Requires improvement

South London and Maudsley NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV504	Maudsley Hospital	Eileen Skellern 1 (PICU) Eileen Skellern 2 John Dickson Aubrey Lewis 3 Ruskin on Aubrey Lewis 2	SE5 8AZ
RV505	The Bethlem Royal Hospital	Gresham 1 Gresham 2 Croydon Triage	BR3 3BX
RV536	Foxley Lane Womens Service	Foxley Lane Womens Service	CR8 3NF
RV509	Ladywell Unit	Johnson (PICU)	SE13 6LH

Summary of findings

		Lewisham Triage Powell Wharton Clare	
RV502	Lambeth Hospital	Eden (PICU) Luther King Nelson Lambeth Triage Bridge House	SW9 9NU

This report describes our judgement of the quality of care provided within this core service by South London and Maudsley NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South London and Maudsley NHS Foundation Trust and these are brought together to inform our overall judgement of South London and Maudsley NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Summary of findings

Overall summary

Acute wards for adults of working age and psychiatric intensive care wards **require improvement** because:

- Staff were not reporting all incidents of restraint and when restraint was recorded, it was not recorded comprehensively according to the Mental Health Act code of practice. This was addressed by the trust immediately after the inspection.
- On Eileen Skellern 1 the environmental risk caused by patients having access to an external fire escape had not been mitigated.
- Individual risk assessments were not consistently up to date and reflecting the current risks to individuals.
- Some wards had significant staff shortages which had an impact on patient care.
- On Lambeth triage ward seclusion had not been recognised and so patients were not being properly monitored to ensure their safety.
- Emergency resuscitation bags did not all contain the listed emergency equipment or in some cases this equipment was present but out of date.
- Patients whose physical health monitoring had identified that their risks were raised had not all been referred for medical input.
- Care plans did not consistently reflect identified needs of patients and there was generally poor involvement of patients in care planning reflected in the care plans we saw.
- The rights of informal patients was not consistently understood in a way which protected their rights and gave them correct information about their right to leave the wards or refuse medications.
- Staff understanding of the Mental Capacity Act was not robust.
- Whilst governance processes were in place, they were not identifying the areas where improvements were needed in sufficient detail.

However, we observed kind and compassionate care being delivered. Patients gave positive feedback about their experiences on the ward. The trust valued innovation and using research to improve patient experience. Staff had a good understanding of safeguarding and were well supported by their ward managers. Staff told us that they felt proud to work for the trust.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Inadequate

We rated safe as **inadequate** because:-

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

However, medicines management was robust. Wards were clean and infection control auditing was carried out frequently and effectively. The trust had systems in place to ensure that learning from incidents was disseminated through the wards and staff were aware of safeguarding procedures.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:-

- Care plans did not consistently reflect identified needs of patients and there was generally poor involvement of patients in care planning reflected in the care plans we saw.
- The rights of informal patients was not consistently understood in a way which protected their rights and gave them correct information about their right to leave the wards or refuse medications.
- Staff understanding of the Mental Capacity Act was not robust.

Summary of findings

However, the ward teams worked well together and involved different professional disciplines effectively. Key information was handed over between shifts. All staff had had appraisals over the previous 12 months and staff received supervision and reflective practice sessions.

Are services caring?

Good

We rated caring as **good** because:-

- Care was delivered with kindness and respect. Patients told us that staff treated them with respect and ensured that their dignity was preserved.
- There were opportunities for patients to feedback their experiences on the wards, through electronic handheld devices which collected information monthly and through regular community meetings where information was shared and followed up.

However, thought was needed to improve patient privacy and dignity for example considering if observation windows in bedroom doors can be closed when not being used.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:-

- Patients and staff had a good understanding of complaints and staff gave patients information about how to make complaints.
- Ward managers actively encouraged complaints and feedback.
- Ward environments were able to meet the needs of patients and there were accessible facilities where necessary. Patients were supported to meet their religious and cultural needs.

However, wards were consistently occupied at well over the levels recommended by the Royal College of Psychiatrists which meant there was a risk patients may not be provided with care in a bed close to where they live.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Whilst governance processes were in place, they were not identifying the areas where improvements were needed in sufficient detail.

However, there was good morale on the wards and staff felt supported by their ward managers. Staff felt a sense of pride working for the trust. The trust encouraged research and quality improvement.

Summary of findings

Information about the service

As a part of this inspection we visited the following services:-

The Bethlem Royal Hospital

Gresham 1 – 20 bed (18 at time of the inspection) female acute admission

Gresham 2 – 25 bed male acute admission

Croydon Triage - 17 bed (12 at time of inspection) mixed gender admission

Foxley Lane – 8 bed female acute admission

The Maudsley Hospital

Eileen Skellern 1 – 10 bed (6 at time of inspection) female PICU

Eileen Skellern 2 – 18 bed male acute admission

John Dickson – 20 bed male acute admission

Aubrey Lewis 3 - 18 bed female acute admission

Ruskin on Aubrey Lewis 2 – 18 bed female acute admission

Lambeth Hospital

Eden ward – 12 bed male PICU

Bridge House Male – 13 bed male acute admissions

Bridge House Female - 12 bed female acute admissions

Lambeth triage ward – 18 bed mixed acute admissions

Luther King – 18 bed male acute admission

Nelson – 18 bed female acute admission

Ladywell Unit

Johnson - 10 bed male PICU

Clare - 17 bed mixed acute admissions

Powell – 18 bed male acute admissions

Wharton – 18 bed female acute admissions

Jim Birley unit - 18 bed (16 beds at the time of the inspection) female acute admissions

Lewisham triage ward – 16 bed (14 at time of inspection) mixed acute admissions

The Bethlem Royal Hospital had been inspected seven times since 2010 and the reports of these inspections were published between July 2011 and March 2015.

The Maudsley Hospital had been inspected four times since 2010 and the reports of these inspections were published between January 2012 and November 2013. The last inspection had taken place in October 2013. The inspection team had visited two acute wards in the hospital, John Dickson and Jim Birley Unit. Following the inspection a compliance action was made because patients were not being protected from risks associated with unsafe and unsuitable premises. Jim Birley Unit, in particular, did not have a suitable design and layout, ligature risks had been identified but not removed and adequate maintenance was not being carried out. At the time of this inspection the Jim Birley Unit had been closed and relocated to the Ladywell Unit in Lewisham while the ward at the Maudsley Hospital was refurbished.

Lambeth Hospital had been inspected four times since 2010 and the reports of these inspections were published between October 2011 and January 2014. The last inspection had taken place in December 2013 and had included Luther King ward. There were no outstanding compliance actions at the time of our inspection.

Ladywell Unit had been inspected six times since 2010 and the reports of these inspections were published between March 2011 and January 2014. The last inspection had taken place in December 2013. The inspection team visited Powell and Johnson wards. Following the inspection one compliance action was made because patients were not being protected from risks associated with unsafe and unsuitable premises. Since that inspection, there has been refurbishment work which has taken place at the unit and therefore this as no longer outstanding.

Summary of findings

Our inspection team

The team that inspected the acute and PICU service consisted of 2 CQC inspection managers, 5 CQC inspectors, 4 Mental Health Act reviewers, 4 nurses, 5 consultant psychiatrists, 4 experts by experience, 2 social workers and one clinical psychologist

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During this inspection visit, the inspection team:

- visited 19 wards at the Maudsley Hospital, Lambeth Hospital, Bethlem Hospital, the Ladywell Unit at Lewisham Hospital and Foxley Lane womens service and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 96 patients who were using the service and 7 carers and collected 63 completed comments cards.
- spoke with the managers or acting managers for each of the wards
- spoke with 183 other staff members; including doctors, nurses, occupational therapists, pharmacists, psychologists, health care support workers, a social worker, a chaplain and an independent advocate
- interviewed the service director and clinical director with responsibility for these services
- attended and observed nine handover meetings, nine multi-disciplinary meetings, and two bed management meetings
- attended and observed two patient community meetings and one daily planning meeting.
- looked at 103 treatment records of patients
- carried out a specific check of the medication management on three wards
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

During our inspection we spoke with 96 patients and 7 carers. Most of the feedback we received was positive.

We also received 63 completed comment cards from patients or staff from the acute and PICU services. Of these, 30 had only positive comments on them and mainly talked about the caring staff, helpful treatment and the safe and clean environments. Five had only negative comments and the rest had both positive and negative comments on them. The areas identified for improvement included the need to keep showers and toilets clean at all times, staff too busy to talk and a few who are less respectful.

Summary of findings

Good practice

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

Areas for improvement

Action the provider MUST take to improve

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

Action the provider SHOULD take to improve

- The trust should ensure that staff continue to increase their completion of mandatory training.
- The trust should ensure the consistency of recording that patients have had their S132 rights explained to them is improved.
- The trust should ensure that staff are aware and have correctly recorded each patients status under the Mental Health Act so their rights can be correctly upheld.
- The trust should ensure staff continue to receive training on the Mental Capacity Act so it can be applied more consistently.
- The trust must ensure that all temporary staff working on the acute wards receive a timely local induction.
- The trust should avoid blanket restrictions for example with-holding access to bedroom keys for patients on acute wards at the Ladywell Centre.
- The trust should continue to look at measures to reduce the numbers of patients who are absent without leave from acute and PICU wards. This includes making environmental changes where needed.

Summary of findings

- The trust should ensure medication is stored at the correct temperature by monitoring medication fridge tempratures and clinic room tempratures. Fridges must also be locked to keep medication secure.
- The trust should ensure that where staff are using personal alarms that there are enough for all staff and visitors.
- The trust should ensure all staff have regular supervision.
- The trust should ensure that staff have training on supporting people with learning disabilities or autism spectrum disorder where they are caring for patients with these needs.
- The trust should ensure patients have accesss to enough therapeutic activities including support to access the gym.
- The trust should ensure that staff are mindful of people's privacy and dignity for example closing observation panels in bedroom doors where possible.

