South London and Maudsley NHS Foundation Trust

Long stay or rehabilitation mental health wards for working age adults

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Good**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement ➔➔

We carried out this unannounced comprehensive inspection to follow up on concerns found at our last inspection of 2019, when we rated the trust overall as requires improvement.

We inspected the three inpatient rehabilitation wards; Heather Close (24 beds), Tony Hillis Unit (15 beds) and Westways (18 beds) .

Our rating of services stayed the same. We rated them as requires improvement because:

- There was insufficient oversight of performance and quality on the three rehabilitation wards, to pick up on inconsistent blanket restrictions, and key performance indicators specific to the rehabilitation pathway.
- Care plans for patients on Heather Close and Tony Hillis Unit were not available in a format that patients could easily understand, with clear goals set to work towards developing independence skills and discharge. On Westways this issue had been addressed through the use of a ward round action plan.
- Patients gave varying reports about the meals provided on the wards particularly to meet dietary and cultural needs. There were insufficient opportunities for self catering on the wards.
- Although there were procedures in place to enable patients to develop self administration of medicines on the wards, at the time of the inspection no patients had progressed beyond the first stage of this process.
- Emergency grab bags on the wards only included one size of airway tube to enable resuscitation (although this was reviewed immediately following the inspection).
- Some staff spoke of a need for improvement in the culture between staff at Heather Close, to ensure that all staff felt valued and respected.
- The layouts on Heather Close and Westways made it difficult for patients to focus on activities held in the dining room or lounge areas.
- Staff retention and vacancies on the wards had been an issue, leading to significant use of bank (as and when) staff which impacted on the relationships developed with patients.
- Staff on the wards noted that they were sometimes under pressure to admit patients that they did not think were ready for rehabilitation, leading to longer lengths of stay.

However:

- There were improvements in the development of a clear strategy for rehabilitation across the service, and in introducing rehabilitation goals for patients to work towards.
- Each ward had a positive atmosphere and we saw good interactions between staff and patients, particularly on Tony Hillis Unit. In-reach and in-house peer support workers were making a difference to patients' support.
- There was good involvement of relatives/carers across the wards when patients consented to this. There was effective participation of patients and relatives in ward rounds.

Our findings

- There was an effective multi-disciplinary team mix on each ward and we found significant improvements in physical health support for patients.
- There was a low use of physical interventions, and reduced blanket restrictions had been put in place across the wards.
- We found improvements around the management of medicines, and clinic rooms across the wards. Patients were able to have conversations about their medicines with staff as needed and staff monitored patients' physical health care providing support.
- On Heather Close the psychologist was piloting virtual reality headsets for patients experiencing anxiety, as well as for staff wellbeing interventions. Staff at Tony Hillis Unit continued to facilitate a group in conjunction with the forensic personality disorder community team to support patients with substance misuse problems alongside their mental health problems.
- Staff at Heather Close continued to involve patients in chairing their Care Programme Approach meetings co-producing the questions they would ask to facilitate the meeting.

How we carried out the inspection

This inspection was unannounced. It involved a three-day visit to the wards and was followed up by interviews with carers and a video call meeting with senior managers.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- toured the service environment
- observed how staff were caring for patients
- conducted a structured short observational framework for inspection to observe the ward culture on one ward
- observed 2 multidisciplinary handover meetings, part of a ward round, a referrals meeting and a care improvement service meeting
- observed some patient activities including a music appreciation group
- spoke with 9 patients who were using the service
- spoke with 11 relatives/carers of patients using the service
- spoke with the 2 ward managers, a practice development nurse and clinical charge nurse
- spoke with 30 other staff members across the multidisciplinary teams including consultant psychiatrists, speciality doctors, occupational therapists, clinical psychologists, activity coordinators, registered nurses, clinical support workers, a pharmacist, a peer support worker, a housekeeper, student nurses and bank (as and when) staff
- reviewed 15 patient care and treatment records
- reviewed 32 patient medication administration records
- looked at documents related to the running of the service

Our findings

- spoke with the service directors for Lewisham and Croydon, and the South London Partnership programme director for the complex care pathway.

You can find further information about how we carry out our inspections on our website: https://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 provided them with help, emotional support and advice when they needed it. They said that staff were sensitive to them, and gave them space when they needed to be alone. Although they said that there were often changes in staff, patients noted that staff were generally cheerful, listened to them and did not speak over them.

Patients said staff treated them well and behaved appropriately towards them knocking and waiting for an answer before entering their bedroom, to respect their privacy and dignity. They said that they were shown around the wards on admission, and given a welcome pack with information about the wards.

Patients generally felt safe on the wards, and had a primary nurse who they had regular contact with. They said that staff were available to support them, although they were often busy, and had a lot of records to complete. They said that staff involved them in making decisions about their care.

Patients and their family members told us how they had made progress since being at the service through the support and care of the staff. Most knew how to contact an advocate if they wished to, and how to make complaints or suggestions about the wards. Some patients were frustrated with the length of time they had been on a rehabilitation ward.

There were mixed reports about the quality and choices of food available on the wards. In general patients were satisfied with activities available to them on the wards. On Tony Hillis Unit, patients told us that there were few activities available at weekends.

Is the service safe?

Good 

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

Safe and clean care environments

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

Safety of the ward layout

Patients told us that they felt safe on the wards. Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff conducted environmental checks every hour and took action to address any areas that required attention. The ward layouts varied across the three units. Each of the wards had some blind spots, which were mitigated by the use of convex mirrors.

Our findings

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. There were some ligature risks on all the wards, but these had been identified, and were managed by continuous or intermittent observations. Staff had access to a ligature risk assessment for each ward including photographs of particular risk areas. They were aware of the ligature anchor points, and how to reduce the risk of them being used. New staff confirmed that ligature risks on the ward were covered during their induction training on the ward.

The wards complied with guidance on eliminating mixed-sex accommodation. All patients had their own bedrooms. Tony Hillis Unit was a male only ward, patients had shared bathroom and toilet facilities. Westways was mixed gender. Male and female areas on Westways were segregated by key controls. Patients had shared bathroom and toilet facilities, which were within the male and female segregated areas. Heather Close had one male only unit as well as one mixed-gender unit. A swipe card system had been installed for patient use so that males and females only had access to their own bedroom area. All bedrooms at 5 Heather Close were ensuite. Staff understood the importance of ensuring bedroom areas remained segregated. Mixed wards had single gender lounges available for patients to use.

Staff and patients had easy access to alarms and nurse call systems. All units had wall-based panic alarms. At Tony Hillis Unit and Westways, staff also used a handheld alarm due to the acuity of the patient group. At Heather Close staff carried radios to communicate with each other. There were no seclusion rooms on the wards. Some staff at Westways noted that the lack of space on the ward made it difficult to manage patients with higher acuity.

Staff undertook weekly fire alarm tests and fire drills on each ward every six months. As recommended at the last inspection in 2019, personal evacuation plans were in place for patients who refused to leave the building in the event of a fire drill. Fire extinguishers were available on all the units and all staff knew where the extinguishers were kept and had a key to access them.

Maintenance, cleanliness and infection control

All ward areas were kept clean, comfortably furnished and were well-maintained. The ward environments were visibly clean and clutter free. Patients were generally satisfied with the cleanliness, although a patient on both Heather Close and Tony Hillis reported occasional odours of urine in the corridors. Staff followed infection control policy, including handwashing, and were aware of protocols to follow in the event of an outbreak of infection including use of personal protective equipment.

Staff made sure cleaning records were up-to-date and the premises were clean. Each unit had dedicated domestic staff responsible for cleaning. Staff and patients said that the levels of cleanliness on the wards were generally good and that repairs were addressed promptly.

Clinic room and equipment

Clinic rooms were well equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff kept an emergency grab bag containing lifesaving equipment in the clinic rooms. Staff undertook checks to ensure all items within the bag were kept in line with trust policy. There was only one size of airway tubing (for resuscitiation) available on the wards, and we brought this to the attention of the trust, who undertook to review this, in line with Resuscitation Council guidance. Following the inspection the trust ordered airway tubing in three sizes for emergency grab bags, and put in place training for staff about their availability.

