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Most patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas on each ward. However, some patients told us that they waited a long time for formal complaints to be addressed. During the pandemic, the complaints process was paused for three months in line with national guidance. However, the trust worked to ensure that all complainants received acknowledgements and an explanation for any delays. They also introduced a triaging process to ensure prompt risk assessment for any issues raised that needed urgent attention.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff gave examples of changes made as a result of a complaint. For example, following a patient property incident, learning included ensuring all property was labelled, and that patients were provided with the use of lockers.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints about a lack of empathy amongst staff when communicating with patients on one ward, were addressed by staff having a session about the use of 'soft words' and verbal de-escalation.

The service also used compliments to learn, celebrate success and improve the quality of care. Staff shared cards and letters of thanks received from patients with their colleagues on each ward.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff spoke particularly positively about the new CEO of the trust, described as very visible, supportive, approachable and present. They also spoke highly of the new service director in Southwark, and his impact on producing a more inclusive atmosphere.

Leaders in the service could describe how staff were working to provide safe, high quality care and were striving for excellence. They were aware of the key risks and challenges and were open in sharing them.

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

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff spoke of supportive team cultures on their individual wards, with recognition from management for the extra pressures involved during the pandemic. Staff on Gresham 1 Ward won an internal trust award for how well they managed during the COVID-19 pandemic. We were very impressed by the resilience of staff despite some exhaustion following waves 1 and 2 of the COVID-19 pandemic. Most patients said staff were caring, kind and polite and listened to what they had to say.

Culture

Most staff felt respected, supported and valued. They said the trust was working to promote equality and diversity in daily work and provided opportunities for development and career progression. Most but not all staff felt able to speak up about their concerns.

Most staff we spoke with told us that they felt respected, supported and valued. They reported that the provider was working to promote equality and diversity in its day-to-day work and in providing opportunities for career progression. However, some said that they had experienced barriers to career progression, or previous bullying within the trust. We carried out an anonymous staff survey on the wards covered in this inspection, which was completed by 36 staff members. Responses indicated that 56% of those surveyed thought there was a strong emphasis on the welfare of staff within the trust, and 20% disagreed. Responses indicated that 76% thought that communication from senior managers was effective.

We found that 56% of respondents to the staff survey reported being often unable to take a break when they were due to do so. On Ruskin Ward there was a poster about coping with stress during COVID, encouraging staff to take regular breaks and use the Rest and Recharge site at Maudsley Hospital. This included an advice and support line available and links to a coronavirus resource page on the intranet. Staff on some wards told us that colleagues had been referred to occupational health for additional support during the pandemic.

Our findings from the staff survey (of 36 staff members) indicated that 73% of staff said that it was safe to report concerns without fear of what would happen as a result. In addition, 61% felt confident using the trust's freedom to speak up process. However, three staff members (8%) did not feel that it was safe to raise concerns, and six (17%) did not feel confident raising concerns through the organisation's freedom to speak up process.

The survey indicated that in the last 12 months, 19 staff members reported experiencing physical violence at work from patients or other members of the public, and only one had not experienced verbal abuse. Overall 86% of staff told us that they had not experienced bullying, harassment or abuse from managers, and 80% had not received this from colleagues in the last 12 months. Seven (20%) had experienced harassment, bullying or abuse at work from colleagues, and six, had experienced this from managers. Three staff said that they had not reported this. Of those who had reported concerns about bullying and harassment to the trust at any time, seven were satisfied with the result, and seven were not (26%). The trust had recently introduced changes to the disciplinary processes following concerns raised by staff and had introduced Listening into Action surveys and sessions for staff to discuss improvements needed.

Ideas for improvement from staff completing the survey included more support for those raising concerns, including an update on what is being done (if appropriate), and staff (including bank staff) completing training in physical restraint and disengagement (PSTS) prior to staff working on the wards.

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

Many staff told us that they were struggling with the impact of the pandemic on the severity of patients' mental health on admission, coupled with the pressure to discharge patients as soon as possible to make beds available. The trust had introduced a number of wellbeing initiatives to support staff during the pandemic. These included access to a new supportive mental wellbeing community, with access to counsellors and online support, and access to resources to help manage stress.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Ward teams were aware of their performance. Managers and staff knew the issues they were facing and where they were missing targets and were working to make improvements and mitigate risks.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Service level risks were identified and had corresponding actions to mitigate those risks. Risk registers reflected the issues and challenges face by the service. It was notable that there were significant differences between the formats and contents of the different borough risk registers.

In the previous inspection report published in July 2019, we noted that the trust should ensure that issues raised on the wards were reflected on local risk registers as necessary and further embed communication across the boroughs regarding learning from incidents. We looked at the risk registers for the four directorates on this occasion and found that these did reflect the issues raised by staff and patients on the wards, and findings from recent incidents. Risks noted included staffing levels, access to personal protective equipment (PPE), fire safety, availability of beds, IT access, and managing the COVID-19 pandemic particularly on ES1 ward where patients with and without COVID-19 were accommodated as the only female PICU unit. Some also included violence and aggression, prone restraint, and rapid tranquilisation. The trust was using the Perfect Ward auditing tool to monitor performance across the wards, with performance scrutinised at monthly performance and quality meetings.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, staff on several wards including Virginia Woolf, Gresham 1 and Wharton wards told us that intermittent issues with computers and IT made accessing and inputting information very time consuming at times.

Managers had access to information on their team's performance collected through clinical audits. This included information on completion of patient risk assessments, care plans, physical health care and medicines administration.

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

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff engaged actively in local and national quality improvement activities. These included local quality improvement initiatives to implement Four Steps to Safety, including safety huddles, intentional rounding (checking in with patients regularly). Gresham 1 Ward staff were undertaking a pilot project looking at barriers to discharge. John Dickson Ward staff were piloting Point of Care testing, for clozapine levels, with results produced in seven minutes. On LEO Ward the multidisciplinary team arranged ADHD assessments for patients on the ward. The clinical psychologist on Clare Ward had obtained funding for virtual reality headsets to work with patients on known anxiety scenarios. The plan was to begin using these in June 2021.

Following an incident several years previously resulting in the death of a patient whilst being restrained by police, the trust and metropolitan police had produced a collaborative training video, about expectations from trust staff and police. This included undertaking a thorough risk assessment, and safe restraint and communication.