South London and Maudsley NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Gresham 1 Gresham 2 Croydon Triage	The Bethlem Royal Hospital
Foxley Lane	Foxley Lane
Eileen Skellern 1 (PICU) Eileen Skellern 2 John Dickson Aubrey Lewis 3 Ruskin on Aubrey Lewis 2	Maudsley Hospital
Johnson (PICU) Lewisham Triage Powell Wharton Clare Jim Birley Unit	Ladywell Unit
Eden (PICU) Luther King Nelson Lambeth Triage Bridge House	Lambeth Hospital

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Acute wards:

85% of staff had training in the Mental Health Act. However, on Jim Birley Unit only 46% of staff had been trained. At the time of our inspection, staff had not received training relating to the new Mental Health Act code of practice which was operational and had been since April 2015. Staff did not have access to copies of the current Mental Health Act code of practice 2015 on the wards.

Capacity to consent to treatment forms were completed effectively and accurately.

Documentation about patients who were detained having their rights read to them under S132 was inconsistent. For example, for one patient on Wharton ward, there was no record of them having been read their rights and it was not clear that this had been done. Another patient on Clare ward told us they had not been explained their rights to appeal against their section until over a week after they were detained and we found no record of them having been told their rights. Another patient who had been detained on Clare ward for a few months, told us that they had not been aware of their rights to appeal until the day before our visit and we did not see a record of this having taken place.

Some nurses and junior doctors did not understand the rights of informal patients to leave the ward and to refuse medication offered to them. On some wards, for example, Aubrey Lewis 3, and wards on the Lambeth site, informal patients were asked to sign 'contracts'. At Lambeth, patients who were informally admitted told us that they did not believe they were able to leave the ward unescorted. On Aubrey Lewis 3, the 'contract' set out what nursing interventions would be provided and included the sentence 'I will comply with my medication'.Accepting a bed should not come with a blanket agreement to take any medication offered and this was not clear in the contract. On John Dickson ward, the contract document stated 'if you wish to go out, please ask staff to open the door for you. This will be done within a reasonable time unless there is a known and valid reason not to do so'. There was a risk that rights of informal patients to leave the wards would not be respected and their rights to liberty would not be upheld. This information contradicted the trust leaflet 'being an informal patient'. On Aubrey Lewis 3, we reviewed care plans of two patients who were not detained under the Mental Health Act. For one patient there were no care plans in place addressing their informal status. The second patient had a care plan stating they were in the hospital informally. However, the care plan stated "if a doctor feels you are not safe to leave the ward, he/she will explain why you are not allowed to leave" and went on to state that the patient had a right to complain. There was no further explanation of the rights of the informal patient. There was a risk that staff would prevent informal patients from leaving hospital without having legal authority to do so. To state that the patients' only redress would be to complain was incorrect and misleading.

On Clare ward, one patient had been on four different sections of the Mental Health Act in a four month period, including sections 2, 3, 5(2) and 5(4) with periods of being admitted informally between this. It was not clear in the records that this patient was aware of his rights as an informal patient when he was not detained. One patient on Wharton ward had been placed on section 5 (2) of the Mental Health Act in the week before our visit. This section had expired with no assessment being requested or undertaken. After this section lapsed, the patient asked to leave the ward and was not allowed to leave. They were given medication. We did not see evidence they were given any indication of their rights as an informal patient.

Patients had access to independent mental health advocates. Posters were displayed on the wards.

Psychiatric intensive care units:

94% of staff had completed training on the Mental Health Act.

Most staff had a good awareness of mental health legislation and the rights of patients detained under the Mental Health Act.

There were Mental Health Act offices on each site. Staff were aware of where and how they could access support. Staff had not received specific training related to the new code of practice.

Detailed findings

Patients had access to an independent mental health advocate who could support them. Information about how to access advocacy was displayed on the ward.

Mental Health Act paperwork was filled in correctly and stored appropriately. Where required, consent (T2) or authorisation (T3) certificates were completed and attached to medicine charts.

Staff explained patients' rights to them and this was documented on the PICU wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

Acute wards:

49% of staff have had training in the Mental Capacity Act.

Foxley Lane had submitted an application for an authorisation under the deprivation of liberty safeguards. We reviewed the paperwork for this and found that the application included a decision specific capacity assessment and that there was a care plan in place to reflect the need and staff actions.

Knowledge of the Mental Capacity Act and how this impacted on practice was varied. Some staff had a very poor understanding whereas others were able to explain legislation more clearly. For example, most staff told us that all mental capacity decisions would be made by doctors in ward rounds. This did not reflect an understanding that a decision-maker, according to the Mental Capacity Act, can be anyone who works with a patient in a professional capacity and that if the question relating to capacity was an issue that related to the nursing care of a patient, it would be appropriate for a nurse to assess capacity.

We saw that in some situations where a capacity assessment may have been required, there was no formal record. For example, one record on Wharton ward, we saw that a mental state examination of a patient indicated that there was reason to query their capacity to consent to an admission, however, no assessment of capacity had been recorded. Another patient on Wharton ward, who staff told us had a diagnosed learning disability, had been an informal patient on the ward. There had been an application for a holding detention under S5(2) of the Mental Health Act because this patient lacked capacity to consent to a formal admission. However, this section lapsed and there was no assessment stating that they had regained capacity in the 72 hours that the 5(2) was in operation for.

We reviewed five care records on Gresham 2 and in three of the records, there was no evidence to show consent for treatment had been sought or that an assessment of capacity had been undertaken where there were reasons to question capacity. We reviewed four care records on Gresham 1. In all four cases, there was little or no evidence that informed consent for treatment had been sought. In two patients' records there was no evidence that any assessment of mental capacity had been undertaken where there was reason to believe capacity may have been in doubt. We saw good examples of recording of capacity of patients to consent to care and treatment on Eileen Skellern 1.

The trust had a policy in place to inform and support staff in the use of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Psychiatric intensive care units:

72% of staff across the PICU wards had completed training on the Mental Capacity Act. This was 58% on Eden ward.

Some members of staff told us that they did not feel fully confident in understanding the Mental Capacity Act and its usage on the ward. For example, two members of staff on Johnson ward told us that it would be the doctor's responsibility to assess capacity without indicating an understanding of the different kinds of decisions that are made which may be more appropriate for a nurse to assess.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Acute wards

Safe and clean environment

- Most wards were designed to ensure that there were clear lines of sight from the nursing offices into the ward area. However, Foxley Lane, which was a converted house, did not have clear lines of sight. Some other wards at the Bethlem Royal Hospital did not have clear lines of sight – for example, Gresham 2. The trust had a policy of a minimum of hourly observations. These records were completed.
- Wards had a number of ligature risks which were identified in ward-specific assessments and staff were aware of these. The trust had a works schedule in which work was highlighted to take place where risks had not been minimised. Together with individual patient observations, this served to mitigate some risks. On Gresham 2, we saw that ligature risks and management had been in individual staff supervision. Ligature cutters were available on all wards and staff were aware of their location.
- The trust had some mixed sex wards such as Clare ward at Lewisham and the triage wards. Where there were mixed sex wards, there were separate corridor areas for men and women, and women had access to separate lounge areas.
- Wards had fully equipped clinic rooms. Staff ensured emergency equipment was in place and was regularly checked. There were records to confirm these checks took place. However, at the Maudsley Hospital some items of equipment were out of date, including a syringe in the resuscitation bag on Ruskin ward. Two airways in the resuscitation on Aubrey Lewis 3 had expired in January 2014 and another airway expired in August 2015. On Eileen Skellern 2 the sodium chloride in the emergency resuscitation bag had expired in January 2015. There was a risk to patients from this out of date equipment. We raised these concerns immediately. However, regular checks had not identified this. On Jim Birley Unit at the Ladywell Unit, the documentation to check emergency equipment had not been updated for two weeks at the point of the inspection. Controlled drug keys were held separately from the main keys. However, we found a drugs fridge was not locked on Luther King in Lambeth. This fridge remained unlocked for two days despite it being raised on site immediately by the inspection team on the first day of the visit.
- Croydon triage ward had a seclusion room which was spacious and had a toilet and shower. There was a communication panel with room temperature and lights controlled externally.
- The wards were clean. There were appropriate furnishings. In some wards, we saw that there was some need of cosmetic refurbishment, for example, at the Maudsley site.
- Infection control audits were carried out regularly as were environmental risk assessments. Some wards, such as Powell and Wharton at the Ladywell Unit, had link members of staff to lead on infection control. Handwashing facilities were available in the ward areas and alcohol gel was accessible at the entrance to wards.
- Staff at the Maudsley had access to personal alarms. Gresham 2 had wall mounted alarms and while Gresham 1 also had wall mounted alarms, staff had also been issued with personal alarms. Staff on Gresham 1 were not using the personal alarms as there were not enough for all members of staff to access them. This meant there was a risk that some staff and visitors to the ward may not have access to support offered by an alarm. The Ladywell Unit had a wall based fixed system but was moving to a personal alarm system which staff told us would be an improvement.

Safe staffing

- Across the acute wards, on the four sites, there were 85 vacancies for qualified nurses and 36 vacancies for health care assistants out of an establishment number of 361 staff (both nurses and health care assistants). The highest vacancy levels were on Lewisham triage ward and Bridge House which had 7 vacancies.
- Staffing levels varied between the wards, depending on the type of ward and the site where the ward was based. Wards provided staff to the emergency team that could

be called to any of the wards on site if they needed additional support. The wards at the Maudsley took turns to provide staff for the Southwark health based place of safety when a patient was admitted. An additional fifth member of staff had been added to allow for this. The ward managers with five staff on every shift said that this had improved the consistency of care provided and safety on the wards. The places of safety at Lewisham were staffed from the ward establishment at Johnson psychiatric intensive care unit. The trust also had a separate 136 team which floated between the health based places of safety and provided extra staff where needed.