Our findings

Staff checked, maintained, and cleaned equipment. Records showed that staff checked emergency equipment weekly. There was an emergency drug box in each clinic room. Equipment was labelled with the date it was last checked and calibrated. Staff cleaned equipment after use and weekly in line with a cleaning schedule. Staff kept records of cleaning checks, and these were generally up to date, although there were some gaps in records in the clinic rooms at Heather Close. Staff used a sharps bin to dispose of needles and sharps, and these were dated on opening, and not over-filled.

Safe staffing

The service had taken action to address shortages in nursing and medical staff, however there were some issues with retaining staff.

Staff knew the patients well, and received basic training to keep people safe from avoidable harm.

Nursing staff

Managers had calculated the number and grade of registered nurses and non-registered nurses required on each shift. The number of registered nurses and non-registered nurses matched this number on most shifts. Managers and staff on all units reported that there were usually sufficient staff deployed on each shift to keep patients safe. Managers were aware of their vacancies and recruitment to fill vacant posts was ongoing. At the time of the inspection, we found that there were no vacancies at Heather Close, Tony Hillis Unit had one registered nurse vacancy at band 6, and Westways had two registered nurse vacancies at band 5, and two non-registered nurse vacancies. The staff vacancy situation had improved significantly from the previous year, although managers were aware that staff retention was still an issue.

Staff and managers felt supported by senior management, in their approach to ensuring wards were staffed safely. The trust had worked hard to reduce vacancy rates and ran ongoing recruitment programmes. The wards were safely staffed with the use of regular bank nurses and permanent staff working additional shifts. When necessary, managers deployed bank nursing staff to maintain safe staffing levels they were staff who came to the wards regularly and were familiar with patients and ward routines.

All three wards held safer staffing huddles, to ensure that there were sufficient staff on each shift, using the trust's Safe Care System. Heather Close had experienced significant staff sickness in recent months. Tony Hillis Unit had some long term staff sickness, resulting in increased use of bank staff covering.

Westways, had experienced recent staff shortages due to an outbreak of Covid-19 on the ward, which included staff affected, and difficulties arranging cover from bank staff. They had experienced a high turnover of staff including some staff being promoted within the trust. They were looking to increase staffing at night by one staff member to meet the acuity of patients on the ward.

Managers supported staff who needed time off for ill health. Westways had the highest rate of staff sickness in March 2023 with 6% sickness for registered nurses, and 20% sickness for non-registered nurses. For the same month Tony Hillis Unit had 15% sickness for registered nurses, and 2% sickness for non-registered nurses, and 4% registered and 3% non-registered staff on Heather Close.

All units we visited had high levels of bank staff use to ensure the agreed numbers of staff were present. Bank staff covered staff vacancies and sickness and enhanced observations for patients when needed. Bank staff received an induction to familiarise them with the ward and completed a checklist to demonstrate they had been inducted to the ward. There was always a permanent member of staff on shift. Patients' escorted leave, one to one sessions with named nurses, and ward activities were rarely cancelled because there were too few staff. Patients said they could speak to their named nurse or a member of staff when needed.

Our findings

Staff turnover for the units was highest on Tony Hillis Unit, at 10% for registered nurses, and 36% for non-registered nurses at the end of March 2023. This compared with a turnover rate of 21% non-registered nurses on Westways, and 4% registered, and 9% non-registered nurses on Heather Close.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the wards quickly in an emergency. Teams could access a consultant psychiatrist promptly when they needed one. Medical cover on each ward was provided by a consultant, with support from a ward doctor or a specialist doctor. Managers made sure all locum medical staff had a full induction and understood the service. On Heather Close there was a locum consultant psychiatrist in place for the ward providing full time medical cover, who knew the patients well.

Staff told us that there was adequate medical cover to meet the needs of patients. Ward staff had access out of hours to a duty doctor and consultant. A doctor could attend the wards promptly when needed.

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff training rates on Tony Hillis Unit were lower than on the other rehabilitation wards in basic life support at 67% compared to 90% on Westways, and 96% at Heather Close at the end of March 2023. Training in immediate life support was 100% on all the wards.

Whilst the other wards largely met the trust target of 85% or above, Tony Hillis Ward had fire warden training at 56%, and clinical supervision training at 50%. Training in the national early warning score (NEWS) was low across the units, at 48% on Tony Hillis Unit, and 64% at Heather Close, and 77% at Westways, at the time of the inspection.

The Lambeth directorate governing Tony Hillis Ward trust reported that all staff members with gaps in training has been emailed personally to complete non-compliant areas, and that this would be followed up. As mitigations they had put daily safecare huddles in place and ensured that rosters were managed to ensure that sufficient trained staff were working on each shift, with support from senior staff as needed.

The mandatory training programme was comprehensive and met the needs of patients and staff. The promoting safer and therapeutic services training for staff was being replaced with new Seni Lewis training in de-escalation and safe use of restraint (introduced following the tragic death of Seni Lewis within the trust). This included online and face to face learning, to work towards levels 1, 2 and 3. At the end of March 2023, staff completing this new training was at 72% on Tony Hillis Unit, 59% at Heather Close and 65% on Westways. All remaining staff were booked on the next available courses.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They had reduced restrictions on the wards whilst maintaining safety in order to facilitate patients' recovery. However, some inconsistent restrictions remained in place.

Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Our findings

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

During the inspection, we reviewed the risk assessments of patients across all three units. Staff had completed a risk assessment for every patient on admission and updated it regularly for most patients, including after any incident. Staff at each of the units formally reviewed risk assessments at care planning meetings and ward rounds using a standard risk assessment tool. Staff prepared a risk management plan for each patient detailing risks specific to the patient and how staff should respond to these risks. Risk assessments were individualised and considered the patients' mental and physical well-being, for example, their risk of harm to themselves or others or risks from medical conditions such as diabetes.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks, but there were some inconsistencies in restrictions across the wards. Staff identified and responded to changing risks to or posed by patients. They discussed any changes in patients' behaviour at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings. We observed handovers and a ward round and found them to be effective at discussing risk areas.

Staff said they regularly checked patients' vital signs and recorded these on a NEWS chart. NEWS is a tool developed by the Royal College of Physicians, which improves the detection and response to clinical deterioration in adult patients. It is a key element of patient safety and improving patient outcomes. Staff knew when and how to escalate concerns about NEWS scores.

Staff followed procedures to minimise risks where they could not easily observe patients. They followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff completed observation records for each patient in accordance with trust guidance. Staff knew the levels of observation patients required, and varied the times at which they conducted observations. Staff said they had received training on how to conduct searches. Staff at Heather Close and Tony Hillis Unit staff said that all patients were searched on their return from unescorted leave, whilst this was risk assessed individually at Westways. There were random room searches including searches for illegal drugs using dogs on a regular basis.

Wards had reducing restrictive practice meetings on a monthly basis, but there was further work to do to improve consistency in reducing restrictions and enabling positive risk taking. At Heather Close and Tony Hillis Unit patients used plastic cutlery and plates at mealtimes. However, on Westways ordinary crockery and cutlery were in use. At 1 Heather Close patients could not use the garden area unsupervised, whilst this was possible at 5 Heather Close. Only patients at Heather Close were given keys to lock their bedroom doors. We discussed this with the trust who undertook to review this issue.

Patients at all units could make drinks at any time and there was no limit on takeaways, other than agreements made with individual patients in their care plans. Bathrooms were kept open, and there were no late night restrictions on watching television in the communal lounges.

Staff adhered to best practice in implementing a smoke-free policy. Patients were able to purchase e-cigarettes onsite. Other nicotine replacement therapies were also available.

For patients who required this, personal emergency evacuation plans were in place to follow in the event of a fire or other emergency.

Our findings

Use of restrictive interventions

Levels of restrictive interventions were low. We were informed by the ward managers that restraint rarely occurred. There had been no use of prone restraint (face down). Incidents of restraint were reported following the trust's incident reporting procedure. Staff had improved recording of details of how each restraint took place such as which member of staff held which part of the patient's body. Staff used restraint only after de-escalation had failed and used the correct techniques.

The wards in this service participated in the provider's restrictive interventions reduction, the 'safe wards' programme. The 'safe wards' programme aimed to reduce conflict and incidents on hospital wards. The programme recommended specific actions for staff in response to potential triggers to incidents. At Heather Close staff held a daily safety huddle, to discuss and minimise risk areas as part of the safe wards methodology.

Staff had been trained in physical interventions as part of their mandatory training. This meant that staff had the required skills to deescalate patients who became aggressive to minimise the use of restrictive interventions. Staff had also been trained in how to restrain people safely and knew to avoid restraining people in the prone position where possible.