- All managers said they were able to request additional staff when they needed them. Bank and agency staff were used frequently to ensure safe staffing levels were reached and to cover the close observations of patients who were most at risk. At Lambeth, staff on all wards stated that short staffing was a problem for them and they were using high levels of bank and agency staff. For 75% shifts in June and July 2015, Lambeth triage ward had not met determined safe staffing levels. This meant that out of 183 shifts, 89 shifts for qualified staff had not been fully staffed, including all (31) the night shifts in July which had been staffed with three rather than four qualified members of staff and out of 183 shifts, 14 shifts for unqualified staff had not been filled. Often the gaps for qualified staff had been filled with unqualified staff. Over the same period, June and July 2015, Bridge House, at Lambeth Hospital had not met the safe staffing targets set by the trust on 64% of shifts. Out of 183 shifts, 117 shifts for qualified staff had not been at the levels determined by the trust. All the shifts for unqualified staff had been met and unqualified staff had provided additional support where qualified staff had not been available. All the early shifts in June and all the late shifts in July had not reached the required number of qualified nurses on shift.
- All wards at the Maudsley had some shifts they had been unable to fill during the last month. For example, on Eileen Skellern 2 there had been 14 unfilled shifts and on John Dickson ward there had been five. Sometimes the appropriate skill mix between qualified and unqualified staff had not been achieved. For example, on Eileen Skellern 2 in August 2015 nine shifts on the ward that should have had two qualified nurses only had one. Sometimes it was not possible to obtain sufficient numbers of bank and agency staff to provide cover. The ward manager had raised concerns with senior managers regarding obtaining sufficient temporary staff. The Eileen Skellern 2 ward manager told us that staffing shortages resulted in the cancellation of approximately one-fifth of the activities on the ward.
- At the Ladywell unit, staff and patients told us that leave was occasionally cancelled due to staffing levels. Four members of staff at this site told us that activities or leave to go to the garden or 1:1 time with named nurses was cancelled due to staffing levels and three patients told us that activities were also cancelled. At the Royal Bethlem Hospital, staff told us that patient leave was cancelled on occasion due to staffing levels. At Lambeth Hospital, patients told us that their escorted leave had never been cancelled and staff always try to get them out for this.
- Wards had specific induction processes for bank staff including orientation to the ward and general housekeeping. Gresham 2 provided agency induction paperwork for two staff members, both of which were incomplete.
- Staff on several wards at the Maudsley Hospital site told us they sometimes felt unsafe at night. This was because not all bank and agency staff on duty at night had completed the required training (promoting safer and therapeutic services or PSTS) to be able to restrain a patient safely. They needed to work a minimum number of days in the trust before they became eligible for the training. A staff member who was not trained in this way was not allowed to take part in a restraint. Managers were not always aware of the training status of bank and agency staff before they came on duty. The duty senior nurse for the acute wards contacted all wards at the beginning of each shift to find out how many PSTS trained staff were available. Staff told us they would like all bank and agency staff to be trained in PSTS before working on the acute wards. The shift activity and incident report recorded how many staff were available on each ward at the Maudsley Hospital, how many were trained in PSTS and how many enhanced observations of patients were taking place on each ward. On 22 September 2015 13 of 18 staff had completed PSTS training which was 72% of staff. There was a risk that there were not enough trained staff on a shift to restrain a patient safely.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- There were enough doctors available during the day and at night to meet patients' needs.
- The data we received from the trust regarding mandatory training completion rates across the acute wards was mixed. For example, 87% of staff had completed health and safety training. However, on Wharton ward this was 50%. Training for immediate life support was 77% across the wards, with some wards like Clare and Jim Birley Unit at 100% and others significantly lower, for example, Wharton 42% and Gresham 1 at 55%. Moving and handling of patients was at 64% across the wards including 44% on Ruskin on Aubrey Lewis 2 and 50% on Wharton ward where, at the time of our visit, there was one patient who required assistance to mobilise and needed to use a hoist to transfer. 81% of staff had completed mandatory promoting safer and therapeutic services training (teamwork). This meant that across the service, there were some significant gaps in mandatory training.

Assessing and managing risk to patients and staff

- Across the acute wards we visited, in the period between December 2014 and the end of May 2015, there were 395 incidents of restraint records which included 120 incidents of the use of prone (face down) restraint. 84 of these prone restraints took place in order to administer rapid tranquillisation. Staff told us that restraint was used as a last resort and that was an integral part of their training. However, we saw examples of restraint taking place which was not recorded and therefore would not be reflected in the above figures. For example, on Wharton ward, the care records demonstrated that for one patient, two incidents of restraint had taken place on 23 September 2015, one of which was described in the notes as a prone restraint and neither had been recorded through the trust reporting system. Where some incidents of restraint were reported, staff were not guided to indicate how long the restraint took place for and which staff members were involved. The database where this information was stored allowed an option for 'various restraints' and that meant that there was a risk that reported restraint which took place in the prone position, may not have been recorded as such. On four restraint records on Powell ward, 'various restraints' had been indicated without specifying the hold used. As the data provided was not accurate due to a lack of consistency in recording, the trust could not be sure that information about restraint and the use of prone restraint reflected actions on the ward.
- There was no recorded seclusion on the acute wards. On Lambeth triage ward, the 'chill out' room was being used for seclusion. We were informed that when this happened, seclusion monitoring forms had been used to document patient monitoring and reviews. Ward staff were unable to locate copies of these forms and the data we received from the trust indicated that no seclusion had taken place on Lambeth triage ward. Therefore, we were unable to confirm that the procedure for seclusion had been completed for these patients in line with the code of practice requirements.
- Records showed that staff carried out individual patient risk assessments when they were admitted. However, on some wards, these were not always detailed enough. The risk assessments did not always link to patients' care plans and there were no risk management plans for some of the risks identified. We reviewed the risk assessment records of 13 patients across the four acute wards at the Maudsley Hospital site. We found that 5 risk assessments were not completed appropriately or had not been reviewed for six months or more. The quality of risk assessments varied between wards. On John Dickson ward patient risk assessments were completed appropriately. On Ruskin on Aubrey Lewis two, risk assessments lacked detail and had not been fully completed. We checked 20 records at the Ladywell unit. Eight of these did not reflect current risks identified. For example one patient had been admitted to Wharton ward and there was no full risk assessment available a week later. On another record, we saw that specific risks relating to a patients' physical health had not been reflected in the risk assessment. We reviewed six care records at Foxley Lane. Only two patients had had full risk assessments completed on admission to the service. Three of the six records we checked did not demonstrate that identified risks such as self-harm had been translated into a plan of care. We reviewed five care records on Gresham 2 and found that all patients had an up to date risk assessment.
- We observed handovers of patient information between nurses and doctors and between shifts when these changed. Clear written documents were used to

handover information. Staff used a red, amber, green risk rating to highlight which patients were high, medium or low risk. Staff discussed patient risks in the community as well as in hospital especially when leave was being considered. On John Dixon ward the ward manager had developed a risk assessment checklist for staff to use to assess the suitability and safety of the leave before the patient went out of the ward. Staff used a risk assessment tool called dynamic appraisal of situational aggression. The tool predicts the likelihood of aggression over a short time period. Assessments using this tool were very detailed and provided a visual presentation of risk and changes in risk over time.

- Staff checked patients' vital signs on a regular basis to ensure potential physical health problems were identified quickly. The results of checks were recorded on a form called modified early warning signs (also known as MEWS). Information from the MEWS forms was then transferred on to the electronic patient record. On most of the wards we visited, these charts were completed and used to escalate concerns. However, on Eileen Skellern 2 we reviewed the MEWS charts of five patients who had scored four or more. This score meant there was a risk to their physical health and staff should escalate concerns to medical staff. We checked the five individual patient MEWS charts against the electronic records for the same patients. Of the five charts only two had been documented correctly and resulted in appropriate action. One patient scored four on the MEWS chart, indicating a concern requiring escalation by staff, but this was documented as a score of two on the patient electronic record and there had been no medical follow up, which was required. The second patient MEWS chart, which had also scored four, was not documented at all on the electronic patient record. As a result no further action had been documented or taken. The third patient had scored four on the MEWS chart but the score was recorded on the patient's electronic record as zero and there had been no escalation or follow up. For the two other MEWS charts there was evidence that the scores of seven and four had been documented correctly on the electronic patient records and appropriate action had been taken. Staff had not taken appropriate action to escalate concerns to medical staff on three of the five occasions we reviewed, despite scores of four on the patient MEWS charts. Risks to the patients had been identified but action had not been taken to follow up or mitigate the risks, which meant care and treatment was not being provided in a safe way to patients.
- There were some blanket restrictions in place across different sites. For example, in Lewisham patients did not have keys to their bedrooms. On Wharton ward, we saw one patient requested the bedroom door keys but this was not discussed in a ward round.
- The acute wards across the trust had different rates of detained patients leaving the ward without permission, failing to return from authorised leave or leaving while on escorted leave without permission. For example, between February and July 2015, 13 patients from Gresham 2 at Royal Bethlem Hospital had been absent without leave from the ward or garden and 19 had failed to return from authorised leave in the same time period. On Wharton ward at the Ladywell Centre, 7 patients had been absent without leave in the same time period and 11 had failed to return from authorised leave. Nelson ward, at Lambeth Hospital, 5 patients had been absent without leave and 15 had failed to return from authorised leave and at John Dickson ward at the Maudsley Hospital 4 patients had been absent without leave and 35 had failed to return from authorised leave. No detailed reviews had taken place of these incidents and so it was not possible to know the impact on individual patients although there was clearly a potential risk to people's safety.
- Staff had a good understanding of safeguarding processes and knew how to access support when necessary. Some wards at Lewisham had identified safeguarding leads who took a particular role in ensuring safeguarding policies were embedded.
- There was good medicines monitoring and management throughout the wards at the Maudsley Hospital. We reviewed the medicine administration records of 10 patients on Aubrey Lewis 3 and Ruskin on Aubrey Lewis 2 . These had all been completed appropriately. There were no missing signatures on the records, allergies were recorded and medicines were reconciled. The wards received good support from pharmacists who carried out regular medicines audits on the ward. However, we found on Aubrey Lewis 3 and Ruskin on Aubrey Lewis 2 that maximum and minimum

temperatures of fridges used to store medicines requiring cold storage were not being recorded. The fridge used to store medicines needing cold storage on Aubrey Lewis 3 was not locked.

- At the Royal Bethlem Hospital, all medicines were stored correctly and transported securely. At the Ladywell Unit, medication was managed from the Lewisham Hospital site with a pharmacist from the acute trust providing support and ensuring medicines were dispensed, administered and audited effectively. However, Jim Birley Unit, which had transferred from the Maudsley Hospital to the Ladywell Unit, we saw some discrepancies with the medicines. For example, information about patients' physical health was not recorded on the medication chart and nor was information about patients' Mental Health Act status.
- At the Maudsley Hospital, there were rooms off the wards where children could visit patients safely.

Track record on safety

- Between August 2015 and August 2015, there were sixteen incidents which required investigation across the acute wards according to the NHS Framework. Two were at Lambeth Hospital, four were at Bethlem Hospital, seven were at the Ladywell Unit, one was at Foxley Lane and two were at the Maudsley Hospital.

Reporting incidents and learning from when things go wrong

- Most staff knew how to report incidents.
- Staff received information about incidents that had occurred in other wards and services. Learning was shared across the trust through emails called 'blue' and 'purple' bulletins. The different colours of the bulletins signified differences in seriousness and urgency of communication. Learning from incidents was also discussed at reflective practice meetings.
- The trust were very aware that many of the incidents on the acute ward were linked to patients assaulting other patients. The trust was piloting the 'four steps to safety' programme to work on reducing violence and aggression on the wards. This had very positive feedback from staff who were involved in the wards which were starting to use it and this meant that the trust was looking at new ways to improve practice.
- Staff gave us examples of changes and improvements they had made in response to incidents. For example, on Ruskin on Aubrey Lewis 2 there had been an incident where a patient had taken home medication meant for another patient. When the mistake was discovered staff apologised immediately. The manager had introduced additional checks on take home medicines when they arrived from the pharmacy to minimise the chances of it happening again. On John Dickson ward the ligature risk assessment for the ward had been reviewed following a serious incident at another of the trust's hospitals. As a result of incidents occurring at meal times on Eileen Skellern 2 a protected meal time had been put in place to ensure that ward staff were always present at meals to help de-escalate any problems.
- Clinical service leads from different parts of the trust met every week and discussed concerns. A representative from this group went to lessons learned meetings. Information from these meetings was shared with staff through staff supervision and reflective practice meetings. Staff provided examples of how discussions in reflective practice meetings had led to the development of better patient care plans.
- Staff held a debrief session after incidents. Patients involved in incidents were offered an individual debrief where the reasons for what had happened were discussed and lessons for the future identified.

Psychiatric intensive care units

Safe and clean environment

- The wards had blind spots and numerous ligature points. All wards had an up to date ligature risk assessment and all ligature points were identified on them. On Eileen Skellern 1, some bedrooms were out of sight at the end of each corridor. Staff carried out regular checks to make sure patients were safe. At Johnson ward, where there were blind spots, staff were aware of the need to observe patients. However, on Eden ward, we were not adequately reassured that these were mitigated, despite being identified on the risk assessment. Eden ward had numerous taps, radiator covers, wardrobe tops and hinges on doors. Staff were not aware when additional work was due to be carried out. However, the trust works programme had further ligature reduction work scheduled on Eden on a programme running up to July 2016. We also found

that the risk assessment for the garden area on Eden ward suggested staff were always there. However, we saw patients could access this without staff being present. The toilets had exposed pipe work as well as taps and these were left open. Staff we spoke to on inspection were not aware of these ligature risks. This was the same for the bathroom which we found to be open on our visit. On a return visit to Eden ward we found a door open that should have been locked and in the corridor there were large planks of wood from a bookcase that had been broken, patients were freely walking in this area and staff had not realised this. This was raised immediately with the service manager who addressed it.

- The psychiatric intensive care units had fully equipped clinic rooms. Emergency equipment was in place and records showed that this was checked regularly. Staff were aware of the location of ligature cutters which were readily available. Staff had received training in life support techniques and the use of automated external difibrillators which enabled them to respond effectively in emergencies.
- The seclusion rooms in the three intensive care units allowed staff to observe patients clearly. Any patient inside the seclusion room could see a clock and had a method of communicating with staff outside the room. Patients had direct access to a toilet and shower.
- The PICUs were visibly clean with appropriate furnished.
- Medical devices were cleaned and labelled with the date of cleaning.
- There were some risks in the ward environments. For example, on Eileen Skellern 1, there was a staircase in the garden area which acted as a fire escape for other wards in the building. Patients could access the stairs when they were in the garden. Staff told us that risks to patients from the stairs were mitigated by staff accompanying and observing patients in the garden. However, we observed one patient alone at the top of the staircase when there was no staff member in the garden. We alerted staff to this and they attended the garden and the patient immediately. Johnson ward had a dedicated garden area. Patients were observed in the garden area. However, during our inspection visit, one patient absconded from the garden by jumping over the fence. This meant that there was an ongoing risk of patients' safety being at risk due to the design and observations in the garden area.
- Comprehensive health and safety audits and infection control audits were carried out regularly on the ward with any identifiable risks, leading to specific time-limited actions.
- Staff at Lambeth Hospital and Maudsley Hospital had personal alarms on the unit. At the Maudsley Hospital site, we noted that there were not enough alarms for all the staff and visitors on the ward at the time. At the Ladywell Unit, the ward was switching from a fixed alarm system to a personal alarm system. Some personal alarms were available for staff and visitors but there were not enough for all members of staff to have one each. The fixed alarm worked in a way that any time it was triggered, in any part of the building, it was heard on the ward. Staff told us that these noise levels could be disruptive, particularly during the night. However, the trust was moving to a personal alarm system.

Safe staffing

- When we visited Eileen Skellern 1, we found there were staff shortages. The manager told us that there were five vacancies for band 5 nurses and two vacancies for band 6 nurses out of an establishment of 24 staff. There had been a high turnover on this ward with four band 6 nurses leaving since July. This meant that most staff were very new to the ward and nearly all the band 5 nurses were newly qualified. There was a shortage of experienced staff. Some staff we spoke with told us that they felt anxious on the ward. More experienced staff told us that they felt under pressure to deal with more complex situations because of the inexperience of the other staff. The ward manager had been spending 80% of their time in direct patient care to support the newer staff. They said that this had had an impact on their managerial work and ability to complete audits and action plans.
- Data on safe staffing provided by the trust showed that across the PICUs, the agreed levels of staffing on Eden and Johnson wards had not been achieved in under 5% of shifts across May-July 2015. On Eileen Skellern 1, in May the target had not been reached 26% of the time, 13% in June and 11% in July. The trust had reduced

beds on Eileen Skellern 1. The trust had taken action to try to support ward staff on Eileen Skellern 1 where there had been higher levels of unfilled vacancies. Some band 5 and 6 nurses had been seconded from other wards for a few months or weeks to support the staff team while new staff were recruits. The number of beds on the ward had been reduced from 10 to 6 to ensure patients were being cared for safely.

- Staff on the PICU wards covered the respective health based places of safety in the three boroughs in which they were located. Additional staff were brought in to cover this role. On Johnson ward, there was no specific area in the place of safety where police could speak confidentally to staff so they walked through the PICU unit to the nurses office.
- There were enough doctors available during the day and at night to meet patients' needs.
- The completion of mandatory training was variable across the wards. For example, 66% of staff had completed equality and diversity training, 74% of staff had completed immediate life support training and 80% of staff had completed safeguarding adults training and 57% of staff had completed safeguarding children training at level one. This meant that there were some significant gaps in mandatory training across the wards.

Assessing and managing risk to patients and staff

- For the six months between December 2014 – May 2015, 70 incidents of seclusion on the PICU wards with no use of long term segregation. The highest levels were at Johnson ward which had 35 incidents. We checked seclusion records and saw that they were comprehensively completed. The beginning and end time of the seclusion was recorded. Staff had documented appropriate seclusion reviews which took place during and after the episodes of seclusion.
- There were 140 incidents of restraint of which 47 were in the prone (face down) position and 37 of these were to administer rapid tranquillisation medication. Staff told us that they did not carry out planned face down restraints. If patients were restrained in a face down position, staff said that this was done for the shortest time possible and then the patient was moved to a different position. We checked two records of restraint on Johnson ward. One detailed the type of hold position. However, it did not indicate the positions of the staff involved in the restraint or the length of time the patient was restrained for. The other record indicated that 'various' restraint positions were used. However, the case record for this stated that it was a prone restraint which had been actioned in order to administer rapid tranquillisation. This meant that the restraint had not been flagged in the electronic database as a prone restraint. This was raised with the trust during the inspection and changes were made immediately to both the reporting system and the information staff are given about reporting restraint. However, it meant that the data provided by the trust regarding numbers of prone restraints may not be being collected accurately. Staff were aware of the trust policy on rapid tranquillisation which had recently changed.
- Staff checked patients' vital signs on a regular basis to ensure potential physical health problems were identified quickly. The results of these were recorded on modified early warning signs (MEWS) charts. This helped staff to identify when patients had abnormal results which required immediate escalation to medical staff.
- Staff had a good understanding of safeguarding procedures and were aware of actions to take when they had concerns. There were social workers who were attached to the wards who were also able to provide advice.
- On Eden ward and Eileen Skellern 1, pharmacy support was provided by the trust. We reviewed four medicine administration charts on Eileen Skellern 1. They had all been completed appropriately. The units received good support from pharmacists who carried out regular medicines audits on the wards. However, on Eileen Skellern one, the temperature of the clinic room had reached 28 degrees centigrade on 22 September 2015. Recommended room temperature is 25 degrees centrigrade and for the seven days before our visit, temperatures above 25 degrees centigrade had been recorded.
- There were rooms away from the ward areas where children could visit patients safely. All visits were risk assessed.