There had been one incident which required the use of rapid tranquilisation on Tony Hillis Unit, and on Westways in the last year, but none on Heather Close. Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation, including regular vital signs observations after the dose was administered. Wards had safety pods in place to be used during restraints and rapid tranquilisation to prevent the patient being put in a prone position.

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. Staff were trained in safeguarding and knew how to make a safeguarding alert and did so when it was appropriate. Training in safeguarding adults at level 3 was at 50% on Tony Hillis Unit, 88% at Heather Close and 100% at Westways. Training in safeguarding children at level 3 was at 100% on all wards. Staff training in other levels of safeguarding training were above 75% on all wards.

Staff knew how to identify adults and children at risk of, or suffering from significant harm. This included working in partnership with other agencies. Each ward had a safeguarding lead who staff could approach for guidance. On Heather Close a weekly safeguarding meeting was held with the safeguarding lead, for staff to discuss any concerns or queries. Staff could give examples of safeguarding alerts they had made. Staff completed records of safeguarding referrals and submitted them to the local authority safeguarding team. Staff put protection plans in place to keep patients safe. The trust had a policy in place for visits from children and staff were aware of this. Visits from children were rare but rooms were available outside of the units for this to take place.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Managers took part in serious case reviews and made changes based on the outcomes.

Our findings

Staff access to essential information

Staff had easy access to clinical information and maintained clear electronic clinical records.

All staff could access patient records easily. Staff used an electronic system to document patient records. Most information was recorded on the electronic patient record. Some information, such as the results of blood tests, electrocardiogram results and records of other physical observations were held in paper records and subsequently scanned onto the system. All information needed to deliver patient care was usually available to staff when they needed it and was in an accessible form. We noted on one ward, staff found it difficult to locate the recent Care and Treatment Review report for a patient with learning disabilities.

Records were stored securely. All clinical staff employed directly by the trust, including permanent and bank staff, had access to the electronic system. This included when patients moved between teams.

All teams across the trust recorded information on the same electronic patient record system. Staff were familiar with this system. Staff used this system to record and access each patient's progress notes, care plan, risk assessments and other information relating to their care and treatment. When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The trust had 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. Improvements were needed to ensure there was a clear review process to support patients progress with administering their own medicines.

Staff followed systems and processes to prescribe and administer medicines safely. They followed good practice in medicines management. Staff ordered, stored, dispensed and disposed of medicines safely. Staff checked controlled drugs and fridge temperatures daily to ensure they remained within safe limits. Staff noted allergies and potential adverse reactions on the patients' records. The prescriber gave staff clear directions about when staff should administer 'as required' medicines. Audits of medicines administration records were completed each month.

Pharmacists visited the wards weekly to review prescribing and supply ward medicines stock. Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Staff told us that patients could raise concerns about their medicines, and these would be considered and reviewed. Staff described increased pharmacist support on each of the wards, since the previous inspection in 2019.

A number of patients were started on step 1 of the trust self-administration policy and had been on this level for a while. This involved taking medicines directly, but in the clinic room, under staff observation. Some patients had progressed to later stages in the self medication process previously on Westways. However, there was no regular review in relation to self medication and it was unclear how patients would progress to the next stage of self medication. Following the inspection, Heather Close had put in place a process for patients to progress to step 2 of the self-administration process, with lockable safes provided in their bedrooms.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When a patient was ready to be discharged, staff consulted and involved the community psychiatric team to ensure safe and ongoing support in the community.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trust had a medicines safety officer in post, who ensured that when incidents occurred, learning was shared.

Our findings

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us that prescriptions for medicines that control behaviour were rarely used and when needed only given in small quantities, especially when prescribed as and when needed. We saw examples of daily reviews of the use of these types of medicines and that prescribing was stopped when it was no longer needed.

Staff reviewed the effects of medicines on patients' physical health regularly and in line with the NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Staff monitored the side effects of medicines using an antipsychotic side-effects measurement scale. Each ward had systems in place to ensure that appropriate physical health checks were carried out for each patient such as liver function tests and electrocardiograms.

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 apologised and gave patients honest information and suitable support.

In the last 12 months prior to the inspection, there had been 131 incidents on Heather Close, 127 incidents on Westways, and 56 incidents on Tony Hillis Unit. There was one serious incident on Westways, and one on Heather Close. There were no serious incidents on Tony Hillis Unit within the last year.

Staff knew what incidents to report and how to report them. They reported serious incidents clearly and in line with trust policy. The service had no never events on any of the wards.

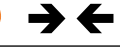
Staff understood the duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

Staff told us that managers debriefed and supported them after any serious incident. There were also reflective practice sessions provided. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. These were discussed at team meetings, and in supervision sessions.

There was evidence that changes had been made as a result of feedback, and staff were able to describe these. This included improvements in the frequency of physical health monitoring for a patient in poor physical health, and training in managing a deteriorating patient.

Is the service effective?

Requires Improvement  

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

Our findings

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans through multidisciplinary discussion. Care plans reflected patients' assessed needs, but they were not always reviewed regularly, and available in an accessible format to patients, with clear, holistic and recovery-oriented goals towards developing independence skills.

Most patient care and treatment records demonstrated good practice in terms of assessment, treatment and risk management. However, although there was some improvement since the previous inspection in 2019, there was still limited information around rehabilitation provided with a view to discharge. Recovery goals and steps towards discharge were not clearly recorded for patients at Heather Close and Tony Hillis Unit. This was compensated for on Westways by the addition of a 'my ward round action plan' for each patient, which did break goals into clear and achievable tasks for each patient. However, on the other wards it was still difficult to find clear goals for each person designed to support their recovery, and evidence of progress made.

Staff completed a comprehensive mental health assessment of patients soon after admission. Most admissions to these wards were planned transfers from other mental health wards. Staff carried out an assessment prior to each admission to ensure the patient was suitable for rehabilitation. Staff noted that they sometimes felt under pressure to admit patients that they did not think were ready for rehabilitation.

Staff assessed patients' physical health needs on admission and documented the frequency of follow-up checks required. They developed care plans that met patients' individual needs. The care plans we reviewed were individualised and included information about meeting physical health needs. However, most care plans did not include clear achievable recovery goals and had little detail about the relevant support needed for patients to work towards discharge. For example, one person's care plan indicated that staff should continue to prompt them to have a bath, and wash their clothes, and this had remained the care plan for over a year.

Some records were not dated, making it difficult to be certain which was the most up to date information, and there were some long gaps in review of care plans of over six months. On Tony Hillis Unit and Heather Close, care plans were generally not recovery orientated, and did not demonstrate evidence of skill development or personalised activities. Activities tended to be generic such as going for walks and cooking, they did not cover patients' culture and preferences.

On all wards we saw good evidence of family/carer involvement in care planning, when patients had consented to this. Whilst we saw that patients were engaged in discussions about their care in ward reviews, evidence of co-working with patients to develop their care plans was less consistent.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. However, there were limited opportunities for patients to learn self catering skills on the wards. Staff supported patients with their physical health and encouraged 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 patients in the service. Staff followed National Institute for Health and Care Excellence (NICE) guidance in the range of care and treatment offered. There was an improvement in the provision of psychological interventions at Heather Close since the previous inspection, with the recruitment of a clinical psychologist. Psychologists described psychosocial, and biosocial recovery models. Psychological therapies

provided to patients included cognitive behavioural therapy for psychosis, dialectical behavioural therapy (for people with personality disorders), emotional regulation, stress tolerance and other psychological interventions. Individual and group therapies were available for all patients, integrating a trauma informed approach. On Heather Close the psychologist was piloting virtual reality headsets for patients experiencing anxiety, as well as for staff wellbeing interventions.

Approximately 50% of patients on all the rehabilitation wards had substance misuse issues in addition to mental health problems. At Tony Hillis Unit and Heather Close there were dual diagnosis assistant psychologists in post who helped facilitate substance misuse groups. At Tony Hillis Unit the group was run in conjunction with the forensic personality disorder community team. On Westways patients were able to attend a weekly trustwide cannabis peer support group, and alcoholics anonymous meetings at the Bethlem Royal Hospital site.