Track record on safety

- No serious incidents had been reported on the PICU wards between April 2014 and August 2015.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. They knew the type of incidents they should report. Staff provided examples of learning from incidents. Staff were able to tell us about recent incidents in the service and how this had changed practice.
- Clinical service leads from different parts of the trust met weekly to discuss concerns. Information from these meetings was shared with staff through staff meetings and reflective practice meetings.
- Staff received information about incidents that had occurred in other wards and services. Learning was shared across the trust through emails called 'blue' and 'purple' bulletins. The different colours of bulletins signified differences in seriousness and urgency of communication.
- The manager of Eileen Skellern one was aware of the duty of candour requirements. These had been discussed as a national association of psychiatric intensive care and low secure units meeting.
- The ward manager on Johnson ensured that debriefings were offered to staff after serious incidents.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Acute wards

Assessment of needs and planning of care

- Staff assessed patients on admission. The exception to this was Foxley Lane where recorded assessments were not completed. Assessments included physical and mental health needs. Care records showed that physical health assessments had taken place.
- Some care plans were personalised and patient centred, for example, the records we saw on John Dickson ward. Other care plans were mostly generic and often failed to address patients' assessed needs. We reviewed seven care records on Aubrey Lewis 2. All seven patients had similar care plans with little recording of patients' views, strengths, personal concerns, or goals in any of the Ruskin on Aubrey Lewis 2 care plans. Two patients' care plans were inaccurate, for example, a care plan for one patient stated they were detained under section 3 of the Mental Health Act when this was no longer the case. The other care plan did not address the patient's known physical health care problems. On the other wards at the Maudsley Hospital, we reviewed ten care plans. Six were not personalised, holistic or recovery orientated. At the Ladywell Unit, we found few care plans reflected holistic needs, including social care needs and discharge plans. For example we saw a care plan for a patient who had specific physical health care needs which were not specified on the care plan and another care plan for a patient who was identified as having a learning disability but the care plan did not make any reference to differing needs relating to communication. At Lambeth Hospital we reviewed 18 care records. We found that care plans had been completed, however, they were not updated after admission. Care plans we saw did not include patient views. Patients we spoke with did not know they had care plans. They told us that they had not provided input into them and did not have copies of them.
- We saw some good examples of physical health care needs being managed. For example, plans addressing diabetic care needs. However, in some wards, such as Ruskin on Aubrey Lewis 2, we found that physical health care plans were generic and did not address patients' known physical health needs. For example, we spoke with a patient who told us that they had problems with their mobility which caused them significant distress. When we reviewed their physical health care plan there was no record of this. Staff told us that the patient had diabetes. This was also not included in their physical health care plan. There was no separate care plan related to diabetes management. Staff confirmed with us that physical health care was discussed in ward rounds.
- The trust used an electronic record system called EPJS. This was password protected and all staff had individual passwords.

Best practice in treatment and care

- Staff considered national institute for health and care excellence (NICE) guidelines when they were making treatment decisions. For example, when prescribing medicines and providing psychological interventions. Patients at the Maudsley Hospital had access to groups run by a psychologist, including mindfulness groups. Staff were aware that the guidance on rapid tranquillisation had recently changed. Changes in guidance were discussed in team meetings and doctors' management rounds. Staff were able to access NICE guidelines electronically. This helped ensure that professional practice was evidence based. Maudsley prescribing guidelines were also followed.
- The trust had implemented a no smoking policy across all hospital sites in October 2014. .Staff had been trained to support patients to stop smoking and a wide range of nicotine replacement therapies were available. Nicotine replacement therapy could be prescribed by nurses following trust agreed patient group directions (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). On one ward we saw that additional support for a patient who was struggling with the smoking ban was discussed in the management handover meeting involving a ward manager and a doctor.
- Most patients had access to psychology services although this was limited. Long term psychological therapies took place in community teams so referrals could be made from inpatient wards into the community teams in the psychosis clinical academic group (CAG). Patients who required ongoing

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Requires improvement

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psychological support who were moving into different clinical academic groups required a different referral process. One psychologist we spoke with identified this as a concern as seamless therapies would not take place for all inpatients on discharge as a result.

- Patients had access to good physical healthcare including access to specialist services. The Lewisham and Maudsley sites were located close to acute general hospitals. Patients accessd physiotherapy and dieticians through the trust and access to podiatry was through primary medical services on a referral basis.
- The trust used health of the nation outcome scales to assess and evaluate the effectiveness of interventions. Most of the records we checked had up to date evaluations completed.

Skilled staff to deliver care

- Care and treatment was provided by multi-disciplinary teams of professionals. This included nurses, psychiatrists, social worker, occupational therapists and psychologists. Occupational therapists were ward based except on the Lewisham site and at Foxley Lane where they were not, but rather, went to wards to complete specific pieces of work such as assessments of activities of daily living. There was no pharmacy input into ward rounds on the Lewisham site. However, on the other sites, trust pharmacists were part of the multi-disciplinary team.
- Staff received training in addition to mandatory training. Several nurses were taking or had completed Masters level degrees. Managers had taken leadership and coaching courses.
- New staff received an induction when they started working in the trust. This included mandatory training around the prevention of violence and restraint. Agency and bank staff also had an induction programme to ensure they were familiar with the wards.
- Staff supervision records were mixed. For example, on Gresham 2 ward we saw that there were some gaps in February and March 2015 where 24% and 20% of staff, respectively had received supervision. Gresham 1 were not able to provide records for supervision prior to the appointment of a new manager who had been in place for two weeks. However, they had developed a system to log this.
- All staff had received annual appraisals.
- Team meetings happened monthly on most wards. However, there were some gaps in the regularity of team meetings on Wharton ward. Ward meetings did not have a standard agenda. This meant that sometimes issues such as complaints, incidents and issues which affected the ward were not discussed.
- On two of the wards we visited at the Ladywell Unit, Clare ward and Wharton ward, there were patients who had been identified as having learning disabilities or autistic spectrum disorders. Staff on these wards had not received specialist training related to managing or working with people with these specific needs. There was some training which was due to be delivered on Clare ward relating to people who had autistic spectrum disorders.
- Ward managers were able to explain their understanding of how to apply staff performance management processes and told us that the human resources team would support them.

Multi-disciplinary and inter-agency team work

- All the wards had regular multi-disciplinary team meetings. Representatives of different disciplines attended bed management meetings which took place at each site. These meetings reviewed the number of beds available in the trust and discussed potential discharges and admissions. Where delays in discharges were identified, possible solutions were discussed.
- There were effective handovers between shifts. We observed handovers on all the sites. Comprehensive information about the needs of patients and up to date risks were shared between staff. This information was recorded and was accessible on the wards for staff coming onto the ward. However, we observed one handover on Wharton ward where information which was shared about patients was not accurate as staff were not aware of the legal status of a patient.
- There were effective working arrangements in place with several external agencies such as local substance misuse support organisations. However, one social worker told us that sometimes there were delays in communication between ward based staff and community based staff.

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- Community care co-ordinators were invited to attend ward rounds and care programme approach meetings. Ward managers told us that care coordinators who were based locally often came to these meetings.
- Each site had wards from different CAGs based on them. Each CAG had different management structures. There were site based meetings for the four main hospital sites which are attended by representatives from different teams providing an opportunity for information to be shared.

Adherence to the MHA and the MHA Code of Practice

- 85% of staff had training in the Mental Health Act. However, on Jim Birley Unit only 46% of staff had been trained. At the time of our inspection, staff had not received training relating to the new Mental Health Act code of practice which was operational and had been since April 2015. Staff did not have access to copies of the current Mental Health Act code of practice 2015 on the wards.
- Capacity to consent to treatment forms were completed effectively and accurately.
- Documentation about patients who were detained having their rights read to them under S132 was inconsistent. For example, for one patient on Wharton ward, there was no record of them having been read their rights. Another patient on Clare ward had not been explained their rights to appeal against their section until over a week after they were detained and there was no record that this had been done. Another patient who had been detained on Clare ward for a few months, told us that they had not been aware of their rights to appeal until the day before our visit and there was no record that this had been done.
- Some nurses and junior doctors did not understand the rights of informal patients to leave the ward and to refuse medication offered to them. On some wards, for example, Aubrey Lewis 3, and wards on the Lambeth site, informal patients were asked to sign 'contracts'. At Lambeth, patients who were informally admitted told us that they did not believe they were able to leave the ward unescorted. On Aubrey Lewis 3, the 'contract' set out what nursing interventions would be provided and included the sentence 'I will comply with my medication'.Accepting a bed should not come with a blanket agreement to take any medication offered and this was not clear in the contract. On John Dickson ward, the contract document stated 'if you wish to go out, please ask staff to open the door for you. This will be done within a reasonable time unless there is a known and valid reason not to do so'. There was a risk that rights of informal patients to leave the wards would not be respected and their rights to liberty would not be upheld. This information contradicted the trust leaflet 'being an informal patient'. On Aubrey Lewis 3, we reviewed care plans of two patients who were not detained under the Mental Health Act. For one patient there were no care plans in place addressing their informal status. The second patient had a care plan stating they were in the hospital informally. However, the care plan stated "if a doctor feels you are not safe to leave the ward, he/she will explain why you are not allowed to leave" and went on to state that the patient had a right to complain. There was no further explanation of the rights of the informal patient. There was a risk that staff would prevent informal patients from leaving hospital without having legal authority to do so. To state that the patients' only redress would be to complain was incorrect and misleading.
- On Clare ward we saw that one patient had been on four different sections of the Mental Health Act in a four month period, including sections 2, 3, 5(2) and 5(4) with periods of being admitted informally between this. It was not clear in the records that this patient was aware of his rights as an informal patient when he was not detained. One patient on Wharton ward had been placed on section 5 (2) of the Mental Health Act in the week before our visit. This section had expired with no assessment being requested or undertaken. After this section lapsed, the patient asked to leave the ward and was not allowed to leave. They were given medication. We did not see evidence they were given any indication of their rights as an informal patient.
- Patients had access to independent mental health advocates. Posters were displayed on the wards.