Records showed that psychiatrists prescribed medicines appropriately, with low use of as and when medicines for anxiety or agitation. All patients were registered with a local GP who could visit the service if patients were unable to come to the surgery. Staff identified patients' physical health needs and recorded them in their care plans. They made sure patients had access to physical health care, including specialists as required. Staff used electronic recording of observations recorded on national early warning score charts alerting them to deterioration in patients health. Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Some patients were having their food and fluid intake monitored at the time of the inspection, in accordance with their care plans to address concerns about their nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice including smoking cessation support and healthy eating.

On Heather Close a training session on diabetes was provided to patients. We saw that patients at Heather Close with longterm health conditions continued to have health passports which were co-produced with staff with clear information about their physical health issues. On Heather Close, patients diagnosed with learning disabilities and autistic spectrum disorders were referred to specialist teams, such as for sensory needs assessments and communication needs. The Lewisham transforming care team provided some advice on how to support these patients.

Tony Hillis Unit was a high dependency rehabilitation units in a hospital setting, supporting patients to move on to a community rehabilitation unit or supported accommodation. Heather Close and Westways were community rehabilitation units (although Westways was situated within hospital grounds). All the units were 'locked,' although community rehabilitation units can also be run with open access. Whilst there was support to develop cleaning, laundry and budgeting skills, neither Heather Close or Westways were able to facilitate any patients self-catering on the wards at the time of the inspection.

Occupational therapists and activity workers provided some rehabilitation activities for daily living at each of the units. Staff supported patients with some basic supervised cooking skills, following an assessment by the occupational therapist. Sessions included shopping for ingredients and support with budgeting. However, support was not sufficient to enable patients to be fully or even partially self-catering on any of the units. Tony Hillis Unit did not include a kitchen for patients to use with support, so cooking sessions had to take place off the ward.

Staff at all units supported patients to clean their own bedrooms. Patients at Heather Close could attend regular classes to develop their basic literacy and numeracy skills. Patients at Westways and Tony Hillis Unit were able to attend some of the activities provided within the hospital settings, including the recovery college, a gardening group, and work experience in the café. Patients at Tony Hillis had access to an indoor mini-gym, and outdoor gym equipment was provided at Heather Close.

Our findings

Staff used recognised rating scales to assess and record the severity of patients' conditions and measure outcomes for people. These included the health of the nation outcome scores and the model of human occupation screening tool, and CORE 10 (a brief generic measure of psychological distress). Patients completed tools on admission and every three months after that, and results were reviewed to consider the effectiveness of the treatment approach.

Staff took part in local clinical audits, benchmarking and quality improvement initiatives. Regular audits included environmental safety, medicines practice, clinical safety, least restrictive care, patient experience, staffing, physical restraint, infection control and physical health support. Managers used results from audits to make improvements. The results of each audit were sent to the matrons, ward manager and clinical service lead with actions to be undertaken, which were then addressed with relevant staff.

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 service had access to a full range of specialists with the right skills, qualifications and experience to meet the needs of the patients on the ward. The ward teams included skilled staff from a range of disciplines including nurses, occupational therapy, doctors, clinical psychologists, and pharmacists. The clinical psychologist position on Tony Hillis ward was vacant at the time of the inspection, but psychology support was being provided from other Lambeth wards until recruitment had taken place. Most staff, including locum staff, were experienced and had the right skills and knowledge to meet the needs of the patient group. Many staff and managers had worked at the trust for a long time across different mental health settings and had a good understanding of patients' needs.

Managers gave each new member of staff a full induction to the service before they started work. Permanent staff attended the corporate induction run by the trust, and managers provided new staff with an appropriate induction. Each unit had their own local induction checklist to support new staff in their role including details of risk areas such as ligature points on each ward.

Managers supported staff through regular, constructive supervision and appraisals of their work. Managers or an appointed supervisor provided staff with supervision of their work. Records showed that although there were some gaps, most staff had received regular supervision and staff told us these had taken place. Supervision records showed that sessions covered both clinical and managerial areas, including wellbeing, workload, training and development. Managers provided staff with appraisal of their work performance.

Managers made sure staff attended regular team meetings and had minutes available to them from those they could not attend. Business meetings gave staff the opportunity to discuss any general issues relevant to the wards and to exchange ideas.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff were expected to complete competency assessments in key areas including engagement and observation, medicines administration, medical devices, nutrition, and the Mental Health Act. Local level training had been provided in autism, and substance misuse as recommended at the last inspection in 2019.

Our findings

The trust supported non-registered nursing staff to study to improve their skills and develop into the role of associate nurse practitioner. Nurses told us that they were able to undertake practice assessor training to further develop their skills.

Managers dealt with poor staff performance promptly and effectively. Managers took appropriate action and followed the trust's disciplinary policy as required.

The South London Partnership complex care pathway was providing peer support workers to work with the patients on the wards. There were also inhouse peer support workers recruited by the trust. Managers and experienced staff trained and supported peer support workers to work with patients on the wards, and within the community.

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. They had effective working relationships with staff from services providing care following a patient's discharge, and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The wards held weekly multidisciplinary meetings that staff from all disciplines attended. Staff worked together effectively to review each patient every week and manage their progress as well as their discharge or transfer. All staff attending these meetings were able to contribute their views on patients' progress.

Psychologists provided formulations to help staff understand how best to work with individual patients on the ward. They also provided reflective practice sessions for staff. Some staff on Heather Close said that they would like more frequent reflective practice sessions to support them in thinking through how best to support patients.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The ward teams had effective handovers between changes in nursing shift. The lead nurse from the out-going shift briefed all incoming staff about each patient on the ward as well as any incidents which had occurred. Staff provided handovers to other units when patients were transferred from the ward.

The ward teams had effective working relationships with teams outside the organisation. Staff regularly liaised with patients' community care coordinators, and other mental health wards. Staff also communicated regularly with the clinical commissioning group, social services, and patients' GPs, legal advisors and other organisations that provided support to patients. Staff on Westways were liaising with a tissue viability nurse external to the ward, to support a patient with pressure ulcer care.

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 (MHA) 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. All staff at Westways and Tony Hillis Unit, and 96% of staff Heather Close had completed up to date mandatory training in mental health law. This training was mandatory for all inpatient staff and renewed every three years.

Our findings

Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice. Staff knew who their MHA administrators were. They could access support and advice from the MHA office during office hours. Outside these times, legal advice was available by telephone.

Staff had easy access to local MHA policies and procedures and to the Code of Practice. These documents were stored on the trust's intranet site for all staff. Policies were regularly reviewed to ensure they considered the latest guidance as well as any local changes.

Patients had easy access to information about independent mental health advocacy. The service provided all detained patients with written information about their rights under the MHA and contact details of the advocacy service. Wards also displayed contact details of advocacy services on notice boards.

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. Doctors granted patients leave as part of therapeutic intervention. Staff undertook risk assessments prior to patients taking their leave to ensure they did not present a risk at that time. Patients at most of the units were admitted under a section of the Mental Health Act. Staff reminded informal patients that they could leave at will and there were also signs placed on the door as reminders.

Staff 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 staff 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. They completed weekly trackers to ensure that all relevant MHA paperwork was in place. Heather Close had monthly visits from the trust MHA office to ensure that paperwork was stored appropriately.

Good practice in applying the Mental Capacity Act

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.

All staff on Tony Hillis Unit, 95% of staff on Westways, and 94% of staff on Heather Close had completed training in the Mental Capacity Act (MCA). This training was mandatory and renewed every three years. Staff had a good understanding of the principles.

The provider had a policy on the MCA, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it on the intranet.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent. The treating clinician's assessments of patients' capacity to consent to treatment was recorded on patient's records we reviewed. This was revisited regularly in ward review meetings. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Our findings

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. One patient's care record showed that staff were unsure that the patient was making an informed decision with regards to making a permanent change to their appearance. Staff recorded they were looking to make an informed best interest decision with the patient. Staff audited the application of the MCA and acted on any learning that resulted from it.

No deprivation of liberty safeguards applications had been required in the last year.

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.

We observed that staff were discreet, respectful, and responsive when caring for patients. Patients told us that staff provided them with help, emotional support and advice when they needed it. Staff demonstrated a caring, respectful and compassionate attitude towards patients when interacting with them. Patients told us that staff were sensitive to them, and gave them space when they needed to be alone. Although they said that there were often changes in staff, patients said that staff were generally cheerful, listened to them and did not speak over them.