Good practice in applying the MCA

- Forty nine per cent of staff have had training in the Mental Capacity Act.
- Foxley Lane had submitted an application for an authorisation of under the deprivation of liberty

Are services effective?

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safeguards. We reviewed the paperwork for this and found that the application included a decision specific capacity assessment and that there was a care plan in place to reflect the need and staff actions.

- Knowledge of the Mental Capacity Act and how this impacted on practice was varied. Some staff had a very poor understanding whereas others were able to explain legislation more clearly. For example, most staff told us that all mental capacity decisions would be made by doctors in ward rounds. This did not reflect an understanding that a decision-maker, according to the Mental Capacity Act, can be anyone who works with a patient in a professional capacity and that if the question relating to capacity was an issue that related to the nursing care of a patient, it would be appropriate for a nurse to assess capacity.
- We saw that in some situations where a capacity assessment may have been required, there was no formal record. For example, one record on Wharton ward, we saw that a mental state examination of a patient indicated that there was reason to query their capacity to consent to an admission, however, no assessment of capacity had been recorded. Another patient on Wharton ward, who staff told us had a diagnosed learning disability, had been an informal patient on the ward. There had been an application for a holding detention under S5(2) of the Mental Health Act because this patient lacked capacity to consent to a formal admission. However, this section lapsed and there was no assessment stating that they had regained capacity in the 72 hours that the 5(2) was in operation for.
- We reviewed five care records on Gresham 2 and in three of the records, there was no evidence to show consent for care and treatment had been sought. We reviewed four care records on Gresham 1. In all four cases, there was little or no evidence that informed consent had been sought and in two patients, there was no evidence that any assessment of mental capacity had been undertaken where there was reason to query capacity. We saw good examples of recording of capacity of patients to consent to care on Eileen Skellern 1.
- The trust had a policy in place to inform and support staff in the use of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Psychiatric intensive care units

Assessment of needs and planning of care

- Staff assessed patients on admission. Assessments included both physical and mental health needs. Care records showed that physical health assessments had taken place.
- We reviewed the care plans of seven patients. These were personalised and patient centred. Risks identified in the risk assessments were addressed in the care plans.
- All the information about patients was stored in paper or electronic records. We could find more information we requested on the electronic record, although this was not always found quickly.
- The wards used the modified early warning system which is a methodology to ensure that any concerns regarding physical health checks are flagged early for nursing or medical attention. These records were completed and were up to date.

Best practice in treatment and care

- Staff considered national institute for health and care excellence (NICE) guidelines when they were making treatment decisions. For example, when prescribing medicines and providing psychological interventions. Patients at the Maudsley Hospital had access to groups run by a psychologist, including mindfulness groups. Staff were aware that the guidance on rapid tranquillisation had recently changed. Changes in guidance were discussed in team meetings and doctors' management rounds. Staff were able to access NICE guidelines electronically. This helped ensure that professional practice was evidence based. Maudsley prescribing guidelines were also followed.
- The trust had implemented a no smoking policy across all hospital sites in October 2014. Staff had been trained to support patients to stop smoking and a wide range of nicotine replacement therapies were available. Nicotine replacement therapy could be prescribed by nurses following trust agreed patient group directions (written instructions for the supply or administration of medicines to groups of paitents who may not be individually identified before presentation for treatment).

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The wards had good links with local acute general hospitals and accessed necessary support. For example, on Eileen Skellern 1, staff supported a patient with kidney problems who they escorted to the local acute hospital for dialysis three times a week. Staff had managed the patient's physical health effectively and their mental health improved sufficiently for them to be transferred to an acute ward during the week of the inspection. The staff teams were able to access specialist advice when needed. For example, on Eileeen Skellern 1, a diabetic nurse and incontinence nurse had come to the ward to see patients following referrals by staff. Medical staff reviewed records of checks on patients' physical health at every ward round and management handovers. This helped to identify any deterioration in a patients' physical health. Staff on Eileen Skellern 1 had designed a patient health booklet which was given to each patient. The booklets contained information about physical health and mental health, including information on nutrition and diet. Charts were available in the booklets for patients to record their mental and physical health progress.
- Patients had limited access to psychology services. Managers on Eileen Skellern 1 told us that there was supposed to be input from a psychologist for one or two sessions a week. However, in the nine months prior to the inspection, this had rarely been provided. Senior staff told us that the psychologist was also covering acute wards in the hospital and was unable to provide enough time on each ward.
- Staff used health of the nation outcome scales to measure outcomes for patients.
- A number of audits were undertaken on the wards. For example, on Eileen Skellern 1, medical staff had carried out an audit of length of stay and audits of prescription levels were carried out on Johnson ward.

Skilled staff to deliver care

- Care and treatment was provided by a multi-disciplinary team. The team included nurses, psychiatrists, social workers and a psychologist. The wards at Lambeth and the Maudsley had ward based occupational therapists. However, there was no ward based occupational therapy at Lewisham. A pharmacist attended ward rounds at Lambeth and the Maudsley Hospital but at Lewisham, pharmacy support from provided from the acute trust and therefore there was no pharmacy input into the ward round. Wards had activity coordinators.
- Staff received training in addition to mandatory training so that they could develop their skills and be effective in their roles. Senior staff were developing a set of PICU competencies so that new staff could be supported to develop appropriate knowledge and skills and demonstrate their ability to carry out their role effectively.
- New staff received an induction when they started work with the trust. This consisted of mandatory training, including promoting safer and therapeutic services (PSTS) and a period of shadowing other staff on the ward before they took up the full responsibilities of their role.
- Most staff received individual supervision month. However, due to some staff shortages on Eileen Skellern 1, some planned supervision had been cancelled. This had happened nine times in August, five times in July and three times in June. The wards had weekly group reflective practice sessions where staff could access support.
- 100% of staff had had appraisals in the last 12 months.

Multi-disciplinary and inter-agency team work

- The wards had regular ward and management rounds which included nursing and medical staff. However, on Johnson ward there was no consistent input from psychology, pharmacy, occupational therapy or social work except in specific situations regarding specific patients. This meant that there was a risk that the ward round as a whole may focus only on medical and nursing needs of patients and lose the broader multi-disciplinary approach.
- There were effective handovers between shifts. Key information about patients was handed over and there was a clear focus on safety. The physical health of patients, side effects from medication, the legal aspects of care and treatment and the importance of communicating with patients about decisions were discussed.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Community care coordinators were invited to the unit to attend ward round and care programme approach meetings.

Adherence to the MHA and the MHA Code of Practice

- 94% of staff had completed training on the Mental Health Act.
- Most staff had a good awareness of mental health legislation and the rights of patients detained under the Mental Health Act.
- There were Mental Health Act offices on each site. Staff were aware of where and how they could access support. Staff had not received specific training related to the new code of practice.
- Patients had access to an independent mental health advocate who could support them. Information about how to access advocacy was displayed on the ward.
- Mental Health Act paperwork was filled in correctly and stored appropriately. Where required, consent (T2) or authorisation (T3) certificates were completed and attached to medicine charts.
- Staff explained patients' rights to them and this was documented.

Good practice in applying the MCA

- 72% of staff across the PICU wards had completed training on the Mental Capacity Act. This was 58% on Eden ward.
- Some members of staff told us that they did not feel fully confident in understanding the Mental Capacity Act and its usage on the ward. For example, two members of staff on Johnson ward told us that it would be the doctor's responsibility to assess capacity without indicating an understanding of the different kinds of decisions that are made which may be more appropriate for a nurse to assess.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Acute wards

Kindness, dignity, respect and support

- We observed interactions between staff and patients which were kind and caring and which displayed an understanding of individual patient needs. Staff spoke with patients in a supportive and respectful manner. Staff were enthusiastic when they spoke about patient progress and showed empathy, care and compassion when they spoke about patients.
- We spoke with 82 patients across the wards. Most patients told us that they were treated with respect and kindness. Patients at Foxley Lane spoke very highly of their staff and of staff attitudes towards their care needs. At Lambeth, a couple of patients told us that staff ignored them.
- We spoke with four carers of patients on the wards at Lewisham. Their feedback was positive about the general interactions between staff and patients. However, they raised some concerns about staff understanding of the particular needs of their family members.
- On Eileen Skellern 2, regular physical health checks of patients' vital signs were carried out in the clinic room. The top half of the door was left open and we saw other patients leaning into the clinic to speak with staff. This meant that there was a risk to the privacy of patients having their vital signs checked by staff, especially if they wanted to discuss personal matters with staff.
- Wards had privacy glass windows. These were left open all the time. This meant that people could look into the rooms when the door was closed. Staff needed to be able to look into the rooms to check patients were staff. However, they did not need to be left open all of the time for every patient. Curtains were missing from the privacy glass on some wards, such as Aubrey Lewis 3. This could compromise the dignity of patients.