Staff demonstrated that they understood individual patients' needs. Staff gave patients help, emotional support and advice when they needed it prioritising their support. Staff were familiar with patients' histories and recognised changes in mood and behaviour. They worked patiently with people to build trust and improve engagement. The ward manager at Heather Close had remained in contact with patients recently discharged from the ward, to support them to settle in the community.

Staff supported patients to understand and manage their own care treatment or condition. Patients and their family members told us how they had made progress since being at the service through the support and care of the staff.

Patients said staff treated them well and behaved appropriately towards them knocking and waiting for an answer before entering their bedroom, to respect their privacy and dignity. There were notice boards with photos of all the staff members on each ward, with information about their likes and hobbies, to support patients to get to know them. On Tony Hillis Unit there was a notice board with different patients' recovery stories, following their discharge from the ward as examples for current patients.

Staff maintained the confidentiality of information about patients. Handovers, multidisciplinary meetings and ward rounds took place in private to ensure that discussions about patients could not be overheard.

Our findings

Staff told us that they would raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. On Westways the shared values and visions of the ward were prominently displayed on entry to the ward, including hope, respect and empowering patients.

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 used the admission process to inform and orient patients to the wards. Patients received an information booklet on admission that included information about the ward and their rights. Staff also took the time to speak with patients who were new to the ward about the activities available and what their treatment would involve.

Staff involved patients and gave them access to their care planning and risk assessments. There was some evidence that patients participated in their care plans on all units. However, at Westways the introduction of the 'my ward round action plan,' showed the most involvement of patients in this process. Patients were offered a copy of their care plan.

Staff made sure patients understood their care and treatment and could make decisions on their care. Staff held regular individual sessions with patients. Staff also involved patients in their Care Programme Approach (CPA) meetings. Patients at Heather Close were still encouraged to chair their own CPA meetings, and were paid to do so. Staff and patients co-produced the questions they would ask to facilitate the meeting.

Staff involved patients in decisions about the service, when appropriate. Patients had daily planning meetings to discuss activities for each day. They met with staff each week in community meetings. Minutes of these meetings were recorded. Staff followed up issues raised by patients and fed back on progress at the next meeting. Common themes included insufficient variety of meals, maintenance issues and requests for more trips outside of the service. Staff arranged for repairs to be attended to promptly, and arranged meetings with the contractor providing food, to discuss improvements, they also attempted to arrange further trips out to places requested by patients, where possible.

Staff regularly asked patients to provide feedback about the service. Each ward asked patients to complete a feedback questionnaire every month. Staff used the feedback to help them to make improvements. 'You said, we did' notice boards were posted on the units to give feedback to patients about the action that had been taken to address concerns they had raised. Examples included provision of more gym equipment including boxing gloves, yoga, and football sessions on Heather Close, and planning a trip to the beach. On Tony Hillis Unit patients requested improvement in the cleanliness of toilets, a chore rota, suggestions box and more board game sessions. These were all addressed, including arranging for volunteers to support more activities including board games at the weekend. On Westways improvements made included providing an updated sound system, and arranging for patients to have a form to record their views before each ward round.

Staff made sure patients could access advocacy services. Advocacy services visited each ward regularly, and patients had contact details to call them when they wished to.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Our findings

Staff supported, informed and involved families or carers. Staff kept in contact with family members and carers with patients' consent. At Heather Close, a support worker led on the work with carers and was the main point of contact for carers/relatives. They were planning to set up a relatives/carers group for the service. At Westways there was a weekly relatives/carers forum meeting held. At Tony Hillis Ward, relatives told us that they attended the relatives/carers' hub at Lambeth hospital, and found this to be helpful. All relatives that we spoke with gave positive feedback about staff on the wards. Some said that there could be an improvement in communication with them, and the activities available to patients.

Staff helped families to give feedback on the service. Relatives told us that when they gave feedback or expressed concerns, staff took action to address these areas.

Staff invited families and carers to attend ward rounds and other meetings to review patients' individual progress and support the patient. Patient records showed communication with families including invitations to attend review meetings if the patient consented. Records showed that relatives regularly attended meetings and were given the opportunity to express their views. There were comment cards available on each of the units for patients and their families/carers to provide feedback.

Is the service responsive?

Good 

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital to minimise the time spent in hospital once they were well enough to leave.

The wards came under the South London Partnership (SLP) complex care pathway (with two other neighbouring mental health trusts). Beds were available for appropriate patients from any of the South London mental health trusts. As far as possible each unit served patients from different catchment areas. Westways was for patients who lived in Croydon, Tony Hillis Unit had six beds allocated to patients from the National Psychosis Unit also provided by the trust (with patients from all over England). Heather Close was able to take up to five out of area beds.

As part of the SLP complex care pathway, staff across the three trusts carried out trusted assessments, with outcomes within 7 days of referral.

Waiting lists were low for each of the units, but due to the length of stay of patients, the average wait for a bed varied between six weeks to nine months. Each site had a weekly beds meeting where all patients were discussed, updates were also sent to the commissioners on current inpatients and availability of beds. Staff from the units visited patients to assess whether they were suitable for a rehabilitation service prior to admission.

Referrals meetings were held on a weekly basis, new referrals were considered as well as positive moves towards discharge. There was always a bed available when patients returned from leave. Managers and staff worked to make sure they did not discharge patients before they were ready.

Our findings

Patients were not moved between wards unless it was justified on clinical grounds and was in the interests of the patient. Staff told us about a small number of patients who had been moved because the wards were no longer able to meet their needs. Staff did not move or discharge patients at night or very early in the morning.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Wards aimed for slightly different lengths of stay ranging from 6 to 12 months across each of the different units. Some patients had been on the units for many years. On each of the wards, most patients came from acute inpatient wards with a small number admitted from the National Psychosis Unit and forensic wards. The service reported 2 readmissions within 30 days of discharge (across the 3 wards) within the last year prior to the inspection.

Discharges into the community, including to supported living, patients' own homes, or other inpatient wards, always followed a graduated approach. The patient would be prescribed leave to initially spend several hours at their new home or placement followed by an overnight stay, then a weekend stay, until the patient and staff felt confident that the patient was ready to be moved or discharged from the service.

Staff told us that the pressure on acute beds meant that the wards had referrals for some patients who were not suitable. Staff said that they sometimes felt pressurised to admit patients who were not yet ready for rehabilitation, leading to longer stays on the wards. Exclusion criteria varied between wards, but included challenging behaviour and aggression, drug use where the patient was not willing to change, and very high physical health needs.

At the time of the inspection there were 4 beds available at Heather Close (out of 24 beds (16 male, and 8 female)). Staff were in the process of assessing patients for potential admissions. There was one bed available at Tony Hillis Unit (out of 15 male beds) and no beds available at Westways (18 beds (13 male, and 5 female). Tony Hillis ward had one bed allocated for assessments.

Staff attended in-reach meetings to review patients who had been on acute wards for over 60 days, to determine if any were suitable for a move to rehabilitation. Care coordinators from community teams attended ward rounds (usually virtually) of patients who were approaching discharge.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, and knew which wards had the most delays. They were taking action to provide further supported living placements for patients ready to be discharged.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients' discharge planning was not always documented in their care plans until patients were close to being discharged from the service. Managers and staff told us that where possible they planned for patients' discharge from the point the patient was admitted to the service.

At Heather Close, the consultant psychiatrist held 'red2green' meetings on a weekly basis with the multidisciplinary team. This involved discussing and colour coding patients' progress towards discharge. Managers attended weekly bed meetings. At these meetings every patient was discussed and this included discussing patients who were ready to be discharged or transferred and whether anything additional was required to facilitate the discharge.

Discharge was delayed for a range of reasons, but most commonly due to lack of a placement or funding package for patients to receive support in the community. Each ward aimed for a length of stay of 6 to 12 months although there were patients on each ward who had been at the service for many years. Managers noted that it was more realistic for new admissions to be discharged within that time frame because historically, some of the existing patients had been

inpatients for many years. They had made progress at finding placements for patients who had been on the wards for extended periods. Managers also reported that it was sometimes difficult to find placements for patients who had a forensic history. There were often delays in the Ministry of Justice completing the required paperwork to do this. Lewisham directorate (which covered Heather Close) had a flow lead in place to address the issue of delayed discharges from the ward. There had been an increase in discharges from Heather Close since 2021, when 13 patients were discharged, with 18 patients discharged in 2022, and 2023 with 4 patients discharged in the first 3 months. There were 5 patients who had been in service over a year at the time of the inspection (the longest had been there for 907 days). At Tony Hillis Unit there were 2 delayed discharges, and at Westways there were 5 delayed discharges at the time of the inspection. The Croydon directorate (covering Westways) had held mini multiagency discharge events to address the issue of delayed discharge.