The involvement of people in the care they receive

- Patients were given an information pack when they were admitted to a ward. This contained information about the ward, ward timetables and what a patient could expect from an admission. There was also information about support on how to help them stop or reduce smoking. On Wharton ward, patients were given diaries where they could write down things that were important to them and this could be reflected to the ward team.
- Patient community meetings happened regularly on the wards. Planning meetings also took place on most wards, on most days. Staff offered patients individual time to meet once a day. This was recorded at the Maudsley Hospital site when it took place.
- Patients had access to individual advocacy. An independent mental health advocate visited the wards to speak with patients. Advocates attended ward rounds when patients wanted their support.
- Patients were able to give feedback about the services on a regular basis. This was collected electronically.
- Some wards had developed and were running 'Tree of Life' workshops and programmes at the Ladywell Unit. This was a programme which enabled staff and service users to discuss things which were important to them within a coproduced environment. Staff and patients spoke very highly of this.
- Peer support workers and volunteers visited the wards on a regular basis. They were often people who used mental health services and were able to offer encouragement and support from a different perspective.

Psychiatric intensive care units

Kindness, dignity, respect and support

- We observed interactions between staff and patients which were kind and caring. Staff spoke with patients in a supportive and respectful manner. Staff showed that they understood the needs of individual patients.
- Patients told us that they felt supported and that staff were good.
- An independent mental health advocate who worked on Eileen Skellern 1 told us that they had observed good interactions between staff and patients on that ward. Staff took positive steps to encourage patient participation and listened actively to their concerns. Staff advocated for patients on a range of issues including asking for a greater variety of meal choices and moving to less secure environments.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- The privacy windows in patient bedrooms were left open. This meant that others could look into the room when the door was closed. There is a risk that this could compromise the dignity of patients.

The involvement of people in the care they receive

- Patients received welcome packs when they arrived on the wards which had basic information about their stays on the wards and what they could expect.
- Community meetings were held on wards weekly. We observed one meeting on Eileen Skellern 1 and looked at recent minutes from meetings on Eden and Johnson wards. Meetings involved patients, staff, independent mental health advocates and a service user representative from a local voluntary sector organisation. Patients were able to raise and discuss things which were important to them. Staff were reassuring and supportive and responded to patients' requests.
- Patients were able to give feedback regularly using an electronic device to complete feedback. This information was collected and presented to the staff team monthly.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Acute wards

Access and discharge

- The average bed occupancy rate, including patients on leave, for acute wards between April 2014 and the end of March 2015 was 103%. This was highest on Wharton ward 126%, Bridge House (female) 116%, Clare ward (male) 132% and Eileen Skellern 2 113%. Luther King ward had an occupancy of 100% of available beds. The non-availability of 5 beds was due to a 12 week refurbishment programme. The Royal College of Psychiatrists recommend that optimum occupancy rate is 85%.
- While the bed occupancy levels were very high, the trust managed the beds and the needs of patients by commissioning beds, both on a block and spot purchase basis from other organisations. When patients needed to move during their inpatient stay, this was done during the day and with information given to patients about the moves planned with as much notice as possible.
- During the week of the inspection, there were 14 out of area placements of patients in acute mental health beds. Of these, 4 were in the Greater London area and 5 were block purchased in the private sector.
- The boroughs of Croydon, Lambeth and Lewisham operated a 'triage' model where people were admitted initially to the respective triage ward. The expected average length of stay on triage wards was up to five days for brief treatment and assessment to be carried out. People were then either discharged home with support from a community team, including the crisis teams if necessary or transferred to another ward for a longer period of assessment or treatment. We were told that around 50% patients were admitted for a longer stay in hospital and 50% of patients were discharged after being admitted to a triage ward. This ensured that there was a thorough assessment period. Management of the triage services was in a different CAG from the longer term assessment and treatment wards.
- Apart from the triage wards which were borough focused, the psychosis CAG provided a model of care which did not allocate specific beds to a particular local area. Attempts were made as far as possible to ensure people were placed nearest there home areas but it would be within the trust as far as possible. The trust used external placements out of area when patients required an admission and beds were not available. On the day our inspection visit started, there were 25 external placements in acute and PICU beds of which 22 were outside London.
- Between April 2014 and March 2015 the average percentage rate of delayed discharges based on YTD figures across all acute services was 6.5%. The highest was 27% at Clare Ward (female), 23% at Luther King and 22% at Nelson Ward. The lowest was 3% at Croydon Triage (Male) and 0% at Croydon Triage (Female and Unisex).
- The wards had a policy of protecting leave beds on a short term basis (one or two nights) so that if a patient went on leave they would return to the same bed. However, long term leave beds were used for admissions.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward environments differed significantly between the different sites. For example, the Ladywell Unit, in Lewisham, had recently been refurbished by the trust. There had been work completed on the entrance which had improved security. On the wards we visited across the trust, there were communal areas and quiet areas for patients.
- At the Ladywell Unit, none of the wards had direct access to outside areas as they were not on the ground floor. Patients needed escorts to the garden if they did not have unescorted leave. This meant that sometimes access to the garden areas and fresh air could be limited according to the availability of staff. Staff on the wards told us that patients had access to the garden twice per shift. However, for some patients, particularly those at the early stages of their admissions on the triage ward, there were limited leave arrangements. Three patients told us that they did not get daily 'fresh air' breaks, despite wanting them, due to restricted leave arrangements.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- Wards had areas where patients could receive visitors. Some wards, including Wharton ward at the Ladywell Unit and all the wards at the Royal Bethlem Hospital, had separate areas for family visiting with children.
- All the wards had telephones which patients could use. Some of the telephones were not located in areas where they could not be overheard. However, patients were able to use mobile phones in their bedrooms meaning they would be able to make private telephone calls.
- Patients had choices of meals. Hot drinks and snacks were available to patients when they wanted them. However, on Gresham 1, there was a schedule for hot drinks. Hot drinks were available at other times outside the schedule, on request.
- Five patients at the Ladywell Unit, told us that they would like more access to activities and that there were not enough activities on the wards. Wards had activities coordinators but two patients told us that there were no structured activities available outside regular working hours. There was a gym on site in the Ladywell Unit. Access to the gym was available on three days a week. Some patients told us that they would like more access to the gym.
- On Croydon triage ward, over a seven week period, activies had been cancelled five times due to staffing issues.

Meeting the needs of all people who use the service

- On each site, there were some disabled access facilities. However, the disabled bedroom on Croydon triage ward did not have suitably designed ensuite facilities, for example, the small space would not be able to accommodate a wheelchair. On Wharton ward, we saw that equipment had been ordered to assist a patient with mobility difficulties.
- At the Ladywell Unit, patients who were on acute wards and had learning disabilities or autistic spectrum disorders did not have specific allowances made. For example, easy read information was not available on the wards where it may have been useful.
- Information leaflets relating to mental health conditions and medications were available on the wards. This also included information about the rights of detained and informal patients. Wards had developed leaflets specifically about ward rounds and letting people know what happened during them. Some of this information was available in different community languages.
- Staff obtained interpreters to support patients who were not confident in English. This support was accessed in ward rounds and other meetings where patients' care and treatment was discussed. Sometimes volunteers who visited the ward spoke different community languages and could speak with patients.
- Patients had access to meals which met different cultural, religious and dietary needs.
- The staff team on Aubrey Lewis 3 had applied for and been awarded £300 as a part of an initiative for black history month. They were planning a celebration that included the identification of positive role models.
- Patients could access spiritual support. Each site had a chaplaincy service. The chaplains contacted representatives of different faiths to meet patients' individual needs. Faith representatives could attend a ward round if the patient wished to have their support. The chaplains continued to support patients after discharge according to their needs.

Listening to and learning from concerns and complaints

- In the year to June 2015, there were 118 formal complaints from across the acute services of which 83 were upheld. None were referred to the ombudsman.
- The highest levels of complaints were on Nelson ward (12), Jim Birley Unit (12) and Ruskin ward (15). There were no wards where no complaints were received.
- Information about complaints processes was available on all the wards we visited and ward managers kept a record of complaints made. Patients were given information about how to complain as a part of their welcome packs.
- On some of the wards, including Powell ward and Wharton ward, managers actively sought complaints and feedback from patients by having 'drop in' surgeries weekly at an advertised time when patients were able to meet with the ward managers and raise complaints and concerns. All these complaints were recorded and followed up on.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- Complaints were discussed in team meetings. Staff on the wards had an understanding of recent complaints which had taken place.