Staff and relatives expressed concerns over the support that patients could expect once discharged into the community due to staff shortages and high turnaround, leading to frequently changing care coordinators for patients.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards were not ideal for supporting patients' treatment, and opportunities for activities. Each patient had their own bedroom. However, en-suite bathrooms were only provided at 5 Heather Close. There were quiet areas for privacy. Patients expressed mixed views about the choice of food provided especially to meet cultural or dietary needs. They could make hot drinks and snacks at any time, although this was temporarily restricted on Westways at the time of the inspection. No patients were self-catering on any of the wards. Whilst all wards had activity programmes for patient, Tony Hillis Unit did not have any structure activities for patients at weekends.

Each patient had their own bedroom, which they could personalise. On Westways and Tony Hillis Unit, staff could not close viewing panels in the bedroom doors but there were curtains in place to help maintain privacy and dignity for patients. Following the inspection the trust has agreed funding for new panels to be installed on the wards to maintain patients' privacy. Patients could personalise bedrooms and we saw that some patients displayed photos and personal belongings. Patients had lockers to store their possessions safely. Only 5 Heather Close had en suite facilities in the bedrooms for patients to use, other wards had shared bathroom and toilet facilities (although these were segregated by gender). On Westways, staff and patients told us that the ward could get very hot in the summer, and they had rented air-conditioning units in the past.

Staff used a full range of rooms and equipment to support treatment and care. The wards varied in the range of rooms and equipment they had to support treatment and care. Heather Close and Westways had very limited therapy space. 5 Heather Close had recently been renovated, but the environment at 1 Heather Close was quite worn out and in need of renovation. The Tony Hillis Unit had a gym situated next to the lounge, although this could only be accessed when the gym instructor was present. There was an outside gym situated between the 2 houses on Heather Close. At 5 Heather Close, the male lounge had a table tennis table and table football. The female lounge had bean bags provided. At Tony Hillis Unit, there was an outdoor designated graffiti wall available for patients, and patient art work was prominently displayed around the ward.

Patients were able to make themselves drinks, and had access to fruit on the wards. On Heather Close although both the male and female lounges had hot and cold water dispensers and tea and coffee, the fridges were locked. This meant patients had to ask a member of staff if they wanted milk. On Westways, patients and staff ate meals together which

created a pleasant atmosphere on the ward. However, on Westways, at the time of the inspection, snack food and drink items (apart from fruit) were temporarily locked away, and had to be accessed by staff, to meet the needs of one patient. This impacted on all the patients on the ward. We raised this issue with management, who reviewed arrangements, so that this restriction was no longer in place on the ward.

There were activities of daily living (ADL) kitchens on Heather Close and Westways. Patients on Tony Hillis Unit had to use a kitchen outside of the ward. Management on Heather Close spoke of plans to improve the ADL kitchen and make it more homely for patients to use. Patients required an assessment before they could use this. None of the wards were working towards some patients fully or partially self catering at the time of the inspection. There were quiet areas on each ward and a room off the unit where patients could meet visitors. Patients were able to make telephone calls in private. The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients could use their own mobile phones or the ward office cordless phone to make calls.

Heather Close and Westways and Tony Hillis unit had two enclosed outside garden areas that patients could access easily. There was no outside space available at Westways, but managers were working to try to address this. Patients at Westways who had leave within the hospital grounds could access gardens within the hospital grounds.

Patients gave mixed views about the quality of food, with many of them indicating that they were not happy with the varieties available. Patients could make their own hot drinks and snacks and were not dependent on staff. Discussion around food provided regularly featured at the patient community meetings. The staff team approached the meal providers regarding improvements requested, including their attendance at community meetings to speak with patients directly.

Occupational therapists (OTs) and activity workers on the wards put together individual timetables of activities in discussion with patients. On Heather Close, volunteers were helping with art groups and taking patients out in the local community. However, due to the layout of the ward, we noted that it was difficult for patients to focus on some activities held in the dining area, with other staff and patients coming and going, so that sessions could be quite chaotic. Similarly there was no designated room for therapies or activities on Westways, which meant they were carried out in the dining room area, with limitations around mealtimes.

Therapeutic groups provided across the wards included a cannabis support group, music therapy, health promotion, hearing voices group and medicines group. Other weekly activities across the wards included music appreciation, non contact boxing, yoga, gaming sessions, sports and recovery groups, quizzes, karaoke, cooking groups, bingo, games and puzzles. Patients on all wards said that when the occupational therapists and activity workers were not on duty, there was little in the way of activities. Patients on Westways could access the Bethlem Royal Hospital main occupational therapy groups including pottery, wood work, and gardening. At Tony Hillis ward there were no weekend activities scheduled at the time of the inspection. Managers explained that this was in keeping with the rehabilitation programme to encourage patients to use their weekends and leave productively, without being reliant on ward staff to provide activities. There was some support from volunteers and staff with board games, table tennis and movie evenings. Following the feedback provided from the inspection, weekend activities had been incorporated into a timetable for patients.

Our findings

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. Relationships between the wards and local education and employment opportunities needed to be further developed.

There were some opportunities for patients to access community programmes for education and work. Staff on each ward could support patients to attend college and paid or voluntary work. However, at the time of the inspection, few patients were doing this. At Westways and Tony Hillis Unit patients could undertake voluntary work at the hospital café, with a view to them progressing to paid work in the local area once they felt confident to do so. Patients on all wards could attend courses at the local recovery colleges.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. At Heather Close, one patient was attending the local leisure centre, but no patients were attending college or voluntary work. There were some job roles on the wards, but most of these were unpaid.

On Tony Hillis Unit, two patients were in full time college, on a course including employment support for a year afterwards. The OT had built a relationship with this college and a local charity offering educational courses and work placements, to ensure patients had appropriate support. The ward also had links with a local organisation offering work experience, and employment support. Staff supported patients to attend local job fairs and provided employment groups on the ward. Patients on the ward could be paid for gardening work.

On Westways, patients wishing to resume employment as they approached discharge, were referred to both NHS and third-sector employment support organisations. Patients could also access paid vocational groups at the main OT department.

At Heather Close there were relationships with the local recovery college and adult learning education tutor who provided educational sessions within the unit to support patients with literacy, numeracy, information technology and English for speakers of other languages. There were no specific links in place with local charity shops or other employment opportunities for patients on Heather Close.

Staff supported patients to participate in activities outside of the units. Activities off the wards included strawberry picking, visiting museums, and galleries. Patients were encouraged to access existing groups in the community, such as cafes, the local library and activity groups.

Staff helped patients to stay in contact with families and carers, and relatives that we spoke with told us that when needed staff could support patients to visit family at home.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. However wheelchair users could not be accommodated on Westways, as there was no passenger lift. Staff helped patients with communication, advocacy and cultural and spiritual support.

Some of the wards in the service could support and make adjustments for physically disabled people. Two of the units were accessible to patients with mobility disabilities. At 5 Heather Close there were bedrooms on the ground floor, and two of the bedrooms had been adapted to accommodate patients with some degree of physical disabilities. The unit also had use of a hoist if required. There was a lift to the upper floor, although this was not used out of hours due to a lack of emergency support at those times. At 1 Heather Close there was a disabled toilet available on the ground floor.

Our findings

Tony Hillis Unit was on the ground floor and able to accommodate patients with some degree of physical disability. There was no disabled access on Westways, with no passenger lift to reach the ward, although a goods lift could be accessed in an emergency. Patients were reviewed by the South London Partnership prior to being placed on any of the units, and those requiring specific support with mobility or wheelchair users could be accommodated on other units.