Psychiatric intensive care units

Access and discharge

- The average bed occupancy for the year between April 2014 and the end of March 2015 for PICU beds was 100%. The recommended maximum occupancy level according to the Royal College of Psychiatrists is 85%.
- At the time of our inspection, there were 8 men and 1 woman placed in external psychiatric intensive care beds. 6 of these beds were in south London.
- Staff on the acute wards told us that they had the impression that there was a shortage of intensive care beds in the trust and accessing intensive care beds could be problematic. We were told that this meant higher levels of acuity were managed on the acute wards. The trust had plans to open another male PICU the following year.
- A discharge coordinator had been recruited to focus on supporting the discharge of patients who were being cared for and treated in hospitals in the independent sector. At the time of our inspection, there were no current delayed discharges. Between April 2014 and March 2015, 41% of discharges from Eileen Skellern 1 had been delayed. In the same time periods, it had been 17% for Eden ward and 24% for Johnson ward.
- Staff at the Maudsley site, explained that patients were usually transferred to acute wards when they were well enough to be cared for in a less secure setting. Discharges or transfers were considered to be delayed 24 hours after staff had indicated that the patient was ready to move to another ward. Delays were not lengthy and did not seriously impact the capacity of the PICU to take new admissions.
- The clinical lead for the three PICUs in the trust told us that there could be delays in finding beds for patients who needed to be transferred to low or medium secure services. There were few beds available in these services. There could also be significant delays in transferring patients who were on a Ministry of Justice restriction. There could be long waiting times for approval for patient transfers in these circumstances.
- The length of stay for patients on Eileen Skellern 1 was between 26-28 days. An audit had been carried out of length of stay on the unit and associated clinical outcomes for patients admitted between 1 October 2014 and 31 March 2015. The audit showed that the average length of stay on Eileen Skellern 1 was 27 days. Three patients had stayed longer than the eight week maximum stay recommended by the national association of psychiatric intensive care and low secure units. At discharge 86% of patients were transferred to an acute ward, 6% to home treatment teams and 4% to a forensic service.

The facilities promote recovery, comfort, dignity and confidentiality

- There were full ranges of rooms available on the wards to support care and treatment. At Eileen Skellern 1, many of these were in need of refurbishment and this work was scheduled to take place. Johnson ward had been recently refurbished.
- On Eileen Skellern 1 and Eden wards, occupational therapists provided a range of activities throughout the week including art, music and exercise groups. There was no ward based occupational therapist on Johnson ward. However, there was an activities coordinator. On Eileen Skellern 1, a whole ward project was run in conjunction with a voluntary sector organisation. Patients could access complementary therapies such as head massage, healthy eating groups and breathing and meditation groups on three days a week. We saw these taking place during our visit to the ward.
- The telephone on the ward was on the corridor. This meant that it did not allow for private telephone calls. One patient on Johnson ward told us that they were not able to use mobile phones on the ward which meant that patients could not make private telephone calls on the ward.
- Patients had access to outside space. There were garden areas attached to the wards. Patients had access to their rooms during the day and their bedrooms could be locked on request.
- The door to the shower and toilet on Eileen Skellern 1 had transparent panels that allowed staff to observe

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

patients and make sure they were safe. However, the panels gave a full length view of patients using the shower which could compromise their privacy and dignity.

- The place of safety was located at the far end of Johnson ward. While there is a separate entrance for patients who are being admitted to the place of safety, there was no area for staff conversations to take place so when people are brought in by the police, the police enter the ward area to speak with staff. This means that there is a risk that patients on the ward will find this disruptive. However, the ward had taken some mitigating actions by inviting police onto the ward so that patients could familiarise themselves with the police in a non-emergency situation.

Meeting the needs of all people who use the service

- The wards were accessible to people who had mobility difficulties. They were on the ground floor. There were bathrooms available that were easier for people to use, if necessary.
- Staff were able to obtain interpreters when this was needed. Interpreters attended ward rounds and other important patient meetings. They supported patients who did not speak English well enough to understand their care and treatment options.
- Information was available in the ward and in the welcome pack which patients received on arrival which included information about advocacy services, rights of detained patients and how to complaint.
- Patients on the ward had access to food related to specific religious needs, such as halal and kosher food. Foods which met specific dietary needs such as gluten free food or vegetarian meals were also available.
- Patients had access to chaplaincy services to support their religious and spiritual needs.

Listening to and learning from concerns and complaints

- There were 9 complaints for the 12 months to June 2015 of which 8 were upheld. The main themes of the complaints related to staff attitudes. The staff on the ward had an understanding of the complaints and complaints procedures. Information was available on the ward about how to make complaints and the manager encouraged patients to make complaints both formally and informally.
- Complaints were discussed at team meetings and in supervision to ensure that learning was embedded in the service.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Acute wards

Vision and values

- Staff on the ward displayed a good understand of the purpose and mission of the trust. They were aware of the trust promises and displayed an understanding of the trust values.

Good governance

- The ward managers had access to a range of information about staffing levels, training and information from audits which had happened which were relevant to the wards.
- Managers regularly received information about the performance of their ward. This information was presented in the form of a dashboard. The trust had piloted a tool called quality effectiveness and safety trigger tool (QuESTT) to provide an early warning system to managers and alert them to concerns that could impact on quality and safety, such as increasing vacancies or levels of sickness, and lead to poor care. The tool was completed by ward managers using both data from the ward and data provided to them centrally.
- Audits were used as a way of assessing and monitoring the safety and quality of care. Results of audits were discussed with staff so that improvements could be made. However, some audits we saw were not an accurate reflection of the area audited. Therefore they were not a useful tool for improving the quality and safety of care and provided false reassurance to managers. For example, an audit of care plans on Ruskin on Aubrey Lewis 2 had failed to identify that patient care plans were not personalised or person centred or that they often failed to address patients' current needs. The audit recorded that patients had care plans, including physical care plans, in place but did not assess or monitor the appropriateness or quality of the plans.
- We found a high number of areas for improvement in terms of safety of equipment and environment and the quality of risk assessments. This suggests that the governance of the challenging wards was not sufficiently thorough.
- There were no local risk registers available to ward managers and risks were escalated to the CAG level.

Leadership, morale and staff engagement

- Most staff were very positive about their immediate management and the ward management support.
- Staff had an understanding of the senior management in the team and knew who they were although some staff told us that they felt detached from the senior management team. They were aware of the names of the chief executive and key members of the executive teams. Staff were generally positive about the new chief executive and felt that he would effect change in the trust.
- Staff sickness (up to 31 July 2015) on the acute wards ranged between 12% (Wharton) and 3% (John Dickson).
- Staff on the wards felt able to raise concerns. They described their managers as supportive. Staff were able to suggest improvements and these were acted upon. Junior doctors said they were well supported by consultants.
- Staff knew there was a whistleblowing procedure and talked about what they would do if they had concerns they did not feel able to raise directly with senior managers. All staff told us they felt able to raise any concerns they had about patient care and thought they would be listened to.
- The trust provided a leadership training programme. One ward manager told us that they had accessed this.

Commitment to quality improvement and innovation

- Some wards had been accreditated by the Royal College of Psychiatrists through the accreditation for inpatient mental health services scheme. This included Eileen Skellern 2, John Dickson, Ruskin on Aubrey Lewis 2, Aubrey Lewis 3, Wharton, Powell, Luther King , Gresham 2 and Clare wards.
- On Fitzmary 2, medical staff were taking part in a research project about physical health. Fitzmary 2 had featured in a journal as providing case study examples. All wards at the Bethlem Royal Hospital were involved in a scheme to improve family involvement through education provided by the trust about mental health, conditions and treatment.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Psychiatric intensive care units

Vision and values

- Staff understood the values of the organisation and were committed to their work.

Good governance

- The ward managers and consultant psychiatrists worked well together. The wards were well-led from both a nursing and medical perspective. On Eileen Skellern 1, the ward manager and consultant psychiatrist had raised concerns about staffing levels together, which had led to a temporary reduction in patient numbers until the ward was better staffed. Safe staffing levels had not been achieved on this ward on 26% shifts in May. This had been reduced to 11% in July 2015.
- Ward managers had access to basic information on dashboards about their service. There were systems in place to ensure that supervision, appraisals and training of staff was up to date.
- The psychiatric intensive care units had a single management line and a senior lead who provided management support for the ward managers at the three different sites. While managers told us that this was a supportive structure, it meant that some ward managers did not have their direct manager onsite and utilised informal support structures to build links with local peers and managers. This was not recognised formally. For example, the wards with different management structures on the same site did not have any regular documented meetings where information could be shared that was relevant to the site specifically, for example, security at the Ladywell Unit.
- The services did not hold local risk registers at a ward or site level but could enter risks on the CAG risk register.

Leadership, morale and staff engagement

- The PICUs were well-led. Managers were visible on the wards and staff told us they felt supported by the ward managers. However, staff on Eileen Skellern 1 told us it could be a stressful place to work due to the lack of permanent staff and the relative inexperience of most nurses.
- The sickness levels on the PICUs was between 8% and 9%. This was higher than the average sickness levels across the acute services.
- Staff knew how to raise concerns about patient care and treatment and said that they thought they would be listened to by their senior managers.
- Ward managers had opportunities to develop their leadership skills through particular training courses and coaching.

Commitment to quality improvement and innovation

- The consultant psychiatrist on Eileen Skellern 1 was actively involved in research and the development of national guidelines and standards for psychiatric intensive care units.
- The use of dynamic appraisal of situational aggression tool was a very useful way of measuring risk and was a good visual tool for showing patients how much progress they had made.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. Some patients did not have care plans that met their individual needs. Patients needed to be offered more opportunities to be engaged in developing their care plans. This was a breach of regulation 9(1)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured that care and treatment was provided in a safe way for patients Staff were not reporting or recording the details of each use of restraint which meant the use of restraint could not be monitored. Individual risk assessments were not consistently up to date and reflecting the current risks to individuals. On Lambeth triage ward seclusion had not been recognised and so patients were not being properly monitored to ensure their safety.

This section is primarily information for the provider

Requirement notices

Emergency resuscitation bags did not all contain the listed emergency equipment or in some cases this equipment was present but out of date.

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

This was a breach of regulation 12(1)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Patients were not protected from abuse and improper treatment.**

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

This is a breach of regulation 13(7)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The trust had not ensured the premises and equipment used by the patients was appropriately secure, suitable and maintained**

This section is primarily information for the provider

Requirement notices

On Eileen Skellern 1 the environmental risk caused by patients having access to an external fire escape had not been mitigated.

This was a breach of regulation 15(1)

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed. Some wards had significant staff shortages which had an impact on patient care. This was a breach of regulation 18(1)