All staff at Westways, 96% of staff at Tony Hillis Unit, and 91% of staff at Heather Close had completed trust training in equality, diversity and human rights. Staff could make adjustments for those with communication or other specific needs. Information was available in easy read, different languages and braille on request. Staff had some understanding of the requirements of the accessible information standard. Heather Close had devised communication passports for patients with learning disabilities. Communication passports allowed the patient to share information in an easily accessible format, with external health professionals as well as staff on the ward. Managers ensured that staff and patients had easy access to interpreters and/or signers. Staff said they used interpreters to communicate with patients who did not speak English well especially when they had important decisions to take. Heather Close had a tutor providing sessions for patients to further develop their literacy skills.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This was provided in leaflets, and posters on the wards, and the service could produce information leaflets 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 a choice of food to meet their religious, and other dietary requirements and cultural foods for some ethnic groups. Patients gave mixed reviews about the food, and noted that their was insufficient variety, particularly for vegan and vegetarian patients. Staff were attempting to improve the choices available, in discussion with the food supplier. A dietitian was involved in supporting specific patient dietary needs. In some instances, a speech and language therapist was involved if a patient had been assessed to require their services.

Patients had access to spiritual, religious and cultural support. Staff ensured that patients had access to appropriate spiritual support. Staff supported people to attend places of worship and spiritual significance if the patient wished. Patient information on the wards indicated that the trust spiritual/pastoral team could visit and there was a multi-faith room in Lambeth Hospital which patients at Tony Hillis Unit could use. The Bethlem Royal Hospital also had a multi-faith room which patients at Westways could access. Patients at Heather Close were supported to access places of worship in the community if they desired, and could have visits from a chaplain or other religious leader.

On Tony Hillis Unit staff supported patients to attend black history month events, and staff on Westways arranged an event to celebrate international women's day. Staff had an understanding of the individual needs of patients, including their personal, cultural, social and religious needs. Staff said they had received some training and felt confident to meet the needs of LGBTQ+ patients. On Westways there was a notice board available for LGBTQ+ patients. Each ward had an LGBTQ+ champion, and staff could give examples of support provided to patients with their sexual orientation.

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. During the last 12 months prior to the inspection 8 formal complaints had been received about the service. There were 6 complaints for Heather Close (of which 5 were not upheld, and one was partially upheld), There were 2 for Tony Hillis Unit (of which one was not upheld, and one was partially upheld) and none for Westways.

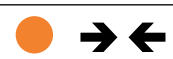
Our findings

The service clearly displayed information about how to raise a concern in patient areas. There were also suggestions boxes located in communal areas on the wards where patients could post their comments, suggestions and complaints.

Staff understood the policy on complaints and knew how to handle them. The trust had a complaints policy and staff knew how to access this. Informal complaints were dealt with as they arose. If patients wanted to make a formal complaint staff supported them to do this. The complaint was logged locally as well as with the central complaints team. The complaints department assigned the complaint for investigation to the most appropriate person. When patients complained or raised concerns, they received feedback. When a formal complaint was made which required investigation, patients received communication from the trust acknowledging their complaint. The investigating office provided a written response which was sent to the complainant. Complainants were also invited to meet with the manager to discuss their concerns and records showed that this happened. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers investigated complaints and identified themes. Staff received feedback on the outcome of the investigation of complaints and acted on the findings. We were told that complaints were discussed at handover meetings as well as in team meetings. For example staff had looked at ways of improving their communication with relatives and carers after a recent complaint. The service also used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, although managers above ward manager level were not always visible in the services.

Leaders had the experience to manage the units safely. The ward managers were experienced and knew the services well. However, staff on the wards did not always feel well supported by senior managers within the trust. Each ward was under a different borough directorate within the trust, and overseen in different ways, whilst the overall complex care pathway was led by the South London Partnership (SLP). Each directorate held separate integrated quality performance reports (IQPRs) each month, and managers noted that the wards were now more integrated into the local pathways, as part of the borough directorates.

Since the previous inspection, staff were clearer and more able to articulate the trust rehabilitation strategy and steps had been taken to ensure that the wards were more recovery orientated for patients.

Senior managers were aware of staffing shortages and the impact this had on both staff and patients, there were ongoing efforts being made to recruit more staff. They understood what the local risks were and what quality assurance measures were in place. Ward managers knew the names of all the patients and had a good understanding of each patient's individual day to day needs. Managers recognised that a coordinated approach was needed to ensure a high-quality service was provided to support patients to become well and learn to live independently and that more work was needed to ensure that this happened.

Our findings

Staff said that the trust CEO sent emails and provided broadcasts to staff. They noted that senior leaders (above ward manager level) were not always visible in the service and did not know staff and patients, but ward managers regularly met with staff and patients. Some staff said that they did not feel listened to or approached by senior managers.

Leadership development opportunities were available, including opportunities for staff below ward manager level. Ward managers had completed various management courses during their time in post. Ward managers also involved team members in managerial development through involvement in investigating incidents and complaints as well as leading on audits.

Vision and strategy

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

Managers understood the trust's vision, and how this was underpinned by clearly defined values. The rehabilitation wards were part of the South London Partnership complex care pathway, with an overall aim for every patient to be placed in the most appropriate and least restrictive setting, as close to home as possible with an outcomes-based care plan. The pathway had been established to define an integrated complex care pathway and identify models of care to optimise the inpatient rehabilitation service.

There was evidence of some good rehabilitation orientated work, and opportunities for patients on each of the wards. Since the previous inspection in 2019, staff had a clearer understanding of the model and approach to rehabilitation on their ward, supporting patients to achieve basic levels of skill prior to discharge, for example better medicines management and graduated community integration. Staff also described greater empowerment to make decisions about patients' care on the wards since the previous inspection. For example, they were able to increase observations on patients if they had concerns for their safety, without seeking medical advice first.

Culture

Staff felt respected, supported and valued. They said the trust had taken steps to further promote equality and diversity in daily work and provided opportunities for development and career progression. Most felt that they could raise concerns without fear.

Most staff felt respected, supported and valued. Staff did not report any cases of staff bullying or harassment on the wards and told us that they felt supported by their colleagues. Most staff felt able to raise concerns and were sure they would be taken seriously. Staff knew how to use the whistle blowing process and a copy of this was available on the trust intranet. On the whole teams worked well together and where there were difficulties managers dealt with them appropriately. A small number of staff did not feel safe to raise concerns, worrying about repercussions later if they did so.

At the last inspection some staff at Heather Close had expressed concerns about their working conditions. At the current inspection, the situation appeared to be improved, however a small number of staff said that registered nurses sometimes shouted at other staff (but not patients) when they were stressed. This meant that they did not always feel valued, and it was sometimes difficult to take their allocated breaks. Following our feedback, the trust advised that Heather Close had taken action to address this issue, with interventions to ensure that all staff members felt valued and respected. They noted that the feedback received regarding these interventions had been positive, with ongoing monitoring including through supervision, appraisals, yearly staff surveys, and appropriate oversight from senior staff.

Our findings

Staff appraisals included conversations about career development and how this could be supported. There were development opportunities available for both registered and unregistered nurses. The wards accepted student placements and encouraged students to join the trust once they had completed their course.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Ward managers and matrons came from diverse backgrounds. All staff were aware of opportunities for career development within the trust.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level, but that performance and sharing best practice were not managed consistently across the three services.

Governance arrangements were in place within each unit that supported the delivery of the service. There was a clear framework of what must be discussed at a ward and team level to ensure that essential information was discussed. Business meetings were held where teams met to discuss the day to day running of their unit.

Monthly governance meetings were held on each ward for all staff. Since the previous inspection the meetings had embedded standard areas to be addressed, further discussion of each topic, and clear records of each meeting for staff unable to attend. Heather Close had been involved in embedding care improvement systems training with a board available on which all staff could post issues of concern to be discussed at a daily meeting. Issues posted included health and safety concerns, lack of administrative support, and patient concerns such as a need for more towels. Staff described improved support on the ward with a clinical nurse specialist, service manager and matron offering support. On Tony Hillis Ward two matrons had recently been allocated to support the ward.

At the time of the inspection, staff mandatory training on Tony Hillis Ward was lower than the other units particularly in fire warden training, supervision and the national early warning score tool (used to monitor changes in patients' physical health).

Senior staff at each of the units attended regular quality meetings that included managers from across the services within their borough directorate. The local governance arrangements differed between wards. The key performance indicators for the other services within the line management, therefore did not always fit well with the rehabilitation wards which had different aims and expectations for patients. Senior managers were aware of this issue and looking to develop a shared suite of key performance issues specifically for the rehabilitation wards. The trust advised that there had been meetings across the rehabilitation pathway with the chief nurse and directorates regarding rehabilitation expectations, for areas such as catering, food, blanket restrictions and care plans.

Senior staff also attended monthly South London Partnership (SLP) meetings as part of the shared complex care pathway. The SLP had arranged for peer support workers to be recruited for each ward in partnership with a local voluntary agency, and also providing dual diagnosis support to each ward (for patients who had substance misuse issues). They were also working towards providing a community rehabilitation unit for each trust. At a recent meeting staff at Heather Close had shared their work to reduce the length of their handover meetings to be more efficient whilst using quality improvement methodology.

Staff participated in local audits. Examples of audits included care plan audits, medication audits as well infection control audits. The audits supported ward managers and team leaders to identify areas of improvement. Since the previous inspection, action plans were put in place for the findings of each audit, to ensure that improvements were made.

Our 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. However, there was not always consistent oversight within the trust of the management of risk, and performance of each ward.

The ward manager on each ward maintained a risk register. Staff had access to the risk register at ward and directorate level. Staff at ward level escalated concerns to their manager, who assessed risks for their likelihood and impact and added risks to the register if they met agreed criteria. The risks identified on the risk register matched concerns discussed with staff during the inspection including staffing, challenging behaviour, restricted facilities and layout of the wards.

The service had plans for emergencies, including contingency arrangements for adverse events. Ward managers knew how to access the plans and would refer to these in the event of an emergency. Continuity plans included basic instructions for staff to follow in the event of a major incident, or disruption to the wards such as in the event of a fire or inadequate staff cover.

Staff on all the units expressed concerns that patients admitted were not always ready for rehabilitation, but there was pressure from acute wards to take patients, leading to extended stays on the ward. This sometimes meant that the restrictions on the wards were more extensive than they might have been, including restricted access to food and drink, and the need for access to garden areas to be supervised.

As the wards sat under different directorates, staff were not always aware of incidents that had taken place on other rehabilitation wards within the trust. In terms of managing risks, there were inconsistencies in how risk was managed across the wards, and staff across the wards did not discuss these. For example, Heather Close used plastic cutlery and crockery, whilst Westways was using ordinary cutlery and crockery without incident. Only Heather Close enabled patients to have keys to their own bedrooms.

All three wards held safer staffing huddles, to ensure that there were sufficient staff on each shift, using the trust's Safe Care System. For example, they focussed on patients' physical ailments, and risks of using illicit drugs on leave. They were due to move from the Lambeth Hospital site, and hoped to have a sensory room in place for patients to use at their next location.

Information management

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

The service used systems to collect data from wards and directorates that were not overburdensome for frontline staff. The ward managers were required to collate and submit data to various central teams, for example the local borough directorate and human resources. Managers used data to have oversight of their ward.

Staff had access to the equipment and information technology needed to do their work. There was a suitable information technology infrastructure, and telephone system. The trust had been subject to an extended outage of the electronic patient records system in the last year. They had managed this incident with the use of an alternative recording system until access was restored. Staff described some improvements in technology provided, for example at Heather Close a new large screen was available for staff to use to display patient information during staff meetings, and a similar screen had been ordered for staff on Westways.

Our findings

In general staff told us that the online patient record system was easy to use. Information governance systems included confidentiality of patient records. Where paper copies were used, these were scanned on to the system. Staff could only access electronic patient records by entering a personal user name and password. Information governance training was included within the trust's mandatory training modules. The training informed staff on how to maintain confidentiality.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers also received monthly data on the number of staff who had attended mandatory training and the rate of staff sickness, and performance information about patients' length of stay and discharge rate.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. Information for ward managers was easy to understand and updated every month. Staff made notifications to external bodies as needed. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about the possible abuse of patients.

Engagement

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.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff kept patients up to date by displaying information on notice boards as well as discussion any relevant matters during their one to ones. Staff received regular bulletins and newsletters from the trust that kept them informed of developments and incidents in other parts of the trust.

Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs. There were also opportunities for carers to provide feedback directly to the ward, and through ward round meetings, and relatives/carer forums. Patient community meeting minutes showed that patients were given the opportunity to provide feedback about the service. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. We saw 'you said, we did' boards which demonstrated that staff had reacted to feedback from patients and made improvements when they could such as improving the ward environment, and provided more activities outside of the ward. On Westways staff had conducted a quality improvement project into increasing patient and carer involvement. This had led to the use of new forms in ward rounds including surveys, 'my achievements,' ward round action plans and moving on plans.

On Heather Close, staff had completed surveys on their wellbeing, and as a result actions had been put in place including provision of massage chairs, virtual reality relaxation headsets, and arranging a night out for staff.

The trust was in the process of consultation with staff, patients and relatives/carers on Tony Hillis Unit regarding the proposed move of the ward to a new site following the closure of Lambeth Hospital.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. The units had introduced innovative and successful approaches to care and treatment. They continued to run a behavioural treatment of substance misuse group at Tony Hillis Unit, and patients at Heather Close had the opportunity of chairing their own care programme approach meetings. Heather Close continued to use health passports and communication passports in easy read format for patients with an identified learning disability.

Our findings

Staff used quality improvement methods and knew how to apply them. All units were successfully using a quality improvement approach to bring about change and improvements in care. Heather Close continued to use the red2green initiative to increase the focus on patient discharge. This involved recording steps taken to move each patient in the direction of a safe discharge from the ward. They also had quality improvement projects to reduce the number and length of meetings (reducing the time taken for handover meetings from two hours to 30 minutes), and a staff wellbeing project. Managers said that they were starting a new quality improvement project on Heather Close to look at how they could improve patients' length of stay.

Westways staff were concentrating on implementing specific elements of safewards methodology, including agreed mutual expectations, a staff photo board, use of soft words, a calming box, and use of a family room. They provided bean bags in one of the lounges, and produced a risk plan for each weekend. Staff on Westways also talked about the use of personal health budgets could be used to provide personalised packages for patients including access to a bicycle, fishing trips and even yachting.

Wards participated in accreditation schemes relevant to the service and learned from them. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. Shortly after the inspection Westways had been AIMS accredited through the Royal College of Psychiatrists.

Through the South London Partnership work was underway to provide supported living accommodation for each trust, with clinical in reach (as a step down from the rehabilitation units). The opening of a unit at a neighbouring trust, had already led to the recent discharge of several patients from the wards. It was hoped that this initiative would help to reduce the length of stay for patients who were ready to be discharged.

Our findings

Outstanding practice

We found the following outstanding practice:

- On Heather Close the psychologist was piloting virtual reality headsets for patients experiencing anxiety, as well as for staff wellbeing interventions.
- Staff at Tony Hillis Unit continued to facilitate a group in conjunction with the forensic personality disorder community team to support patients with substance misuse problems alongside their mental health problems.
- Staff at Heather Close continued to involve patients in chairing their Care Programme Approach meetings co-producing the questions they would ask to facilitate the meeting.

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:

Long stay/Rehabilitation wards for working age adults

- The trust must ensure that care plans on Heather Close and Tony Hillis Unit provide clear information about the independence skills and goals patients are working towards prior to discharge. **Regulation 9(1)(2)(3) Person centred care**
- The trust must further improve oversight of performance and quality on the three rehabilitation wards, to ensure that areas for improvement (such as consistency of blanket restrictions, and key performance indicators specific to the rehabilitation pathway) are in place. **Regulation 17(2)(a)(b) Good governance**

Action the trust Should take to improve:

Long stay/Rehabilitation wards for working age adults

- The trust should continue to work to work to fill vacancies and address issues of retaining staff on the rehabilitation wards.
- The trust should further review blanket restrictions for patients across the wards to ensure that only restrictions necessary for the safety of patients are in place.
- The trust should continue to work with the catering supplier to improve the quality and variety of meals offered to all patients including meeting their cultural needs.
- The trust should provide further opportunities for patients to develop their self-catering skills on the wards.
- The trust should further develop opportunities for patients to self-administer their medicines to improve patients' experience and engagement.

Our findings

- The trust should complete actions following a review of the provision of airway tubes for resuscitation in emergency grab bags, so that all relevant sizes are included in line with the Resuscitation Council guidance.
- The trust should continue to address concerns raised about the culture between staff at Heather Close, to ensure that all staff feel valued and respected.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors, an inspection manager, a medicines specialist, a specialist advisor nurse, a specialist advisor occupational therapist, and an expert-by-experience (who had experience of using or supporting someone who uses similar services).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance