Requires improvement

South London and Maudsley NHS Foundation Trust

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

Quality Report

Trust Headquarters
1st Floor Admin Block
Maudsley Hospital
Denmark Hill
London
SE5 8AZ
Tel: 0203 228 6000
Website: www.slam.nhs.uk

Date of inspection visit: 30 January 2017 - 2 February 2017
Date of publication: 05/05/2017

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	Ruskin on Aubrey Lewis 2 John Dickson Eileen Skellern 2 Aubrey Lewis 3 Eileen Skellern 1	SE5 8AZ
RV505	The Bethlem Royal Hospital	Gresham 1 Gresham 2 Croydon Triage Croydon PICU	BR3 3BX
RV509	Ladywell Unit	Wharton	SE13 6LH

Summary of findings

		Lewisham Triage Clare Powell Jim Birley Unit Johnson PICU	
RV502	Lambeth Hospital	Luther King Lambeth Triage Nelson Leo Bridge House Eden	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?	**Requires improvement** 
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

Contents

Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** because:

- Although the trust had addressed the most serious issues that had caused us to rate safe as inadequate following the September 2015 inspection, we still rated safe as requires improvement following this most recent inspection.
- Following the last inspection in September 2015, we rated effective and well-led as requires improvement. At this most recent inspection, we found that although some issues of concern had been addressed and others had improved, the work was not fully embedded. In addition we identified new concerns and an area of concern which had deteriorated since the inspection of September 2015.
- At the inspections in September 2015 and May 2016, we found that some wards had significant staff shortages, which had an impact on patient care. At the current inspection in January 2017, we found that, despite significant efforts by the trust to improve staff recruitment, there was a high number of nursing vacancies on some wards. This led to cancelled escorted patient leave and patient activities.
- During the inspection in September 2015, we found that trust governance processes were not sufficiently robust to identify where improvements needed to be made. At the current inspection, we found that although a new governance structure had been put in place it was too early to determine how effective this would be in ensuring quality and safety in the acute care pathway. The new arrangements and processes were not embedded enough to identify all of the areas where improvements were needed.
- During the last inspection in September 2015, we found that not all staff were receiving regular supervision and recommended that the trust made improvements. At the current inspection, we found that staff supervision was still not always taking place in line with the trust policy. This meant that there was risk that some staff were not receiving appropriate professional support to enable them to carry out their duties safely and effectively.
- More than 360 patient restraints in the last seven months involved patients being restrained in a prone position. There was no detailed plan in place to reduce the use of prone restraint.
- Staff on the acute wards at the Bethlem Royal Hospital did not always recognise safeguarding incidents and therefore follow trust safeguarding procedures.
- Staff on the psychiatric intensive care units (PICUs) had not recognised and addressed a number of ligature risks on the ward.
- On some PICUs information available to staff about fire safety procedures was not up to date. This put patients and staff at potential risk in the event of a fire.
- Not all staff had completed mandatory training. Planned training for staff in working with people with autism and learning disabilities was being rolled out across the wards.
- Ward environments at the Ladywell Unit were either too hot or too cold making it unpleasant for patients and staff. Pest control at the Maudsley Hospital was not completely effective. The seclusion rooms in Johnson and Eden PICUs were in need of repair.
- Patients transferred to Clare ward at the weekend had to wait until Monday for their leave to be reviewed, which meant they could be restricted to the ward unnecessarily. Patients on several wards were not always clear that they could ask for a hot drink at night. Some patients had difficulty accessing secure storage for their belongings, and had lost possessions.
- Powell ward had a much higher rate of detained patients going absent from authorised leave than other wards. Two patients had gone absent without leave from Johnson PICU over the garden fence.

Summary of findings

- Confidential patient information was visible to other patients and visitors on some wards.
- During the last inspection in September 2015, we found that some patients did not have care plans that met their individual needs. Although this had improved considerably on the acute wards, the care plans of some patients, particularly on the PICUs, were very general in nature and not individualised.
- The acute wards for adults of working age and psychiatric intensive care units were not meeting Regulations 12, 13, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

However:

- Following our inspection in March 2016, we rated the acute wards for adults of working age and PICUs as good for caring and responsive. During the current inspection we found that the services remained good in these areas.The trust had also taken action to make the acute wards and PICUs safer since the inspections of September 2015 and May 2016 and had successfully addressed many of the areas of concern we had identified at that time
- At the inspection in September 2015, we found that some wards had emergency resuscitation bags that did not contain the listed emergency equipment or in some cases this equipment was present but out of date. When we visited in January 2017, we found all required emergency equipment and medication was in place and in date.
- At the inspection in September 2015, we found there were not always enough alarms for staff on the wards. At the last inspection in May 2016, we found that the alarm system on Gresham 1 ward was not working. When we visited in January 2017, we found that all the wards had appropriate alarms available and they were in good working order.
- At the inspection in September 2015, we found that individual patient risk assessments were not fully completed or not updated with current information about risks. At the inspection in January 2017, we found staff completed risk assessments and the assessments were regularly reviewed. The trust was rolling out a new risk assessment template, which was working well.
- During the inspection of the trust in September 2015, we found that although staff carried out regular physical health monitoring of patients they did not always escalate risks and concerns to a doctor when needed. At the current inspection, we found that staff escalated concerns about patients' physical health promptly.
- During the inspection in September 2015, we found that incidents of restraint were not being accurately recorded. At the inspection in January 2017, we found that staff recorded more detailed information that allowed the trust to accurately monitor how restraint was used.
- At the inspection in September 2015, we found that staff on Lambeth Triage were not clear about the meaning of seclusion, sometimes did not recognise that they were secluding patients in their bedrooms and therefore did not follow trust seclusion procedures. During the January 2017 inspection we found that staff on Lambeth Triage understood the meaning of seclusion and if patients were prevented from leaving their rooms for a period of time the seclusion policy was followed.
- At the inspection in September 2015, we found that drugs fridge temperatures were not always being monitored. At the current inspection we found on the acute wards and three of the four PICUs that fridge temperatures were being regularly monitored and recorded.
- During the inspection of September 2015, we found that an environmental risk on ES1 was not managed appropriately. At the inspection in January 2017 we found that staff were mitigating the risk posed to patients by a staircase in the garden.
- During the last inspection in September 2015, we found that some patients on the acute wards did not have care plans that met their individual needs. At the current inspection, we found that overall, the

Summary of findings

quality of care plans had improved on the acute wards. Most patients had care plans in place that were holistic, patient centred and recovery orientated.

- At the inspection in September 2015 we found that temporary staff did not always have a timely local induction. At the current inspection we found that temporary staff completed a brief induction when working on a ward for the first time.
- During the last inspection in September 2015, we found that not all patients had their status under the Mental Health Act (MHA) recorded correctly; it was not always clear whether patients had their rights explained to them as this was not recorded; and many staff had not completed training in the MHA. During the current inspection we found that all of these areas had been successfully addressed.
- During the last inspection in September 2015, we found that informal patients were not given clear information about their rights. During the current inspection we found staff provided informal patients with accurate information about their rights.
- At the inspection in September 2015 we found that many staff had not received training in the Mental Capacity Act (MCA) and did not understand their responsibilities in relation to it. At the current inspection we found that the majority of staff had completed training in the MCA and understood how it applied in practice.
- At the inspections in September 2015 and May 2016 we found that observation windows in patient bedroom doors were regularly left open. At the current inspection we found that staff kept viewing panels and exterior curtains closed, maintaining patients' privacy and dignity.
- At the inspection in September 2015, we found that patients did not always have access to therapeutic activities and the gym. During the current inspection we found that the wards provided a range of activities to patients including access to the gym.
- At the inspection in May 2016, we found that there was not always enough private space for patients to meet with independent advocates. During the current inspection we found there were rooms available for patients to meet privately with advocates.
- Staff assessed the physical health needs of patients well. Many physical health care plans were very detailed and provided clear guidance to staff on how best to support patients with long term conditions, such as diabetes. Staff actively supported patients to stop smoking and provided good access to nicotine replacement therapy with a range of products available to patients.
- Good working relationships between ward staff and home treatment teams supported the delivery of effective patient care through the acute care pathway.
- The trust had significantly reduced the number of patients being cared for in other hospitals, outside the local area, in the last 15 months. Most patients were on wards located in, or close to, their home boroughs.
- The majority of patients described staff as kind and caring. Staff interacted with patients in a respectful manner. They spent time with patients and offered practical and emotional support. Staff understood the individual needs of patients. Staff morale was generally good. Staff felt well supported by managers and colleagues. The trust and ward staff were committed to quality improvement and innovation.
- Improvements meant that the acute wards for adults of working age and psychiatric intensive care units were now meeting Regulations 9 and 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Summary of findings

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

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- During this most recent inspection, we found that the services had addressed the issues that had caused us to rate safe as inadequate following the September 2015 inspection. However, we found that although some issues had improved they were still having a negative impact on patient care. In addition we identified some new areas of concern.
- At the inspections in September 2015 and May 2016 we found that some wards had significant staff shortages, which had an impact on patient care. At the current inspection in January 2017, we found that, despite significant efforts by the trust to improve staff recruitment, the trust was still struggling to recruit nurses and there was a high number of nursing vacancies on some wards. As a result staff sometimes cancelled planned patient activities because there were not enough staff to facilitate them. Staff sometimes could not take patients on agreed escorted leave or accompany patients to hospital gardens because there were not enough staff to do this. This had a negative impact on patients' experiences during their admission to the acute wards.
- More than 360 patient restraints in the last seven months involved patients being restrained in a prone position. Fifty six per cent of restraints overall involved the prone position. The rate of prone restraint on one ward was as high as 75%. Although the trust had a long term plan to reduce violence, aggression and restrictive practices on the wards there was no detailed plan in place to reduce the use of prone restraint.
- Staff on the acute wards at the Bethlem Royal Hospital did not always recognise safeguarding incidents and therefore follow trust safeguarding procedures. There was a risk that patients were not being protected appropriately as potential abuse was not always recognised and reported.
- Staff on the psychiatric intensive care units (PICUs) had not recognised and addressed a number of ligature risks on the ward. Not all staff were aware of what constituted a ligature anchor point risk and were therefore unable to adequately mitigate the risk.
- Information about fire safety procedures had not been updated on the PICUs. One ward had not held a fire drill in nine months. This put patients and staff at risk in the event of a fire.

Summary of findings

- At the inspection in May 2016 we had found insect infestations on AL3 at the Maudsley Hospital. At this inspection in January 2017 we found the wards at the Maudsley Hospital continued to struggle with pest control. The trust had a plan in place and was continuing to try and address this problem.
- At the inspection in September 2015, we found that not all staff were up to date with mandatory training and recommended that the trust should continue to focus on increasing staff completion of required training. At the inspection in January 2017, we found that staff completion rates for mandatory training had improved and most staff had completed their mandatory training. However, wards were still not meeting the trust target of 85% staff completion of all training.
- At the inspection in September 2015, we had concerns about the high number of detained patients who went absent without leave. We recommended that the trust should continue to look at measures to reduce the numbers of patients absent without authorised leave. During the current inspection, although we found that most ward environments were secure and patients did not routinely abscond from the wards, Powell ward had a much higher rate of patients going absent without leave from the ward, from escorted leave or not returning from leave than other wards. Although the garden fence on Johnson met PICU requirements for height and despite attempts by the trust to make the garden more secure, two patients had climbed the fence and left the ward without authorisation.
- The seclusion rooms on Johnson and Eden PICUs were in a poor state of repair.

However:

- The trust had taken action to make the acute wards and PICUs safer since the inspections of September 2015 and May 2016 and had successfully addressed many of the areas of concern we had identified.
- At the inspection in September 2015, we found that some wards had emergency resuscitation bags that did not contain the listed emergency equipment or in some cases this equipment was present but out of date. When we visited in January 2017, we found that improvements had been made. All required emergency equipment and medication was in place and in date.
- At the inspection in September 2015, we found there were not always enough alarms for staff on the wards. At the last

inspection in May 2016, we found that the alarm system on Gresham 1 ward was not working. When we visited in January 2017, we found that all the wards had appropriate alarms available for staff and they were in good working order.

- At the inspection in September 2015, we found that individual patient risk assessments were not fully completed or not updated with current information about risks. At the inspection in January 2017, we found this had improved significantly. Staff completed risk assessments shortly after patients were admitted and the assessments were regularly reviewed. The trust was rolling out a new risk assessment template, which was working well.
- During the inspection of the trust in September 2015, we found that although staff carried out regular physical health monitoring of patients they did not always escalate risks and concerns to a doctor when modified early warning scores indicated that they should. At the current inspection, we found that this had improved. Staff escalated concerns about patients' physical health promptly when indicated.
- During the inspection in September 2015, we found that incidents of restraint were not being accurately recorded. At the inspection in January 2017, we found that the trust had improved the incident reporting template so that staff were prompted to enter the details that they needed to. This more detailed and accurate recording allowed the trust to monitor how restraint was used and drive improvement.
- At the inspection in September 2015, we found that staff on Lambeth Triage were not clear about the meaning of seclusion, sometimes did not recognise that they were secluding patients in their bedrooms and therefore did not follow trust seclusion procedures. During the January 2017 inspection we found that staff on Lambeth Triage understood the meaning of seclusion and if patients were restricted to their rooms for a period of time the seclusion policy was followed.
- At the inspection in September 2015, we found that drugs fridge temperatures were not always being monitored, which meant there was a risk that medicines requiring cold storage were not being stored at the right temperature. At the current inspection we found on the acute wards and three of the four PICUs that fridge temperatures were being regularly monitored and recorded, and medicines stored appropriately.

Summary of findings

- During the inspection of September 2015, we found that an environmental risk on ES1 was not managed appropriately. At the inspection in January 2017 we found that staff were mitigating the risk posed by a staircase by making sure that staff observed patients whenever they were in the garden.

Are services effective?

Requires improvement

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

- During this current inspection, we found that the services had addressed most of the issues that had caused us to rate effective as requires improvement following the September 2015 inspection. However, we found that one issue we had identified in September 2015 had deteriorated and new concerns were identified.
- During the last inspection in September 2015, we found that not all staff were receiving regular supervision and recommended that the trust made improvements. At the current inspection we found that staff supervision was still not always taking place in line with trust policy. This meant that there was a risk that some staff were not receiving appropriate professional support to enable them to carry their duties safely and effectively.
- At the last inspection in September 2015, we found that staff on the acute wards and PICUs had not received training in providing care to patients with learning disabilities. Following the inspection we recommended to the trust that staff should have training on supporting people with learning disabilities or autism. At the current inspection we found the trust had started to roll out specialist training to staff in supporting patients with learning disabilities but not all staff had yet received the training.
- During the last inspection in September 2015, we found that some patients did not have care plans that met their individual needs and patients needed to be offered more opportunities to be involved in planning their care. At the current inspection, although we found that improvements had been made to most care plans on the acute wards this was not always the case on the PICUs. Many care plans in the PICUs were brief, did not identify patients' goals and were not particularly personalised.
- When patients were transferred from Lewisham Triage to Clare ward at the weekend their section 17 leave was not reviewed

until Monday morning. This meant that some patients who had been going out into the community and using the hospital garden safely while on Lewisham Triage were unnecessarily restricted to the ward.

However:

- At the inspection in September 2015 we found that temporary staff did not always have a timely local induction. At the current inspection we found that this had improved. Temporary staff, who were new to a ward, completed a brief induction. This ensured they were familiar with emergency procedures and were introduced to patients.
- During the last inspection in September 2015, we found that not all patients had their status under the Mental Health Act (MHA) recorded correctly; it was not always clear whether patients had their rights explained to them as this was not recorded and many staff had not completed training in the MHA. During the current inspection we found that status under the MHA was clearly recorded for all patients on their electronic record and on patient information boards in the staff offices. Staff explained patients' rights under the MHA and documented this. The majority of staff had received training in the MHA.
- During the last inspection in September 2015, we found that informal patients were not given clear and accurate information about their rights to leave the ward and refuse medication. During the current inspection we found staff provided informal patients with accurate information about their status and rights. Posters on display on the wards gave patients this information clearly.
- At the inspection in September 2015 we found that many staff had not received training in the Mental Capacity Act (MCA) and did not understand their responsibilities in relation to it. Following the inspection we recommended that the trust should continue to ensure that staff received training in the MCA so that the legislation could be applied more consistently. At the current inspection we found that the majority of staff had completed training in the MCA and understood how it applied in practice.
- Staff assessed the physical health needs of patients well. Many physical health care plans were very detailed and provided clear guidance to staff on how best to support patients with long term conditions, such as diabetes. Staff actively supported patients to stop smoking and patients had good access to nicotine replacement therapy with a range of products available to them.

Summary of findings

- Ward teams worked well with the home treatment teams. Recent changes to structure of the acute care pathway had brought the wards and home treatment teams closer together. Good working relationships supported the delivery of effective patient care.

Are services caring?

Good

We rated caring as **good** because:

- At the inspections in September 2015 and May 2016 we found that observation windows in patient bedroom doors were regularly left open. This meant that other people could see into patients' bedrooms when the doors were closed. At the current inspection we found that staff kept viewing panels and exterior curtains to bedrooms closed and maintained patients' privacy and dignity.
- The majority of patients we spoke with described staff as kind and caring. We observed staff interacting with patients in a respectful manner. They spent time with patients and offered practical and emotional support. Staff understood the individual needs of patients.
- Staff gave patients written information about the wards when they were admitted. Most patients knew about and understood their care and treatment. Many patients had worked in collaboration with staff to develop care plans.
- Staff tried to involve families and carers in patients' care when patients wanted this to happen. Several ward managers and a consultant held regular meetings and surgeries where families and carers could come and speak about their relatives' care and treatment and ask any questions they had.
- Patients gave feedback about their care via hand held electronic devices. The feedback was analysed so that staff could make improvements in care.

However:

- On several wards, notice boards in staff offices containing confidential patient information were visible to other patients and visitors from the ward corridors. This meant that personal information about patients may not have been kept confidential.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- At the inspection in September 2015, we found that patients did not always have access to therapeutic activities and the gym.

Summary of findings

We recommended that the trust make improvements in this area. During the current inspection we found that the wards provided a range of activities to patients including access to the gym.

- At the inspection in May 2016 we found that there was not always enough private space for patients to meet with independent advocates and recommended that this should improve. During the current inspection we found there were rooms available for patients to meet privately with advocates.
- The trust had significantly reduced the number of patients being cared for in other hospitals outside the local area in the last 15 months. Most patients were on wards located in, or close to, their home boroughs.
- Staff focused on discharging patients as soon as they were well enough. Staff from different teams met together in bed management meetings to look at ways of overcoming barriers to discharge.
- Patients knew how to make a complaint. Staff responded to complaints and acted on the findings of complaint investigations.
- Wards were accessible for people with disabilities. Wards provided written information on a range of topics. Some information leaflets had been translated into local languages.

However:

- On some wards patients had to ask staff to access snacks and hot drinks at certain times of day. Some patients did not know that drinks were available when they wanted one, including at night.
- Although most wards offered locked boxes or staff could lock patients' bedroom doors, patients did not have their own keys and could not access the secure storage without assistance from staff. Some patients were reluctant to ask for assistance or to wait for staff to be available to help. There had been incidents of patients' belongings going missing.
- Some of the wards at the Ladywell Unit were either too hot or too cold. On the day of inspection Clare ward was very uncomfortable, with a temperature of 29ºC.

Are services well-led?

Requires improvement

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

- During this inspection in January 2017, we found that the trust had addressed many of the issues that had caused us to rate

Summary of findings

the acute wards and PICUs as requires improvement for well-led following the September 2015 inspection. However, we found that while improvements had been made they were not yet fully embedded.

- During the inspection in September 2015 we found that trust governance processes were not sufficiently robust to identify where improvements needed to be made. At the current inspection we found that although a new governance structure had been put in place it was too early to determine how effective this would be in ensuring quality and safety in the acute care pathway. Currently processes were not identifying all of the areas where improvements were needed, in sufficient detail.

However:

- Staff morale was generally good. Staff felt well supported by managers and colleagues.
- The wards were committed to quality improvement and innovation.
- Staff had opportunities for leadership development.

Summary of findings

Information about the service

The South London and Maudsley NHS Foundation Trust provides acute mental health services in four London boroughs: Southwark, Lambeth, Lewisham and Croydon. The trust serves a local population of 1.3 million people. The acute care pathway consists of 17 in-patient acute wards and four psychiatric intensive care units (PICUs) based at four hospitals. Staff in the acute referral centre review all referrals for admission to an acute ward or PICU in the trust. The trust employs more than 4,700 staff overall and had more than one million patient contacts in the last 12 months.

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

The Bethlem Royal Hospital:

Gresham 1 – 20 bed female acute admission ward

Gresham 2 – 25 bed male acute admission ward

Croydon Triage - 17 bed mixed gender admission ward

Croydon PICU – 10 bed male only psychiatric intensive care unit

Maudsley Hospital:

Eileen Skellern 1(ES1) – 10 bed female psychiatric intensive care unit

Eileen Skellern 2 (ES2) – 18 bed male acute admission ward

John Dickson – 20 bed male acute admission ward

Aubrey Lewis 3 (AL3) - 18 bed female acute admission ward

Ruskin on Aubrey Lewis 2 (Ruskin on AL2) – 18 bed female acute admission ward

Lambeth Hospital:

Eden ward – 12 bed male psychiatric intensive care unit

Bridge House male – 13 bed male acute admissions ward

Bridge House female - 12 bed female acute admissions ward

Lambeth Triage – 18 bed mixed acute admissions ward

Luther King – 18 bed male acute admissions ward

Nelson – 18 bed female acute admissions ward

Leo – 18 bed mixed ward for patients experiencing a first episode of psychosis

Ladywell Unit:

Johnson PICU - 10 bed male psychiatric intensive care unit

Clare - 17 bed mixed acute admissions ward

Powell – 18 bed male acute admissions ward

Wharton – 18 bed female acute admissions ward

Jim Birley Unit – 18 bed female acute admissions ward

Lewisham Triage – 16 bed mixed gender acute admissions ward

Most wards were last inspected in September 2015 as part of a comprehensive inspection of the trust. Gresham 1 and Aubrey Lewis 3 were also inspected in May 2016 in a focused inspection.

When the CQC inspected the trust in September 2015, we found that the trust had breached regulations. We issued the trust with six requirement notices for acute wards for adults of working age and psychiatric intensive care units. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Summary of findings

When the CQC inspected the trust in May 2016, we found that the trust had further breached a regulation. We issued the trust with one requirement notice for acute wards for adults of working age and psychiatric intensive care units. This related to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

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

Our inspection team

Our inspection team was led by:

Team Leader: Judith Edwards, inspection manager for mental health, learning disabilities and substance misuse, Care Quality Commission

The team that inspected the acute wards for adults of working age and psychiatric intensive care units consisted of one head of hospital inspection, one inspection manager, three CQC inspectors, one assistant inspector, one inspection planner, two Mental Health Act reviewers, and eight specialist advisors, four of whom were nurses, two psychiatrists, one social worker, and a pharmacist. The team included five experts by experience. Three of the experts by experience had experience of using similar services and two had cared for people using services.

Why we carried out this inspection

We undertook this inspection to find out whether South London and Maudsley NHS Foundation Trust had made improvements to their acute wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection of the trust in September 2015 and a focused inspection of two acute wards in May 2016.

When we last inspected the trust in September 2015, we rated the acute wards for adults of working age and psychiatric intensive care units as **requires improvement** overall.

We rated the core service as inadequate for safe, requires improvement for effective and well-led and good for caring and responsive.

Following the September 2015 inspection, we told the trust it must make the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- 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's stay.
- The trust must ensure that environmental risks such as the external fire escape on Eileen Skellern 1 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.

Summary of findings

- 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.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 Person-centred care

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding service users from abuse and improper treatment

Regulation 15 Premises and equipment

Regulation 17 Good governance

Regulation 18 Staffing

Following the May 2016 inspection of Gresham 1 and Aubrey Lewis 3 wards we told the trust it must make the following additional action to improve acute wards for adults of working age and psychiatric intensive care units:

- The provider must ensure that all alarm systems are working.

This related to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 12 Safe care and treatment

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?

Before the inspection visit, we reviewed information that we held about these services, and asked other organisations for information.

During the inspection visit, the inspection team:

- visited all 21 acute wards and psychiatric intensive care units at the four hospital sites, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 80 patients who were using the service
- spoke with one carer
- collected feedback from 99 patients using comment cards
- attended and observed 10 patient groups including community meetings, planning groups, a psycho-education group, an art group and two cooking and baking groups
- looked at 99 treatment records of patients
- spoke with the managers or acting managers of each of the wards
- visited and spoke with staff in the acute referral centre
- spoke with the chief executive of the trust, the director of nursing, the head of pharmacy, the director of human resources, the assistant director of nursing for professional development, the director and senior managers of the acute clinical academic group with responsibility for these services and borough acute pathway leads
- spoke with 120 other staff members; including doctors, nurses, consultants, occupational therapists, health care support workers, social workers, clinical psychologists, student nurses, administrators, clinical service leads, a pharmacist, a chaplain, a trainee psychologist and a housekeeper
- spoke with an independent mental health advocate

Summary of findings

- attended and observed six staff hand-over meetings, nine multi-disciplinary meetings, a bed management meeting and a staff reflective practice session
- attended the trust board meeting held the week before the inspection
- carried out a specific check of the medicine management arrangements on six acute wards and two psychiatric intensive care units
- looked at a range of policies, procedures and other documents relating to the running of the acute services

The trust was given one week notice of this inspection.

What people who use the provider's services say

Feedback varied between the wards and between patients. The majority of patients spoke positively about the care and treatment they received and their relationship with staff. Many patients told us that they were treated with kindness and respect and that staff were hard working. Patients felt safe on the wards. Feedback from patients on the PICUs was very positive on all wards. For example, patients gave positive feedback about the caring nature of staff. They said staff were professional, polite, and did a good job. Patients on Croydon PICU said the care they received was excellent. Two patients on ES1 said staff supported them and believed in them. Similarly the majority of comments cards completed on the acute wards and PICUs contained positive statements. Patients wrote that staff were caring, supportive and helpful.

However, some patients were less positive. For example, on Croydon Triage, patients reported that a few staff spoke in their own languages in front of them and would sometimes use their personal mobile phones when conducting observations. Patients had raised and discussed this with staff in ward community meetings on two occasions. Returned comments cards identified a number of areas that patients thought could improve. For example, patients on Powell ward wrote that toilets were sometimes dirty and frequently blocked. Patients on Clare commented that the ward was extremely hot. Patients on Lewisham Triage said staff sometimes appeared to be stressed and under pressure. Some patients on Ruskin on AL2 and John Dickson ward did not feel that staff listened to them or that they could influence decisions regarding their care.

Good practice

The trust was piloting a new electronic system for recording patients' physical observations. This system automatically prompted staff on the frequency of required observations and when an observation should prompt a response or escalation. They hoped to develop the system to cover all ward observations.

Areas for improvement

Action the provider MUST take to improve

- The trust must continue to address the high number of nursing vacancies on some wards.
- The trust must ensure that all staff recognise potential abuse and report safeguarding concerns appropriately.
- The trust must ensure that all ligature anchor point risks on the psychiatric intensive care wards are recorded on the ward ligature risk assessment and that staff are aware of the risks and how they are mitigated.
- The trust must develop clear plans to reduce the number of patients being restrained in the prone position and monitor the impact of actions taken.

Summary of findings

- The trust must ensure that information about fire safety procedures and evacuation is up to date on all wards. Fire drills must take place regularly.
- The trust must ensure that all staff have regular managerial and clinical supervision.
- The trust must ensure that governance processes are sufficiently robust so that they identify where improvements need to be made.

Action the provider SHOULD take to improve

- The trust should take all necessary steps to ensure effective pest control on the wards at Maudsley Hospital.
- The trust should ensure that staff continue to increase their completion of mandatory training, including Mental Capacity Act 2005 training.
- The trust should consider why the number of detained patients leaving without authorisation on Powell ward is much higher than other acute wards, with a view to reducing this number. In addition the trust should review the safety and security of the garden fence on Johnson ward to prevent patients going absent without authorisation.
- The trust should ensure that the seclusion rooms on Johnson and Eden PICUs are repaired promptly.
- The trust should ensure that patient care plans on the PICUs are individualised and goal orientated.
- The trust should ensure that planned training in learning disabilities and autism continues to be rolled out to all staff on acute wards and PICUs.
- The trust should ensure that any patients transferred to Clare ward at the weekend are not unnecessarily restricted to the ward.
- The trust should ensure that confidential patient information is not visible to other patients and visitors to the wards.
- The trust should ensure that patients know that they can have a hot or cold drink when they want one, including at night.
- The trust should review the possibility of providing more accessible lockable storage for patients.
- The trust should ensure that ward temperatures at the Ladywell Unit are comfortable for patients and staff.

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
Ruskin on Aubrey Lewis 2 John Dickson Eileen Skellern 2 Aubrey Lewis 3 Eileen Skellern 1	Maudsley Hospital
Gresham 1 Gresham 2 Croydon Triage Croydon PICU	The Bethlem Royal Hospital
Wharton Lewisham Triage Clare Powell Jim Birley Unit Johnson PICU	Ladywell Unit
Luther King Lambeth Triage Nelson Leo Bridge House Eden	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.

- During our last inspection in September 2015, we found that not all patients had a clear record of their status under the MHA. During this inspection patients' status was clearly recorded on their electronic record and on patient information boards in the staff offices.
- During our inspection in September 2015, we found it was not always clear whether patients had their rights explained to them as staff did not record this consistently. During the current inspection we found staff were aware of their responsibility to provide patients with information about their rights under the MHA, both on admission and regularly afterwards. Most records showed staff did this in a timely way and made repeated attempts to explain patients' s132 rights. Most patients described being informed of their rights.
- During the last inspection in September 2015, we found that informal patients were not given clear and accurate information about their rights to leave the ward and refuse medication. During the current inspection we saw that the quality of information for informal patients had improved. The service displayed posters explaining informal patients' rights. The wording on posters was clear and unambiguous.
- Most staff received training in the Mental Health Act (MHA) and had an understanding of the guiding principles of the MHA code of practice. Seventy four per cent of staff on the acute wards and PICUs had completed the training, which was updated every three years.
- Independent mental health advocacy services were readily available to support people. Patients knew who their ward advocate was and how to contact them.
- Staff undertook regular audits of the MHA. Staff took action to address any concerns identified. Staff had completed detention paperwork correctly in the files we reviewed.
- Doctors completed Section 17 leave forms appropriately so that patients were able to go out for periods of leave. Staff reviewed patients' leave status regularly at ward rounds. However, patients and staff on Clare ward told us that section 17 leave that had been granted on Lewisham Triage was not available to patients when they transferred to Clare ward during the weekend or evenings. This resulted in a period of restriction to the ward where patients were unable to leave the ward, to visit either the garden for fresh air or the community, until they were reviewed by a doctor on Monday morning.
- Where required, most consent (T2) or authorisation (T3) certificates were completed and attached to medicine charts. However, on Powell ward, one patient had been detained and continuously treated for a period extending beyond three months and yet there appeared to be no authorisation for this or a certificate of second opinion. This was brought to the attention of the ward and rectified the following day. On Clare ward we found one T2 form that had not been updated by the current responsible clinician following the patient's transfer to the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Following the inspection of the trust in September 2015 we recommended that the trust should continue to ensure that staff received training in the Mental Capacity Act (MCA) so that the legislation could be applied more consistently. At the current inspection we found that 66% of staff had completed e-learning training in the MCA. Rates of completion of training varied between wards from 30% to 95% of staff.
- We found that while staff understanding of the MCA varied it was being applied consistently.
- Staff recorded they had reviewed patients' capacity in most records we reviewed. We found many good examples of where assessments of people's capacity

had been completed for specific decisions, such as accommodation and financial choices. Staff held best interest meetings with patients when making some decisions and these were recorded.

- Staff on several wards had made applications for a deprivation of liberty safeguards authorisation. However, there were often delays in the assessment and approval by the local authority. Staff had completed an incident form to highlight concerns about delays and chased up applications with the local authority.
- Patients could access an independent mental capacity advocate when needed.

Requires improvement

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

- All wards had blind spots where it was difficult to observe patients. Most wards had convex mirrors installed to help staff observe hard-to-see areas. John Dickson had one mirror missing, awaiting replacement following a recent incident. All the nursing offices had windows, which allowed the staff to observe corridors. Staff were visible throughout the wards and monitored areas where there were blind spots. Staff conducted hourly observations of all areas on the wards, or more frequently when they identified patients as being of higher risk.
- Staff completed ward ligature risk assessments and audits annually, identified potential ligature anchor points and rated their potential risk on a scale of one to three. The estates team prioritised those risks with the highest score for immediate removal work. The trust had identified that the windows at the Ladywell Unit were a potential ligature risk and was planning to replace all the windows on the wards there. The trust had completed some work to remove higher rated ligature risks since our last inspections. For example, on Ruskin on AL2 ward some bathrooms had new taps fitted. At Lambeth Hospital the trust had undertaken ligature reduction work on all the wards and there were no ligature anchor points evident in high risk areas.
- Some bedrooms had been adapted to make them accessible to patients with disabilities. These contained ligature anchor points. Staff took account of individual risk factors when assigning patients to these rooms. If patients were high risk then observation levels were increased to make sure patients remained safe. Staff on all wards were aware of existing ligature risks and managed them appropriately. Information on ligature risks was given to staff as part of their induction. Ligature cutters were available on all wards and staff were aware of their location. These were easily visible so that staff could find them quickly in an emergency.
- During the week of the inspection, one patient tried to harm themselves with a ligature on Nelson ward. Prompt action by staff made sure the patient was safe. The safety of the environment was immediately reviewed following the incident and all trust wards were alerted to the possible risk posed by a particular type of ceiling tile.
- The wards complied with guidance on same sex accommodation. Most acute wards provided care to either men or women. However, the three triage wards, Leo and Clare wards were mixed gender. Some bedrooms had ensuite bathrooms. In addition the wards all had separate gender specific sleeping, bathing and lounge areas. The female bedrooms were in a separate corridor from the male bedrooms. All patients had access to the male only lounge or the female only lounge.
- At the inspection in September 2015, we found that some wards had emergency resuscitation bags that did not contain the listed emergency equipment or in some cases this equipment was present but out of date. At the current inspection we found that improvements had been made. All of the emergency equipment and medication was in place on the wards and in date. Records showed that staff checked equipment regularly to ensure it remained fit for purpose. The trust had ordered new emergency rucksacks, which would be easier to use and carry. These had already been distributed to some wards.
- All wards had fully equipped clinic rooms. These contained the equipment staff required to complete physical observations. Staff had labelled the clinical waste and sharps bins correctly and not over filled them. Staff also checked fridge and room temperatures regularly. The fridge on Ruskin ward was broken and the team was waiting for a replacement fridge.
- None of the acute wards at the Maudsley Hospital or Ladywell Unit had a seclusion room. There was one seclusion room at Bridge House, though this was managed by the psychiatric intensive care unit and used as a second seclusion room when the primary room was in use. The seclusion room at Bridge House was in good order and had a toilet facility, although there was no

clock visible from the room. There was a seclusion room situated on Croydon Triage. It provided clear observation for staff but also tried to maintain a level of privacy and dignity for patients when using the shower. Patients had sight of a clock from inside the seclusion room. A two way intercom was used by patients and staff to communicate with each other. The level of lighting and temperature could be controlled from outside the room. When the seclusion room was used by other wards, staff and patients could access the seclusion suite via a discrete entrance, which meant they did not have to come through the main ward in front of other patients.

- All of the ward areas appeared visibly clean and most furniture and fittings were well maintained. Some wards at the Bethlem Royal Hospital had recently been refurbished and contained new furnishings and fixtures. However, there was some damage to the floors on Lewisham Triage and Jim Birley Unit. Bedrooms were cleaned every day and we saw cleaning taking place during our visit to each ward. The trust had a cleaning contract that planned for floors on wards to be cleaned twice a week. Some staff at the Maudsley felt this was not frequent enough and resulted in floors not being clean at all times. Most cleaning staff completed records to show areas they had cleaned, except at Lambeth Hospital.
- In the last year, the wards had scored between 98% and 100% for cleanliness in patient-led assessments of clinical environments (known as PLACE) assessments, which is similar to or above the England average of 98%.
- Staff followed infection control principles when supporting patients. The wards had suitable handwashing facilities and staff completed regular hand hygiene audits. Information for staff on how to wash their hands effectively was displayed in the sluice rooms. Alcohol hand gel dispensers were located throughout the ward and at the entrance to each ward.
- Staff undertook regular infection control and mattress audits. However, we found some mattresses did not meet infection control standards. We looked at three mattresses on AL3 ward and found that two of them had holes. The trust immediately ordered new mattresses to replace the damaged ones.
- Equipment was labelled to show the date it had last been cleaned. Staff applied 'I am clean' stickers once clinical equipment was cleaned by staff. Staff segregated waste material appropriately for disposal. The wards also had spill kits in each sluice room to clean any bodily fluid spills.
- Some bedrooms on the wards at the Maudsley had old night-light fittings, some of which did not contain bulbs. Patients told us they stored items of clothing in these fittings. During the inspection we highlighted to the trust that these could present an electrocution or fire risk. The trust responded immediately, blocked off these fittings and alerted all wards in the trust, asking them to check whether they had similar fittings.
- At the inspection in May 2016 we had found insect infestations on AL3 at the Maudsley Hospital. During the current inspection patients on all four acute wards at the Maudsley raised concerns regarding ongoing pest control problems. The trust knew about these concerns and had a pest control plan in place to respond to infestations, although struggled to keep this problem under control.
- At the inspection in September 2015, we found there were not always enough alarms for staff on the wards. At the inspection in May 2016, we found that the alarm system on Gresham 1 ward was not working and staff therefore did not know the location of potential emergencies. At the current inspection we found that all the wards had appropriate alarms available for staff and visitors. Staff used these to summon help in an emergency. All wards had call bell buttons on the walls and staff carried personal alarms. There were sufficient alarms for all staff on a shift to carry one. When the alarm sounded they also indicated where on the ward the alarm had been activated. This meant that staff could respond promptly if they were required on other wards. Gresham 1 was now located on a different ward from the one we visited in May 2016 and had an effective alarm system.

Safe staffing

- At the last inspections of the acute wards in September 2015 and May 2016, we found that some wards had significant staff shortages, which had an impact on patient care. At the current inspection, we found that, despite significant efforts to improve staff recruitment,

the trust was still struggling with a high number of nursing vacancies on some wards. This had a negative impact on patient experience. Staff sometimes cancelled patient activities because there were not enough staff to facilitate the activities. Staff sometimes could not take patients on agreed escorted leave or accompany patients to hospital gardens because there were not enough staff to do this as well as keep patients safe on the ward.

- The shortage of staff had a negative impact on patient experience on some wards. At Bridge House and Luther King wards patients' escorted leave was often cancelled at short notice or was only able to be given for short periods at a time. Activities were sometimes cancelled as a result of short staffing. On Gresham 2, three staff reported that when the ward was short staffed this affected patients' ability to take escorted leave and activities were cancelled. At the Ladywell Unit, staff and patients told us the staffing levels meant that patients' leave to go into the garden, for which they required staff escort, did not happen as often as they would like. The staffing levels on wards and the impact on escorted leave had been discussed during the community meeting on Powell ward. During the meeting, staff and patients had reviewed the frequency of escorted leave to the garden and had agreed that they would endeavour to provide this four times a day, which was a reduction from six times a day. Staffing levels also affected the number of activities that were offered on wards. This was particularly true at weekends when on a number of wards there were limited activities for patients.
- Staff vacancy rates were over 40% on seven acute wards. The highest was a 49% vacancy rate on Powell ward. Staff sickness rates were above 10% on three wards, Wharton ward (17%), Jim Birley Unit (14%) and Clare ward (10%). Staff turnover rates varied between 0% on AL3 and 53% on Jim Birley Unit. Three wards had turnover rates of more than 40%.
- The proportion of shifts filled by bank or agency staff to cover sickness, absence or vacancies in the last six months varied from 29% on Bridge House to 72% on Croydon Triage. The trust had employed a number of agency staff on a long-term basis to cover staff vacancies and help ensure that staff were familiar with patients and ward routines and to help ensure continuity of care.
- The proportion of shifts that were not filled by bank or agency staff in the last six months and remained unfilled, also varied across the acute wards. On six wards more than 10% of shifts were not filled by staff with the same designation as the vacancy. For example, if there was a vacancy for a nurse on a shift and this could not be filled with a nurse, the position would be filled with a health care assistant. Nineteen per cent of shifts on Lambeth Triage had been unfilled in the last six months and 18% on Nelson ward. Lambeth Triage had a higher staffing level than other wards that were not designated as triage, and had four nurses per shift. Unfilled shifts were usually covered by a health care assistant replacing the fourth nurse on the shift.
- At Lambeth Hospital, Bridge House had the most significant staffing issues. Forty two per cent of nursing posts were vacant. This was attributed to the fact that the trust announced four months before our inspection that Bridge House would close at some point in early 2017. Many staff had left their posts. The trust was successfully filling 92.5% of vacant shifts at Bridge House with bank or agency staff. The trust put a freeze on admissions to Bridge House during the week of our inspection because of concerns about staffing levels and had plans to close half of the beds at the end of the week.
- The trust acknowledged the high level of vacancies, particularly for nurses, in many acute wards. The trust had developed a workforce strategy, which explored a range of ways to address the shortfall. The trust had reviewed the staff skill mix on acute wards and was working with two other south London trusts and a local university to train and support band 4 assistant practitioners who would eventually replace the third registered nurse on a shift. Recruitment to the assistant practitioner programme was taking place at the time of the inspection.
- The trust had recently opened a single health based place of safety based at the Maudsley Hospital. Three other places of safety had been closed. The new health based place of safety had a dedicated staff team and

there was no longer a need to take staff from the acute wards when a person was brought in to the health based place of safety. This had reduced pressure on ward staffing levels.

- All wards had a consultant in post and provided medical cover throughout the week. There was good medical cover out of hours.
- At the inspection in September 2015, we found that not all staff were up to date with mandatory training and recommended that the trust should continue to focus on increasing staff completion of required training. At the current inspection we found that staff completion rates for mandatory training had improved but varied between wards. Some wards had high numbers of staff who were not up-to-date with mandatory training. For example, on AL3 ward fewer than 70% of eligible staff had completed six out of 21 courses. On Lewisham Triage and Gresham 1 fewer than 70% of staff had completed eight out of 21 courses. On other wards, such as Clare, Nelson, Croydon Triage and Lambeth Triage, staff had achieved high rates of mandatory training completion. There was a risk that staff who had not completed mandatory training were not fully prepared for their role.

Assessing and managing risk to patients and staff

- At the inspection in September 2015, we found that individual patient risk assessments were not fully completed or not updated with current information about risks. At the current inspection we found this had improved significantly on most wards. The trust has introduced a new risk assessment template. This was being rolled out during the week of the inspection. The system automatically highlighted recent patient risks, prompting staff to complete risk plans. Staff felt this would help in completing risk assessments.
- Staff completed risk assessments shortly after patients were admitted and the assessments were regularly reviewed. They were easily accessible to staff, reflected the individual circumstances of the patient and came with associated risk management plans. For example, staff had completed comprehensive risk assessments that reflected current risks in all 13 patient records we reviewed on Ruskin, ES2 and AL3 wards. Similarly patient risk assessments we reviewed on most of the other wards were fully completed and updated. Patients on some wards had a high risk of falls. If this was the case staff had completed falls risk assessments and put care plans in place. Staff had a good understanding of risk.
- On a few wards staff had not always completed risk assessments appropriately or in a timely way. On John Dickson staff had not updated four of the five risk patient assessments to reflect up-to-date risks in the records we reviewed. Staff on John Dickson ward were not yet using the new risk assessment template, which may have contributed to the poor quality of patient risk assessments on this ward. On Gresham 1 we found one record where staff completed a risk assessment for a patient almost a month after admission. On Gresham 2 a patient's risk assessment had not been updated following an incident. However, these represented six risk assessments out of more than 75 we reviewed.
- During the inspection of the trust in September 2015, we found that although staff carried out regular physical health monitoring of patients they did not always escalate risks and concerns to a doctor when early warning scores indicated that they should. At the current inspection, we found that this had improved. Records showed that staff contacted a doctor and escalated their concerns when patients' physical health indicators suggested it.
- Staff completed comprehensive handovers between shifts and at multidisciplinary meetings. In the handovers we observed, staff gave clear and concise updates on the current risks affecting patients. Staff recorded patient risks clearly on the handover communication sheet. These provided a brief overview of the individual and their potential risks. Staff updated care plans and individual risk assessments in patients' electronic care records during multidisciplinary meetings. This ensured all identified risks were recorded and plans were in place to manage or mitigate the risk. Staff also used a zoning system and assigned a colour to each patient that identified their level of risk and the interventions needed to keep them safe. This helped staff to appreciate individual risks at a glance.
- Staff did not impose any inappropriate blanket restrictions on patients on the wards. Staff worked towards reducing the restrictions they needed to

impose on patients at times. For example, most patients were able to use their own mobile phones. Staff searched patients returning from leave on an individual, risk assessed basis.

- Informal patients told us they knew their right to leave at their own will, and this was displayed on posters on each ward and in ward welcome packs.
- Staff had clear policies in place detailing the level of observation they would undertake on an individual based on their risk. Staff completed records of observations thoroughly.
- During the inspection in September 2015, we found that incidents of restraint were not being accurately recorded. At the current inspection we found that improvements had been made. The trust had improved the incident reporting template so that staff were prompted to enter the details that they needed to. Records of incidents that had involved the restraint of a patient were detailed and clearly recorded. Staff involved in the restraint were named and the part of the body they had held was recorded. The records also showed the position of the patient during the restraint. If they were restrained in the prone position for part of the time it was clearly stated how long this was for. The total time of the restraint was also recorded. This detailed recording allowed the trust to accurately monitor how restraint was used and drive improvement.
- In the six month period from 1 July 2016 to 23 January 2017 the trust reported that staff had restrained patients on 649 occasions on the 17 acute wards. The highest number of restraints was on Jim Birley Unit (78 incidents), Lewisham Triage (68) and Lambeth Triage (66). The ward with the lowest number of incidents of restraint was AL3 who recorded three incidents. At the inspection in December 2015, we found that 30% of restraints in the acute wards between December 2014 and May 2015 involved restraining a patient in the prone position. In the six months prior to the current inspection, we found that 56% of incidents of restraint in the acute wards involved the patient being restrained in the prone position for at least some of the total restraint time. In 44% of the incidents of restraint staff had administered rapid tranquilisation to the patient. The number and proportion of restraints involving prone restraint varied between wards. The rates of prone restraint were much higher on Lewisham Triage and Lambeth Triage. These wards took most new acute admissions in their respective boroughs and tended to have more acutely unwell patients. On Lewisham Triage 75% of restraints had involved restraint in the prone position and similarly, 59% of restraints on Lambeth Triage. The lowest use of prone restraint was on AL3.
- Staff explained, and incident records confirmed, that they reported a restraint as being in the prone position even if the patient was only in this position temporarily. Incident forms recorded the exact number of minutes the patient was held in a prone position before being moved into a safer position. Staff we spoke with on all wards understood the need to avoid prone restraint or to restrain patients in the prone position for the shortest time possible. However, there had been more than 360 incidents of the restraint of patients in the prone position in the seven months before the inspection, which meant patients were put at an increased risk of avoidable harm. Although the trust had a long term plan to reduce violence and aggression on the wards there was no detailed plan in place to reduce the use of prone restraint.
- During the inspection we saw staff proactively intervening, speaking calmly with and supporting patients when they became distressed. Staff on Nelson ward told us that their quality improvement projects on improving communication and the four steps to safety, to reduce incidents of violence and aggression, had helped to improve de-escalation practices and reduce the number of restraints that took place overall. Staff on some wards completed a dynamic appraisal of situational aggression (DASA) score to support potentially aggressive patients. The seven point DASA scale gave guidance to staff on when to involve doctors and when a patient may require nursing on a psychiatric intensive care ward.
- Staff received training in promoting safer and therapeutic services to help them support and restrain patients safely. The majority of staff on the acute wards had completed this training within the last two years. Completion rates were above 75% on all wards except John Dickson (67%), AL3 (68%) and Lambeth Triage (69%).
- The trust had developed a reducing restrictive interventions 5 year strategy, which was due to go to the trust board in April 2017 for ratification. The strategy

Requires improvement

Are services safe?

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

aimed to address national guidance and provide a framework for reducing the use of restrictive interventions, including the use of restraint. The trust was continuing to roll out the four steps to safety programme across all wards, as a way of reducing aggression and violence.

- There were low rates of the use of seclusion across the acute wards. There had been 72 recorded uses of seclusion in the last six months. More than half of these were recorded on Croydon Triage. However, the seclusion room on Croydon Triage was used by many different wards at the Bethlem Royal Hospital, not just the acute wards. Otherwise there had been less than five incidents of seclusion on all wards, except Leo where there had been nine.
- At the inspection in September 2015, we found that staff on Lambeth Triage were not clear about the meaning of seclusion, sometimes did not recognise that they were secluding patients in their bedrooms and therefore did not follow trust seclusion procedures. During the current inspection we found that staff on Lambeth Triage understood the meaning of seclusion and if patients were prevented from leaving their rooms for a period of time the seclusion policy was followed. Most staff on other wards were clear about what constituted seclusion, although three staff at the Ladywell Unit wrongly believed that preventing a patient from leaving their bedroom for any reason was not seclusion. We reviewed three patient seclusion records on Lambeth Triage. The seclusions had all taken place in October 2016. Two of the records related to the seclusion of patients in the seclusion room and one related to the supervised confinement of a patient in their bedroom. Records showed that staff had carried out appropriate checks on patients and reviewed the seclusion every two hours in line with trust policy. Similarly on other wards staff recorded the start time and end time of seclusion, regular reviews by medical and nursing staff and whether the patients were informed of their rights.
- Staff received training in safeguarding adults and children. Eighty six per cent of staff overall had completed training in adult safeguarding. In 15 of the 17 acute wards more than 70% of staff had completed the training. The exceptions were Wharton ward with 60% and Gresham 1 with 52% completion. Ninety seven per cent of staff had completed child safeguarding training. The majority of staff had completed a 'prevent' workshop.
- The wards differed in the number of safeguarding concerns they had raised. Luther King Ward had raised 30 safeguarding alerts in the six months between July and December 2016, whereas John Dickson had raised three. In 2016 Gresham 2 had reported three safeguarding adult alerts and Gresham 1 had reported six. Croydon Triage had reported no safeguarding adult concerns in 2016.
- Staff knew how to raise safeguarding alerts. All staff we spoke with explained correctly what should be reported as a safeguarding incident and how to report. In most wards we found that details of safeguarding concerns were included in patients' care records. Safeguarding incidents on the ward, such as patient on patient assaults, were usually reflected in risk assessments and management plans were in place. However, although staff on the acute wards at the Bethlem Royal Hospital accurately explained situations that would require them to make a formal safeguarding referral, we identified several incidents in patient records and incident forms that should have resulted in a formal safeguarding referral but did not. For example, possible financial abuse of a patient on Gresham 2 and several incidents relating to patient on patient physical assault and verbal aggression on Croydon Triage. There was a risk that patients were not being protected from abuse as potential abuse was not always recognised and reported.
- Staff stored, prescribed and administered medicines in a way that kept patients safe. The wards all had locked clinic rooms and cupboards in which medicines were stored. A pharmacist visited all wards regularly. Medicines management audits took place quarterly. Patients were prescribed medicines within British National Formulary limits. All patients who smoked were prescribed nicotine replacement therapy as required. The administration of controlled medicines was accurately recorded. We reviewed more than seventy five medicine administration records and found that medicines had been signed for by staff when administered or a reason given why not. There were no signatures missing from the records. However at the

Requires improvement

Are services safe?

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

Ladywell Unit we found that the prescriber had not reviewed "as and when required medication" (PRN) for six patients after 14 days. This meant that the prescriber had not assessed whether the medication could be stopped or altered to a regular daily dose.

- At the inspection of September 2015, we found that temperatures of fridges used to store medicines were not always being monitored, which meant there was a risk that medicines requiring cold storage were not being stored at the right temperature. At the current inspection we found that fridge temperatures were being regularly monitored and recorded on all wards. The only exception was on Lambeth Triage where fridge temperature checks were not recorded on seven days in January 2017. Recorded temperatures were all within the correct range.
- The wards used sniffer dogs to search for illegal drugs on the premises when they had suspicions that patients were using illegal substances. The trust had a policy for this and staff knew the procedure for disposal if these substances were found.
- All wards had safe procedures in place to support visits from children and families. Safe visiting and family rooms were made available on all hospital sites. Rooms were away from the wards.
- At the inspection in September 2015, we had concerns about the high number of detained patients who went absent without leave. During the current inspection we found that ward environments were secure and patients did not routinely abscond from the acute wards. Between January and December 2016 patients had absconded from wards or ward gardens on 100 occasions. Nineteen per cent of these incidents were reported on Powell ward. Patients had absconded from escorted leave on 171 occasions in the 12 month period. The number of patients absconding from escorted leave was highest on Powell and John Dickson wards. These two wards accounted for 35% of these types of incidents. Overall, on Powell ward patients had absconded from escorted leave, unescorted or extended leave, or directly from the ward on 107 occasions in 2016. The next highest number of these types of incidents had occurred was John Dickson who recorded patients going absent without leave on 74 occasions from escorted or unescorted leave or directly from the ward.

Track record on safety

- The trust reported there had been 10 serious incidents requiring investigation on the acute wards between July and the end of December 2016. These had occurred on eight different wards. Two were reported on Lewisham Triage and two on Luther King ward. We reviewed reports of five incidents including the death of a patient from a non-suspended ligature, a serious injury to a patient on leave from the ward, an assault on a patient by another patient and a Mental Health Act breach. The incidents were investigated fully and the trust put in place action plans to address recommendations from the investigation reports.

Reporting incidents and learning from when things go wrong

- The trust had an electronic incident reporting system. All staff we spoke with knew how to report and recognise incidents, felt confident in raising concerns and knew how to escalate these if necessary.
- Staff investigated incidents to identify potential learning points and make improvements. For example, the trust had changed the ceiling tiles on John Dickson ward following an incident when a patient broke through them.
- Staff received information about incidents that had occurred in other parts of the trust via bulletins that were emailed to all staff. Blue light bulletins highlighted learning from incidents and purple bulletins highlighted learning from audits. An amber bulletin informed staff about information governance incidents.
- Senior managers held a monthly acute clinical academic group (CAG) serious incident meeting. The meeting reviewed all serious incidents in the acute CAG. Senior acute CAG managers acknowledged that they could do more in terms of following up action plans resulting from serious incidents. They had set up monthly action plan meetings to monitor the progress of action plans and ensure that learning from serious incidents led to sustained improvement.
- Managers shared learning at their regular managers' meeting. However, some staff felt learning themes could be shared better between wards. The wards planned to start local ward-based clinical governance meetings to ensure staff had a more systematic overview of quality.

Most wards discussed learning from incidents at team meetings. However, the frequency and quality of discussion varied and not all wards included incidents as a regular agenda item at team meetings. The trust was introducing a standard agenda to support team meetings and this was just starting to be used by ward teams.

- Staff provided examples of changes and improvements they had made in response to incidents. For example, on Powell ward, staff had improved communication with the patients' families in response to learning from an incident. There was a notice on the staff notice board to prompt staff to do this. In addition, this ward, again in response to an incident, had organised a teaching session for staff on the medicine clozapine and the physical health complications associated with taking it.
- Staff met following incidents to discuss what had happened. Most wards held reflective practice sessions for staff. Psychology staff usually facilitated these sessions. Staff could use these sessions to discuss recent incidents or focus on an individual case discussion. Some ward managers told us that they would have liked additional support or training in how to conduct an effective debrief following an incident.

Duty of Candour

- The trust had a duty of candour policy and staff were aware of it. The trust incident reporting form prompted staff to consider whether the duty of candour applied when completing it. Staff understood the importance of being open and transparent and explaining to patients when things went wrong. For example, on AL3 and Croydon Triage staff had apologised to patients following medication errors.

Psychiatric intensive care units

Safe and clean environment

- The psychiatric intensive care units had some blind spots that required staff to carry out regular environmental checks to ensure patients were safe. Staff were aware of these blind spots and how to manage them.
- Staff carried out ligature risk assessments on the wards. However, we identified potential ligature risks on three of the four wards that staff had not identified in the last ligature risk assessments in August 2016 and December 2016. We highlighted these risks to staff on the day of the inspection. Staff took prompt action to address these once they were pointed out. Several risks we identified were removed on the day of inspection. In addition, work to address some risks identified in August 2016 had been only partially completed or not yet completed. For several identified risks, there were no written plans outlining when these works would be completed. In the mean time staff were mitigating these risks by carrying out individual risk assessments and increasing observation levels when indicated.
- Information for ward staff about ligature risks and ways to manage them was inconsistent across wards. Staff on Johnson ward had a trust information leaflet, but others did not. Staff on the three other wards were not aware of all the ligature risks highlighted on this leaflet. For example, paper dispensers in bathrooms. A ward manager told us that items of clothing identified as risks on the trust leaflet were not considered risks.
- Each ward had a clinic room where emergency equipment and medicines were stored appropriately. Records of regular checks of emergency equipment on two wards were completed but were inconsistent on two wards. On Eden Ward staff did not record some checks in September 2016. On Johnson ward there were no records available for November or December 2016. Staff received training in life support techniques to enable them to respond to emergencies effectively. On Croydon PICU clear signage told staff how to respond in an emergency, who to contact and where ligature cutters were stored. This ensured they could be accessed by any member of staff quickly, in an emergency.
- The trust took part in patient-led assessments of the care environment (PLACE) for all wards apart from Croydon PICU, which was newly opened. PLACE survey data from the PICUs showed scores of 98%-99% for cleanliness.
- Each ward had a seclusion room, which allowed staff to observe a patient inside. Patients could access a bathroom and see a clock. There were intercoms available in each room to allow patients and staff to communicate. On Johnson ward the viewing panel to the bedroom area had been vandalised, which partially obstructed views for patients and staff. This was fed back to the staff at the time, who said there was no date

yet for this to be repaired. The flooring to the seclusion room on Eden ward could be potentially pulled away and used to cause harm to others. Staff were aware of this but did not know when this would be addressed.

- Wards were visibly clean. Croydon PICU had been refurbished in 2016. It was newly decorated and furniture was well maintained. Other wards required some refurbishment and some furniture was damaged.
- Staff took action to prevent and control infection. Staff followed infection control procedures. Signs about infection control principles, including hand washing, were on display on all wards. Each ward had plastic boxes for staff to use to dispose of used needles, in the clinic room. These were assembled, labelled and signed correctly. They were not over-filled.
- Information about fire safety, kept on the wards, was out of date, which put both staff and patients at risk in the event of a fire. On Eden ward the fire evacuation plan was dated February 2012 with a review date of March 2012 that had not taken place. On Johnson ward the local fire policy was dated February 2014. Information about staff responsible for fire safety was out of date on Eden ward and Johnson ward. Records showed the last fire drill to take place on Johnson ward over six months previously in April 2016.
- At the inspection in September 2015, we found that an environmental risk on ES1 was not managed appropriately. There was a staircase in the unit garden, which was a fire escape. We found that patients were not being properly protected as a patient was left alone on the staircase. At the current inspection we found that staff were mitigating the risk posed by the staircase by making sure that staff observed patients whenever they were in the garden. This risk was being managed appropriately.
- Wards used a system of wall alarms and staff personal alarms to ensure incidents were highlighted and responded to. Each staff member carried a personal alarm and there were wall alarms in patient bedrooms and communal areas. Since the last inspection the trust had replaced the alarm system across the wards.

Safe staffing

- All wards had vacancies for nursing staff. This was highest on ES1 and Croydon PICU, where vacancies were 38%. The ward manager at Croydon PICU had recruited six nurses to vacant posts at the time of inspection. Vacancy rates were 26% on Johnson Ward and 4% on Eden Ward. The trust introduced pooled recruitment for the wards two months before the inspection and ward managers said this had improved the number of staff they were able to recruit to posts.
- ES1 had a high rate of newly qualified staff and a high turnover rate, meaning the ward often had a shortage of experienced staff. The turnover rate was 73% on ES1, on the other three wards it varied between 15% and 25%. However, new staff were well supported.
- Ward managers used bank and agency staff to cover shifts not filled by permanent staff. In the six months between July and December 2016 bank and agency staff made up 33% of all shifts worked on Johnson ward, 30% on Eden ward and 79% on ES1. The clinical academic group average was 47%. The PICUs used regular bank and agency staff where possible so that they were familiar with patients and ward routines.
- Each ward had a set number of qualified staff required to care safely for patients. The minimum number of nursing staff required on the early and late shift was three. On the night shift it was two. These nurses were supported by healthcare assistants. In the six months leading up to the inspection, the number of unfilled shifts was between 10% and 15% on the four wards. This was higher than the trust average of 9.3 %. When the trust could not obtain a nurse to cover a vacant shift they would obtain a health care assistant instead in order to maintain the required number of staff, although not the appropriate skill mix. Four patients from ES1, Eden Ward and Croydon PICU said staff were always very busy which meant they did not always have time to spend with patients or support them with activities such as making phone calls.
- The nursing staff team could access a doctor at all times, including out of hours. Each ward was supported by a full time consultant psychiatrist.
- Staff received a range of mandatory training and compliance rates ranged between 75% on Eden ward and 82% on Croydon PICU. This was below the trust

target rate of 85%. The trust had been working to improve these rates from an average of 77% since the last inspection. Staff on Eden ward said the new ward manager supported them to access training.

Assessing and managing risk to patients and staff

- Staff assessed risks for each patient using a trust risk assessment tool and updated these after risk incidents. On admission staff completed a brief risk record, then a more detailed risk assessment once the patient had been on the ward for over a week. Records showed staff completed comprehensive risk assessments and risk plans in a timely way for 21 of 23 patients. For two patients, staff on ES1 and Croydon PICU had started but not completed the risk assessment for patients admitted between six and ten days earlier. For one patient on ES1, staff had not updated their risk assessment following an incident. After assessment, staff used a coding system to identify, which patients were at higher risk and needed a higher level of support. Staff could access this information easily.
- Staff discussed risk in handovers between each shift.
- Staff said blanket restrictions were not used on wards without justification.
- Staff were trained in verbal de-escalation and physical restraint for use only after verbal de-escalation was not effective. We saw staff using de-escalation techniques effectively with patients. Reported incidents of restraint between June 2016 and December 2016 varied from 39 on Croydon PICU to 54 on Johnson ward. The rate of prone restraint varied from 31% on Croydon PICU and 34% on ES1 to 56% on Johnson ward. Overall, across all four PICUs, restraints in the prone position constituted 39% of all incidents of restraint.
- Wards used the four steps to safety approach, which is a method to decrease violence on wards. Staff on Croydon PICU could best describe how this was incorporated into their work and had information about this displayed on the ward for patients to see. Most patients said they felt safe on the wards.
- In the six months leading up to the current inspection staff used seclusion 44 times on Croydon PICU, 28 times on Eden ward, 43 times on ES1 and 54 times on Johnson ward. We reviewed nine patient seclusion records from all four wards. Staff had carried out appropriate reviews and kept thorough records for eight of the nine patients. However, for one patient on Eden ward, who was in seclusion the week before the inspection, there were no records of nursing or medical staff reviews for a period eight hours. This was not in line with the Mental Health Act 1983 code of practice or trust policy. One patient on Johnson ward said they had been cared for in the seclusion room, but had no complaints about how staff had done this. One patient on Eden ward and two on ES1 said staff carried out restraint and seclusion professionally.
- Staff were trained in how to identify safeguarding concerns and make safeguarding alerts. In most cases we saw good practice in terms of safeguarding. For example, on ES1 staff responded promptly to a safeguarding incident, formed immediate and more long term plans to manage this, discussed safeguarding implications and actions, and updated risk assessments. On ES1 staff discussed safeguarding concerns and action plans at daily handover meetings. However, on Johnson ward, staff reported a serious physical assault on a patient by another patient that took place on the ward in the two weeks before the inspection, as an incident but not as a safeguarding concern. Staff confirmed to us that this met the threshold for a safeguarding concern but could not explain why this was not reported as such.
- Staff encouraged patients who were the victims of assaults by other patients to report the incident to the police. There were on site police that staff could access quickly.
- Staff managed medicines well and most medicine administration records were completed appropriately. On ES1 we saw that staff reviewed “as required” medication at daily handover meetings and stopped these if the patient continually refused the medication. Seven medication cards on ES1 were completed correctly and no patients were prescribed more than one antipsychotic medication. On one patient’s medicine administration record on Eden ward the maximum dose for one medication was not outlined on the record.
- Staff checked the temperature of the clinic room and medicines fridge daily on most wards. This was to ensure medicines that needed to be kept cold were kept at the right temperature. However, on Johnson ward,

Requires improvement

Are services safe?

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

staff had not checked the room or fridge temperature on 15 days in November and December 2016. The maximum temperature reading for the fridge on Johnson ward had been recorded as 22 degrees for over ten days without staff reporting this or taking action.

- ES1 was piloting the use of a medicine that could be inhaled rather than administered through an injection, in order to reduce the use of injections during rapid tranquilisation.
- Trust pharmacists visited the wards each week. Posters on wards let patients know how they could speak with a pharmacist about their medication. On Croydon PICU the pharmacist attended the multidisciplinary team meeting once a week. The ward also held a weekly medicines group where patients and pharmacists were able to discuss medicines.
- Each ward had set visiting times and a space located on or off the ward for visits to take place. All visits from people under the age of 18 years took place off the ward.

Track record on safety

- Eden ward reported two serious incidents between January 2016 and December 2016. One was a Mental Health Act paperwork error and one was a patient under 16 admitted to an adult ward. Johnson ward had one serious incident in May 2016, the unexpected death of a patient.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and could describe what type of incidents they were required to report.
- Staff said they received information about feedback and recommendations from significant incidents. This took place in staff meetings. The trust had introduced team meeting agenda templates two months before the inspection, which included an item on discussion and feedback from incidents.
- Staff were able to describe changes on the ward following incidents. For example, on Croydon PICU, a member of staff was designated as a safety lead on each shift and one role was monitoring cutlery after meals to ensure it was all returned. However, on Johnson ward, two patients had absconded from the ward by climbing over the garden fence. Although the trust had taken steps to address this, three further incidents of patients using this method to abscond from the ward had taken place in the last 12 months.
- Staff were supported after serious incidents through debriefs. Ward managers had supported staff to access individual and group counselling where appropriate. Staff confirmed debriefs took place and were aware of the counselling services available.

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 completed assessments of patients on admission. These included a physical examination and initial assessments of patients' physical and mental health needs. Staff carried out a nutrition screen and risk assessment for all patients shortly after admission. The trust was in the process of introducing a new template for completing care records at the time of the inspection.
- Staff checked patients' vital signs, such as pulse and blood pressure, regularly. They recorded the results of these checks on a scoring form called the modified early warning score (MEWS). Staff completed at least daily checks for all patients during the first three days of admission. Following this, staff carried out checks weekly or more frequently if indicated by assessment. Staff had completed MEWS forms in full in all of the 18 records we reviewed in the four wards at Lambeth Hospital. A physical health check audit on John Dickson ward in January 2017 found staff completed appropriate checks recording body mass index, blood pressure, blood glucose levels, weight gain, hypertension, and diabetes risk for 90% of patients. Staff acted upon the results of the checks for most patients. However, staff did not record how they responded to raised MEWS scores, indicating a potential deterioration in a patient's health, in two records on John Dickson ward.
- Staff on ES2 ward had piloted the recording of physical observations electronically. They hoped this would help ensure immediate response to any potential deterioration, as alerts would be automatically generated. The information gathered could also be shared with the local acute trust, if required. The trust had plans to roll out electronic recording of observations across all wards in future.
- Staff developed plans to support patients with their physical health needs. For example, on Ruskin on AL2 we saw examples of staff developing plans to support a patient with their weight gain. Staff developed good plans and managed patients' physical healthcare needs well in 16 of the 18 records we reviewed on wards at the Maudsley Hospital. This was similar to what we found in all the acute wards across the four hospitals. For example, we saw detailed smoking cessation care plans for patients who needed support in this area. On Gresham 1 we saw a comprehensive management plan in place for a patient with diabetes. On Gresham 2 staff compiled a care plan for patient who suffered with severe seizures that included a clear management plan to support the patient.
- During the last inspection in September 2015, we found that some patients did not have care plans that met their individual needs and patients needed to be offered more opportunities to be involved in planning their care. At the current inspection, we found that overall, the quality of care plans had improved. We reviewed the health care records, including care plans, of 99 patients on the acute wards. Physical health care plans, in particular, were very detailed and gave clear and relevant guidance to staff on how to provide safe and effective care to patients. Most care plans were individualised and addressed patients' particular needs. For example, staff completed personalised, holistic plans that contained the patient's view for all 13 patients' records we reviewed on Ruskin on AL2, John Dickson and AL3 wards. Similarly the care plans of patients on the wards at the Bethlem Royal Hospital and Lambeth Hospital reflected patients assessed needs and were holistic, up to date, individualised and recovery oriented. Four patients on wards at Ladywell Unit had very detailed care plans that met their needs. For example, staff provided one patient with autism with a pictorial care plan to help them understand the content. However, on a few wards the care plans were of much poorer quality. On John Dickson ward, none of the five care plans we reviewed were personalised to the patient's individual needs. Staff had completed generic plans, some of which appeared to have been copied and pasted. One contained three different names. Staff had not developed plans with the patients that were recovery orientated or focused on their strengths and goals. On the five Ladywell Unit acute wards 19 of the 23 care plans we reviewed were more generic in nature rather than clearly individualised.
- Patients' views were usually included in care plans, especially when patients were well enough to contribute. Most patients were able to tell us about their care plans and how they had contributed to them. For example, four records we reviewed on AL3

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.

demonstrated staff sought the views of patients through the ward round and feedback forms before developing plans in a collaborative style with the patient. Eighty six per cent of patients who completed the trust's feedback survey on AL3 between 11 October 2016 and 29 December 2016 responded that they felt involved in their care. However, some patients were unclear about their care plans and what they covered. For example, some patients we spoke with on Luther King ward had a poor understanding of their care plans.

- Staff could access information on patients easily through the electronic patient records system, although some staff highlighted that the system could be very slow. All staff had individual passwords and access cards to ensure information was stored securely.

Best practice in treatment and care

- Staff considered medication guidelines from the national institute of health and care excellence, in conjunction with the Maudsley prescribing guidelines, when making treatment decisions. Records showed that doctors had recorded a clear rationale when they had prescribed outside of the guidelines. We observed ward rounds on Croydon Triage, John Dickson, and Ruskin on AL2 wards. Staff discussed treatment decisions and proactively sought to reduce patients' medication dosage when appropriate. Staff discussed changes in guidance at the trust-wide drugs and therapies meeting. Staff then communicated these changes with the rest of the team. Doctors worked closely with trust pharmacists to review the medication history of patients and ensure they received the most effective treatment.
- Most patients had access to some psychological therapies. The trust provided psychological therapy groups on most wards. On Ruskin on AL2 an emotional wellbeing group took place weekly. Staff on wards could refer patients for psychological assessment. Staff on some wards told us there had been limited access to psychological therapies in the previous six months due to staff leaving. The trust was in the process of reviewing and restructuring psychological input across all the acute wards. Plans were in place to provide 15 psychologist sessions at each of the four hospitals every week, so that patients would have similar access to psychological therapies wherever they were admitted.
- Staff provided a number of complementary therapies. For example, on Ruskin on AL2 staff facilitated a weekly yoga session. On ES2 and AL3 staff provided mindfulness sessions.
- Staff carried out regular on-going checks on the physical health of patients. Modified early warning scores were recorded for all patients throughout their stay to monitor their physical health, and these checks were carried out more frequently for individuals who were more recently admitted or had physical health conditions. Care plans for patients with physical health problems were very detailed. Specific care plans were put in place for patients with nutrition or hydration needs. Staff supported patients to access specialist physical health support and attend appointments. For example, on Croydon Triage a patient asked for a referral to a dentist during a ward round and staff agreed to arrange this.
- Patients who smoked had access to a range of different nicotine replacement products and they were encouraged by staff to try different things in order to see what worked best for them. Patients who smoked were prescribed nicotine replacement therapy 'as required' when they were admitted. Patients were able to smoke e-cigarettes in their rooms. Some nurses on each of the wards were specially trained in smoking cessation and provided additional support. For example, a nurse provided a weekly smoking cessation group and support to patients on Croydon Triage in respect of tobacco addiction.
- The trust used health of the nation outcome scales, also known as HoNOS, to assess and evaluate the effectiveness of interventions. Staff had completed these scores in most of the records we reviewed. Occupational therapists used the model of human occupation screening tool to measure patients' progress.
- Clinical staff actively conducted clinical and managerial audits. Many of the audits were used as assurance for the operation of the wards and checked the completion of care records, health and safety checks, completion of Mental Health Act documentation and ensuring equipment was in good working order. Clinical audits

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.

focused on medication. The trust shared important learning from audits with staff via a purple bulletin that was emailed to all staff. Learning from audits was also discussed in team meetings and individual supervision.

Skilled staff to deliver care

- A full range of mental health disciplines provided input to the wards. This included nurses, psychiatrists, occupational therapists and psychologists. Pharmacists visited the wards regularly to review medicines and give input to treatment decisions. The trust had developed a new therapy and benefits co-ordinator role. They hoped this role would allow a member of staff to develop expertise in supporting patients in accessing benefits. Staff from different disciplines attended multi-disciplinary team (MDT) meetings, where patients' needs were discussed in detail. Staff from the home treatment teams attended regularly. Care coordinators from community teams were invited to contribute where appropriate, although they frequently did not attend.
- At the inspection in September 2015 we found that temporary staff did not always have a timely local induction. At the current inspection we found that this had improved. Temporary staff, who were new to a ward, completed a brief recorded induction. Staff ensured that temporary staff received an orientation to the ward and understood what to do and who to contact in an emergency. Records confirmed that inductions were taking place.
- The trust had a preceptorship programme to support newly qualified nurses. The wards had six competencies that all qualified staff needed to work through. Each ward had a practice development nurse, who took the lead on auditing quality and supporting staff to develop their skills. Staff had access to development training sessions. For example, John Dickson ward had a plan of regular teaching sessions. Topics had included welfare benefits and dual diagnosis. Staff told us that when they had been short-staffed it had been hard to focus on their skills and knowledge development.
- During the last inspection in September 2015, we found that not all staff were receiving regular supervision and recommended that the trust made improvements. At the current inspection we found that staff supervision was not always taking place in line with the trust policy. Staff did not always receive regular formal one-to-one supervision every month as required. Four acute wards had achieved a staff supervision completion rate of less than 50% in the six months from July to December 2016. For example, ES2, Wharton Ward and Lewisham Triage had not achieved a staff supervision completion rate greater than 45% in any one month. Four other wards had completed an average of between 50% and 57% of expected staff supervision between July and December 2016. This meant that there was risk that some staff were not receiving appropriate professional support to enable them to carry their duties safely and effectively. However, levels of supervision at the Lambeth Hospital wards were generally higher with all wards completing more than 70% of staff supervision over the same six month period. Staff told us that monthly supervision gave them an opportunity to discuss practice issues, professional development and training.
- Almost all clinical staff had received an appraisal in the last 12 months. Staff appraisal completion rates were above 90% for 15 of the 17 acute wards in the trust. Two wards had completed less than 90%. These wards were Jim Birley Unit, which had completed 89% of staff appraisals and Gresham 1, which had completed 76%.
- Staff who wanted to develop their skills were able to take up specialist training opportunities. Senior nurses could access courses in leadership and management and offering effective supervision. Simulation training was provided to help staff manage challenging situations at work. This was particularly popular. Healthcare support workers were being supported to complete the Care Certificate. Staff on Wharton Ward had undertaken training on women's sexual health with a view to being able to better support patients on the ward.
- Following the inspection in September 2015 we recommended to the trust that staff should have training on supporting people with learning disabilities or autism. At the current inspection we found the trust was rolling out specialist training to staff in supporting patients with learning disabilities but not all staff had yet undertaken this training or were aware of it. Staff on acute wards at the Bethlem Royal Hospital said they had

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.

been asked to put their names forward for this training if they were interested. The ward manager on Wharton ward had attended specialist training for intellectual disability and mental health at a local university.

- Managers addressed poor performance. Ward mangers knew the processes for managing performance and told us they received support from the human resources department. They had a process to follow if staff performance did not improve.

Multi-disciplinary and inter-agency team work

- All wards held regular multi-disciplinary meetings. These involved input from staff from a range of different professional backgrounds. A pharmacist attended the ward rounds which were held once a week or as often as every day in some wards. They gave information and advice in respect of medicines to the ward consultant. Staff from different disciplines worked closely together to determine treatment plans and approaches.
- We observed six handovers that took place on wards between shifts. Staff gave and discussed an update on each patient's progress and provided information on issues such as individual risks and observation levels. Handovers were comprehensive and staff demonstrated that they had detailed knowledge of patients.
- The trust held regular bed management meetings at all four hospitals to help facilitate the flow of patients into and out of the wards. At the Maudsley bed management meeting staff from different disciplines attended, discussed potential admissions and discharges and looked at ways to remove barriers to discharge.
- Staff on the wards had good working relationships with the home treatment teams, who communicated well with them. Staff on Croydon Triage described the relationship as "seamless". Staff from home treatment teams came to the wards often. They were present at multi-disciplinary team and bed management meetings. They worked closely with ward teams to help facilitate the safe discharge of patients.
- Acute ward staff voiced different opinions about their working relationships with community mental health teams. Some staff told us they had good relationship with psychosis community teams, who would take referrals prior to discharge and support the discharge process. In contrast, they felt the relationship could be improved with the mood and personality disorder community teams who did not take referrals until the day of discharge. Other staff told us that care co-coordinators at community mental health teams changed frequently, which had a negative impact on communication. Community care coordinators were invited to ward rounds and to visit patients but were not often available to attend.
- Staff told us they found the welfare officers based on the Maudsley site a useful resource in facilitating discharge. They were concerned whether this support would still be available when the roles were no longer based onsite.
- The wards worked closely with external organisations in Lambeth to help with housing, benefits and social activities. For example, when we visited Bridge House a patient was visiting their flat with a staff member from a third sector provider to prepare the environment for their discharge.

Adherence to the MHA and the MHA Code of Practice

- Most staff had undertaken e-learning training on the Mental Health Act (MHA). Seventy nine per cent of staff on the acute wards had completed the training which was updated every three years. Four wards had achieved less than 75% completion rate for MHA training. The lowest was Gresham 1 with 57%. Clare Ward had achieved 100% and John Dickson 95%.
- During our last inspection in September 2015, we found that not all patients had a record of their status under the MHA. During the current inspection we found patients' status was clearly recorded on their electronic record and on information boards in the staff offices.
- During our inspection in September 2015, we found it was not always clear whether patients had their rights explained to them as staff did not record this consistently. During the current inspection we found that attempts by staff to explain patients' s132 rights were clearly documented in patient care records. Most patients described being informed of their rights and being given a welcome pack to read.
- Independent mental health advocacy services were readily available to support people. Patients knew who their ward advocate was. Posters displayed on the wards explained how to contact the advocate.

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.

- During the last inspection in September 2015, we found that informal patients were not given clear and accurate information about their rights to leave the ward and refuse medication. During the current inspection we saw clear signs were displayed near the ward exit doors explaining that informal patients had a right to leave. Informal patients told us they were able to leave when they wanted. The wording on the posters was clear and unambiguous. The trust had introduced an informal patient's policy in June 2016, which explained managers' roles and responsibilities in respect of informal patients.
- All MHA paperwork was scanned onto the electronic records system and was easy to access. Consent to treatment records were kept alongside medication records. Staff had completed all detention paperwork correctly in the files we reviewed.
- Staff undertook regular audits of the MHA. In these, they identified whether detention paperwork was going to need renewing in the near future and where patients needed their rights explained to them again. Staff took action to remedy any shortfalls identified in the audits.
- Doctors completed section 17 leave forms appropriately so that patients were able to go out for periods of leave. Staff reviewed patients' leave status regularly at ward rounds. However, patients and staff on Clare ward told us that section 17 leave that had been granted on Lewisham Triage was not available to patients when they transferred to Clare ward during the weekend. This resulted in a period of restriction to the ward where patients were unable to leave the ward to visit either the garden for fresh air or go out to the community, until reviewed by a doctor on Monday morning.
- Where required, most consent (T2) or authorisation (T3) certificates were completed and attached to medicine charts. However, on Powell ward, one patient had been detained and continuously treated for a period extending well beyond three months and yet there appeared to be no authorisation for this, in the form of a certificate of consent or a certificate of second opinion. This was brought to the attention of the ward and rectified the following day. On Clare ward we found one T2 form that had not been updated by the current responsible clinician following the patient's transfer to the ward.
- MHA office staff gave ward staff advice and guidance on the law. MHA administrators were available during working hours to scrutinise detention paperwork. The duty nurse carried out this function out of hours.

Good practice in applying the Mental Capacity Act

- Following the inspection of the trust in September 2015 we recommended that the trust should continue to ensure that staff received training in the Mental Capacity Act (MCA) so that the legislation could be applied more consistently. At the current inspection we found that the majority of staff had completed e-learning training in the MCA. This was updated every three years. Sixty nine per cent of staff in all of the acute wards had completed the training and were up to date. On three wards, Nelson, Croydon Triage and Clare, more than 90% of staff had completed the training. Seven wards had achieved a training completion level of 75%. The other wards had achieved at least 60% completion except Gresham 1, 30% and Ruskin on AL2, 53%.
- We found that while staff understanding of the MCA varied it was being applied consistently. Some staff explained clearly that a patient's capacity may fluctuate and how they could support patients to make decisions. Staff in Lambeth had a good understanding of when assessments of people's capacity should be completed. However, others said that assessing a patient's capacity was the responsibility of medical staff. On Gresham 2 some staff did not understand the basic principles of the MCA. For example, when the need may arise to assess someone's capacity and whether an individual is subject to a deprivation of liberty safeguards (DoLS).
- Staff recorded they had reviewed patients' capacity in most records we reviewed. In Lambeth we found examples where assessments of people's capacity had been completed for specific decisions such as accommodation and financial choices. At the Bethlem Royal Hospital we saw good examples of recording of capacity of patients to consent to care and treatment on each ward. Specific capacity assessment forms were completed appropriately and recorded in the ward round notes by the consultant psychiatrists. Staff had held best interest meetings with patients when making some decisions and these were recorded in patients' notes. However, staff had not clearly recorded that they have reviewed the patient's capacity to consent in two records we reviewed on John Dickson ward.

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.

- At Bridge House an application had been made to authorise a DoLS. However, there were delays in the assessment and approval by the local authority. Staff had completed an incident form to highlight concerns about this delay. At the Bethlem Royal Hospital, Gresham 2 staff had submitted two applications for an authorisation under the DoLS. We reviewed the paperwork and found that neither of the applications had not been authorised. For one patient the ward had applied for a DoLS a few weeks earlier after a mental capacity assessment had been completed. For the other patient, the ward had been waiting for over two months for the local authority to assess the patient for a DoLS. In both cases we saw evidence of the ward chasing up the applications with the local authority.
- Patients could access an independent mental capacity advocate when needed.

Psychiatric intensive care units

Assessment of needs and planning of care

- Care records and trust audits showed that staff carried out physical health examinations when a patient was admitted to a PICU and provided support for ongoing physical health issues. Staff at ward rounds and team meetings considered and discussed healthy lifestyle interventions with patients. Phlebotomists visited wards regularly and medical staff said the electronic system to check results of blood tests was easily accessible. Patients said staff supported them with their physical health and took them to physical health appointments when necessary.
- Care plans were in place for most patients. However, the quality of these varied. Many were brief, did not outline goals and were not particularly personalised. Of the 22 care plans we reviewed, four were detailed, personalised and recovery focused. On ES1, two of five care plans had not been regularly reviewed and were not up to date.
- Information about patient care was stored securely on an electronic record system and staff could access it when necessary.

Best practice in treatment and care

- Patient notes, our observations during the inspection and discussions with staff showed that staff considered professional guidance when prescribing medicines.
- Staff supported patients to access specialist physical healthcare when necessary.
- Staff regularly completed and audited the use of recognised rating scales to assess and record the severity of illness and outcomes for patients. For example, the health of the nation outcome scales (HoNOS).
- Staff carried out regular clinical audits. This included audits of care plans, risk assessments and the reading of section 132 rights under the Mental Health Act 1983. Staff on Croydon PICU carried out a seclusion room environmental audit.

Skilled staff to deliver care

- A range of mental health professionals provided input to wards through a multidisciplinary team, including nurses, psychiatrists, pharmacists and occupational therapists. Patients had limited input from a psychologist as they were not part of each ward's multidisciplinary team. On one ward the psychologist was on long term leave at the time of inspection. Staff said that if a patient needed psychological input they would refer the patient to a psychologist. On ES1, a psychologist attended weekly staff meetings and reflective practice groups to support the staff team. The trust was in the process of reviewing psychology provision across the acute pathway to ensure access was equitable and available to those who needed it.
- New staff received a trust induction and a local ward induction to the ward before they started working.
- Wards had supervision structures in place and staff said they received supervision monthly. Each ward recorded supervision compliance in a different way. On the day of inspection Croydon PICU supervision data was available for April 2016 to January 2017. Compliance was 93%. On Johnson ward, records were available between November 2016 and January 2017 and compliance was 76%. On ES1 and Eden ward, records of supervision were not available before January 2017, where compliance for the month was between 84% and 88%. Staff on Johnson ward said they also accessed peer supervision where cases were presented or debriefs, which were led by a psychologist external to the ward.

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.

- Records showed staff received annual appraisals. Between 96% and 100% of staff had received an appraisal in the last 12 months. This was highest on Croydon PICU.
- Staff could attend team business meetings once a month. Two months before the inspection the trust introduced template agendas to these meetings to ensure all wards were discussing the same items.
- After the last inspection in September 2015 the trust outlined plans to train staff in learning disabilities. However, the majority of staff we spoke with had not yet received this training, although it was being rolled out. Occupational therapy staff and one healthcare assistant had completed the training.

Multi-disciplinary and inter-agency team work

- Each ward had regular multidisciplinary team meetings where staff discussed each patient, their needs and their progress. The multidisciplinary meeting we observed on ES1 was particularly well-led by the psychiatrist and each member of staff from different disciplines had input into the discussion. Staff also held ward rounds once or twice a week where patients, family members and external professionals involved in a patient's care could attend to discuss care. On ES1 the role of chair of the weekly ward round was rotated to allow all staff to develop their chairing and leadership skills.
- Staff held daily handover meetings at the start of the day and between each shift. At handover meetings on Croydon PICU and ES1 staff from each discipline contributed to the conversation and discussed the range of needs of each patient. For example, particular physical health needs and whether referrals to a dietitian and diabetes specialist were needed.
- Staff communicated with other teams inside and outside the trust. For example, with acute or forensic service colleagues if a patient was being transferred to one of these services.

Adherence to the MHA and the MHA Code of Practice

- Most staff received training in the Mental Health Act (MHA) and had an understanding of the guiding principles of the MHA code of practice. Staff said they were aware of whom to speak to in the trust MHA office if they needed advice. Sixty eight per cent of PICU staff were up to date with training on the MHA.
- Staff were aware of their responsibility to provide patients with information about their rights under the MHA, both on admission and regularly afterwards. Most records showed staff did this in a timely way and made repeated attempts to explain patients' rights.
- Detention paperwork that we reviewed was filled in correctly, up to date and stored appropriately.
- Patients had access to independent mental health advocates (IMHA), in line with the code of practice. Staff were aware of how to support patients to access an IMHA and we saw staff discussed this in team meetings. Information about who the IMHA was, how to contact them and when they visited the ward was available to patients in communal areas.

Good practice in applying the MCA

- Staff received training in the Mental Capacity Act 2005 (MCA). However, not all nursing and healthcare assistant staff could clearly describe their understanding of the MCA and how this was incorporated into patient care. They could not describe times where they had queried or assessed a patient's capacity in relation to particular decisions other than being admitted to the ward for treatment. Overall, 62% of staff on the PICUs had completed training in the MCA. However, the training completion rate for Eden ward was 38%.
- Records showed that in most cases medical staff carried out and recorded capacity assessments for patients within seven days of their admission for treatment. Staff recorded assessments in a patient's progress notes rather than the identified tab on the electronic system, meaning they were not easily identifiable without searching through daily progress notes. On Johnson ward, we did not find these assessments recorded for two patients.
- Patients were able to attend weekly ward round meetings to discuss their care and speak with staff. In the ward round for ES1 we saw staff explored the patient's capacity to understand the information given to them to ensure they had a good understanding of this. We saw action plans were discussed with patients who attended the ward rounds.

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

- Staff interacted in a caring manner with patients. We observed staff showing genuine compassion and empathy for the patients they worked with. Staff involved patients in decision making and explained care and treatment in a way that patients could understand. For example, during a ward round on Croydon Triage the consultant psychiatrist took account of patients' preferences and concerns when prescribing medicines and reviewing their leave arrangements. However, on John Dickson and Ruskin on AL2 staff seemed time pressured and did not have as much time to interact with patients.
- Most staff supported patients in a kind and respectful way. On John Dickson ward 89% of patients who responded to the trust's feedback questionnaire in December 2016 said they found staff kind and caring; on AL3 95% of those who responded between September and December said they found staff kind and caring.
- The patients we spoke with on the wards varied in their feedback and opinions of the ward. For example, most patients in the Ladywell Unit stated that staff were kind and responsive to their needs. In Lambeth acute wards most patients said that staff knew them and got on well with them. However, comments cards from patients at Lambeth Triage ward said that whilst most staff were pleasant to them, some were rude. Three patients on Ruskin and two on John Dickson told us they felt staff could spend more time interacting with them and that they did not always have time for them.
- Most staff knew patients' individual needs and sought to support them. Staff we spoke with knew their patients well and understood their individual needs. The acute wards used a system of 'intentional rounding' whereby staff asked patients how they were and whether they needed anything every two hours throughout the day.
- At the inspections in September 2015 and May 2016 we found that observation windows in patient bedroom doors were regularly left open. This meant that people could see into patients' bedrooms when the doors were closed. This could compromise patients' privacy and dignity. At the current inspection we found that staff kept viewing panels and exterior curtains to bedrooms closed when they were not observing patients through them. Some wards had applied stickers to bedroom doors reminding staff to close the panels when not in use.
- AL3 and ES2, at the Maudsley Hospital both scored 88% for privacy, dignity and wellbeing in patient-led assessments of clinical environments (PLACE) assessments in the last year, which is slightly lower than the England average of 90%. The acute wards at Lambeth Hospital, the Bethlem Royal Hospital and Ladywell Unit all scored between 94% and 98% in 2016, all above the national average.
- Staff at the Maudsley and the Bethlem Royal Hospital acute wards did not display any personal information regarding patients in open areas. Patient information was kept hidden from plain view in the staff office so that people outside the office could not see it. However, at Bridge House, notice boards containing confidential patient information in the nurses' offices on both the male and female wards were visible from the ward corridors. Similarly on Lewisham Triage and Clare wards patient information in the staff office could easily be seen through the window by patients on the ward. Staff on Clare ward had obtained a whiteboard that staff could keep covered to ensure that patient information remained confidential and were due to install it. In addition, at Bridge House patients queued at clinic room hatches to receive their medication meaning that patients could hear about medication others were taking and what their side effects were. This compromised patients' privacy at Bridge House.

The involvement of people in the care they receive

- Staff gave patients an information pack when they admitted them to the ward. This contained information about the ward, ward timetable and what a patient could expect from the admission.
- Most patients we spoke with understood the care and treatment they received, were aware that they had a care plan and said they had contributed to it. However, on Luther King ward four patients said they did not have a good understanding of their care plan.
- Initiatives such as the 'tree of life' programme were in place to improve patient involvement in their care.

Are services caring?

Good

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

Some wards at the Ladywell Unit provided 'tree of life' workshops. The programme enabled staff and patients to discuss things, which were important to them together. The programme focused on recovery. Artwork from this programme was on display on the wards.

- All wards held regular community and planning meetings. In planning meetings, staff met with patients and planned the structure and activities of the day. Staff also held weekly community meetings when patients could offer feedback on how the ward was being run and any repairs needed. On AL3 at Maudsley Hospital the ward manager ran a feedback group and the consultant a care planning discussion group, to give patients an opportunity to ask questions and feedback ideas.
- Patients in all wards were able to give feedback about their experience using hand held electronic devices. This feedback was collected and presented to the staff team on a regular basis. On Wharton ward, patients were given diaries where they could write down things that were important to them and share this with the ward team.
- Patients had access to advocacy services. Independent mental health act advocates visited wards regularly. Peer support workers and volunteers also visited. Some of these people had lived experience of mental health services so could offer different perspectives. Peer support workers helped raise patient concerns with ward staff.
- Staff sought to involve family members in care if the patient wished. Carers and family members were sometimes invited to attend ward round meetings. Many wards had a carer's lead who maintained contact with carers. On Nelson ward in Lambeth Hospital carers were invited to attend a surgery each week where they could meet with the consultant psychiatrist for support and advice. The ward manager of Croydon Triage met with carers and friends of patients once a month. The ward manager discussed anything carers wished to raise over coffee and cakes. On Gresham 1, patients were able to meet with the ward manager once a week for an allotted time to discuss any concerns they had. On Jim Birley Unit, parents and carers who lived some distance from Lewisham could receive financial assistance with regard to travel fares.

Psychiatric intensive care units

Kindness, dignity, respect and support

- On all psychiatric intensive care units we observed positive and caring interactions between staff and patients. Staff spoke with patients in a supportive and respectful manner. Staff had an understanding of the individual needs of patients. On Eden ward we saw staff discussing risks for each patient in detail before and after supporting them with an activity.
- At the inspection in September 2015, we found that privacy windows on patient bedrooms were routinely left open. This meant people could see into the rooms when the doors were closed and patients' privacy and dignity could be compromised. At the current inspection privacy windows were closed and signs on the doors reminded staff to close them after observations were completed. Patients said staff generally knocked on the door before entering their room. However, on two wards, Eden ward and Johnson ward, personal information about patients in the nursing office was visible from the ward. This meant other patients or visitors may have been able to see information, which was not appropriate or in line with the principles of confidentiality.
- The trust took part in patient-led assessments of the care environment (PLACE) for all wards apart from Croydon PICU, which was newly opened. PLACE survey data from wards showed scores of 92%-100% for privacy.
- Patients gave positive feedback about the caring nature of staff. They said staff were lovely, professional, did a good job, and were polite and caring. Patients on Croydon PICU said the therapeutic care they received was excellent. Two patients on ES1 said staff supported them and believed in them. Most patients said the staff made the wards feel like safe environments. One patient on Eden ward said the staff worked as a team to keep the ward safe. However, on ES1, two patients said the ward felt chaotic.
- A patient feedback survey of nine patients and one carer carried out in November 2016 on ES1 showed five patients would recommend the ward for treatment while two would not. Patients wrote that the ward could be boring and some staff could engage with patients more. Positive feedback included praise for staff, saying

Good

Are services caring?

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

they listened to and cared well for patients. Seven respondents said staff were kind and caring. On Eden ward, results from a patient survey showed three of ten would recommend the ward and four said staff were kind and caring.

The involvement of people in the care they receive

- Staff gave patients a tour of the ward and written information packs about the ward when they were admitted. Information packs included information about the roles of the different staff, summarised the Mental Health Act, the no smoking policy, how violence and aggression was managed and where patients could store valuables. The information was written clearly.
- Patients were able to discuss their care with staff at ward rounds. However, there was little evidence in care records that staff actively involved patients in the initial discussion and development of their care plans and risk assessments. Staff did not regularly record patient views in their records or always note the reason why this was not possible. For example, if a patient was too unwell or explicitly stated they did not want to be involved.
- Internal trust audits on patient involvement in care plans showed variation across the wards in the recording of patient views and offering copies of care plans to patients. Care plan audits from Johnson ward and Eden ward in the three months before the inspection showed this was not done regularly. On ES1, patient feedback collected by the trust in November 2016 showed five of nine patients did not feel involved in their care.
- Patients were able to access advocacy services and information about these was available on all wards. However, not all patients on ES1 were aware of the service. On Eden ward the telephone number for advocacy services was on display above the telephone. Two patients on Eden ward said the advocate was very helpful.
- Staff said they involved family members in care where possible. On Croydon PICU, staff recorded their efforts to find and engage family members of patients who were from refugee backgrounds.
- Each ward had a weekly community meeting where patients could give feedback about the ward. Staff took minutes of these meetings and displayed them on the ward. On Croydon PICU patients who attended contributed a lot of ideas about improvements in patient care.
- The trust used an electronic device to regularly collect feedback from patients and family members.

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

- During the 6 month period from July to December 2016 immediately before our inspection bed occupancy on all wards was high. The mean percentage bed occupancy levels, excluding patients on leave, had been 85% or less on one acute ward. This is the 'optimal' bed occupancy level recommended by the Royal College of Psychiatrists. Bed occupancy had been between 85% and 95% on five wards. Ten wards had bed occupancy rates between 95% and 100%. Nelson ward recorded a bed occupancy rate of 106%.
- The trust had nine or ten patients accommodated in private sector hospital beds at the time of the inspection as acute or psychiatric intensive care beds were not available within the trust. This was a reduction from about 50 patients in out of area placements in 2015 and 36 in July 2016. The trust board discussed bed occupancy levels and patients in out of area beds at the January 2017 board meeting. At this meeting the chief executive stated his commitment to continuing to work towards reducing bed occupancy levels to 85%.
- Patients were generally able to stay within the borough in which they lived, but beds could be found in neighbouring boroughs if needed. Five of the patients staying at Nelson ward during our inspection were resident in Croydon, where there was more of a shortage of acute beds. The trust had plans to open another acute ward at the Bethlem Royal Hospital and was closing Bridge House at Lambeth Hospital in anticipation of this. Leo ward was the only early intervention ward at the trust and took patients from all four boroughs. Jim Birley Unit at the Ladywell Unit, in Lewisham, had been decanted from the Maudsley Hospital. This ward admitted patients from the borough of Southwark.
- For the three month period from November 2016 to January 2017 there were 111 moves/transfers of patients between wards or hospitals for non-clinical reasons. Of these 57 took place within the hours 9am to 7pm, with 54 outside of these hours. Twenty two moves took place between 11pm and 6am. Of the 111 patients 21 patients had returned from a private sector hospital. The majority of the moves and transfers were to relocate patients back to their local borough so that they could work with their local community mental health team to facilitate discharge. Staff told us that some out-of-hours transfers were due to delays in obtaining transport.
- The trust had focused on reducing length of stays for patients, but some remained high. Five wards, Powell, Clare, Luther King, Nelson and Gresham 1 all had average lengths of stay of over 60 days the last sixth months. Staff tried hard to reduce length of stays by actively reviewing patient progress and considering prospective discharge dates on admission. Lengths of stay on the triage wards were much lower as they had previously taken all new admissions before transferring them to other acute wards. The purpose of the wards was under review and had already changed on Croydon Triage.
- The trust had introduced the acute referral centre (ARC) in the second half of 2016. The role of the ARC was to ensure a prompt response to all referrals of patients to acute care beds; ensuring patients were offered the most appropriate intervention. ARC staff triaged all acute referrals and maintained an up to date view of bed occupancy in acute care, any planned transfers and discharges, patients placed out of area and delayed discharges. The ARC was staffed by staff from the home treatment teams on a three month rotational basis. Early evidence of the impact of the ARC suggested an 8% reduction in admissions had been achieved as some people had been signposted to more appropriate sources of help and did not require admission to an acute bed.
- All wards had some patients who were ready for discharge. For example, on John Dickson ward, staff identified 10 patients on the ward they thought could be discharged to other services. In the six months between July and December 2016 there had been 12 delayed discharges or transfers on Gresham 2 and 11 on Wharton ward, which had the highest numbers of delays of all the acute wards. Staff at the Maudsley acute wards said discharges were delayed due to a lack of social care provision or suitable placements. In Lambeth difficulties with finding accommodation after discharge were the most common cause of delayed discharges. Staff in Ladywell Unit also cited a lack specialist units for patients to be discharged to.

Are services responsive to people's needs?

Good

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

- The trust held regular bed management meetings at all four hospitals. We observed the bed management meeting held at Maudsley Hospital. Representatives from the acute wards and PICUs attended the meeting and discussed patients' progress towards discharge or transfer. Other attendees at the meeting included representatives from the home treatment team, homelessness team, social care and placements. Each patient was discussed and a prospective discharge date updated. The meeting focused on any barriers or likely barriers to discharge or transfer and how these could be addressed or removed. Delays were apparent particularly when patients had a higher level of care needs than when they had been admitted, did not have recourse to public funds or were referred to a local authority social needs assessment and placement (SNAP) team, where the waiting list was very long.
- Patient care plans contained discharge plans, although these were sometimes brief and lacked detail. Staff were clearly focused on discharging patients as soon as possible, in line with their care and treatment needs. Home treatment team staff worked closely with the acute ward teams and attended ward rounds to discuss whether any patients could be discharged to their team for close follow up and support at home.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward environments at Maudsley Hospital were stark and non-homely. They did not provide an appropriate therapeutic environment to support patients. The trust had a rolling ward refurbishment plan. They planned to refurbish ES2 shortly after the inspection. Following this, they hoped to refurbish other wards over the coming years. At the Ladywell Unit some items of furniture on Jim Birley ward and in the meeting room attached to Powell ward were damaged and needed replacing.
- On AL3, the trust had painted some of the rooms to improve the feel of the ward prior to having a full refurbishment. The staff had also framed some photography and artwork done by patients on the walls between the entrance and the ward area.
- All wards had clinic, activity and therapy rooms. Wards contained lounge areas, gender separate lounges where necessary, activity rooms and access to kitchens for occupational therapy groups. Clinic rooms were available on all wards and contained couches for physical examinations. On ES2 the activity room was a converted bedroom and very small. The trust had a plan to develop a new activity room as part of the forthcoming refurbishment. At Lambeth Hospital, although there were enough rooms to provide a comprehensive programme of activities, the environment on Luther King and Nelson wards was cramped, particularly in the dining areas.
- At the inspection in May 2016 we found that there was not always enough private space for patients to meet with advocates. During the current inspection we found there was sufficient space available for patients to meet privately with advocates.
- All wards had spaces in which patients could see visitors. Children could visit their relatives at on-site family rooms, external to the wards.
- Patients could use their mobile phones on the wards. Each ward had a telephone for patients to use. However, the telephone at Nelson ward was damaged at the time of our visit. Patients were able to use a telephone in a private office until it was fixed. Staff kept phone chargers in the nurses' office.
- All patients had access to outside space. At the Maudsley Hospital patients could access the ward garden spaces. However, because these were located away from the ward, staff had to accompany patients to these spaces. Wards also had to share garden spaces, which meant patients could not always access the gardens. At Lambeth Hospital and the Bethlem Royal Hospital patients could access outside space, which was suitable for activities including sports and horticulture. At the Ladywell Unit none of the wards had direct access to outside areas as they were not on the ground floor. Entry to the garden was via a swipe card and therefore controlled by staff. The trust had developed the garden on ES2 as a therapeutic space. This involved planting edible plants for use in activities and landscaping it to be more inviting for patients.
- Most patients were positive about the meal choices available to them and felt that the options were balanced and portions were big enough. Patients had a choice of food from a menu they selected the day before. The trust provided meals that met patients' dietary and cultural needs.

Are services responsive to people's needs?

Good

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

- The patient-led assessments of clinical environments (PLACE) assessments scores for food and hydration in 2016 varied between 87% and 91% at the four hospital sites. This was about or slightly lower than the England average of 90%.
- Snacks and drinks were available to all patients. On some wards patients had to ask staff to access snacks and hot drinks sometimes, but these were available at all times including during the night. On Croydon Triage patients could make hot and cold drinks when they wished to. On Gresham 1 and 2 domestic staff brought out a trolley for drinks four times a day. Staff said that when patients wanted a drink they could ask staff and they would assist. However, some patients we spoke with either did not know this or said that at night from midnight to 6am staff would not assist them with drinks. Patients fed back that they would like to be able to make a drink when they wanted to.
- At the Maudsley Hospital wards patients could lock their bedrooms. Patients did not have keys to their bedrooms and had to ask staff members if they wanted their door to be locked or re-opened. They could store their possessions in a secure box in a locked room, but did not have access to lockable space in their own rooms. Similarly at Lambeth Hospital patients did not have keys to lock their bedrooms themselves. They could access lockers situated in cupboards off the main corridors, but had to ask staff to open them. The trust had received complaints on ES2 and Ruskin wards regarding patients losing personal property and at Lambeth Hospital possessions had gone missing from patients' bedrooms.
- At the inspection in September 2015, we found that patients did not always have access to therapeutic activities and the gym. We recommended that the trust make improvements in this area. During the current inspection we found that the wards provided a range of activities to patients. These included yoga, mindfulness, reflexology, sports challenges, music therapy and art therapy groups. Each ward held daily planning meetings to discuss the ward activities and plans for the day ahead. Hairdressers visited the wards. Patients could access the onsite gyms at certain times. Activities were usually led by the occupational therapists or activity co-ordinators during the week. Nurses and health care support workers led activities during evenings and weekends, but these did not always take place due to the ongoing challenges with staffing levels. Some patients told us they did not have enough choice in activities.
- The remit of the Croydon Triage ward had changed recently and they had become a general acute ward rather than triage. As a result patients' length of stay on the ward had increased. Staff felt that the ward would have benefitted from more space for recreational activities and access to the internet now that patients' needs had changed.
- Lewisham Triage, Clare and Powell wards were not a pleasant temperature. Clare ward was hot and on the day of the inspection the recorded temperature on the ward was 29ºC. Ward staff recorded the high temperature as an incident on the trust incident reporting system. Although the ward had air conditioning, it was not effective. Some of the air conditioning units on Clare and Wharton ward were broken. On Lewisham Triage and Powell wards, there were areas of the ward where it was very hot and other areas where it was cold, both patients and staff highlighted this as an issue during the inspection. This made the wards uncomfortable for patients and staff.

Meeting the needs of all people who use the service

- The trust could support patients with disabilities. For example, Ruskin ward had one wheelchair accessible room. All of the wards at Lambeth were accessible and a toilet and bathroom facilities were available on site for any patient who required easy access. There were two bedrooms on Croydon Triage that had been adapted so that they were accessible to patients with physical disabilities. Gresham 1 was in the process of adapting a room for patients with physical disabilities.
- Information leaflets about treatments, local services, patients' rights and how to complain were available in each ward. Staff provided patients with a welcome pack containing information on the ward when they arrived. The trust had translated some leaflets into other languages commonly spoken by patients. For example, on Croydon Triage we saw information on display in Spanish and Portuguese, languages that were widely spoken locally. At the Ladywell Unit information on the Mental Health Act was available in community languages.

Are services responsive to people's needs?

Good

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

- Staff could access interpreting services should they need support communicating with a patient or their family. Interpreters were provided to support patients during ward rounds and other meetings where the patient care and treatment was being discussed. Interpreters were readily accessible, and could be called at short notice. If there were delays with this, a telephone interpreter was used.
- Patients had access to meals that met different cultural, religious and dietary needs. A recent celebration of black history month had taken place at Nelson ward, which included cooking meals from various global cuisines.
- The chaplaincy service visited the wards regularly. The chaplains contacted representatives of different faiths to meet patients' individual faith needs. The trust was in the process of reorganising and reducing this service. Staff told us they were concerned this would impact on the support patients received. Multi-faith rooms were available for patients to use. In Lambeth, a local community group who supported Muslim women was in touch with ward staff. Staff told us they had accompanied patients to a local mosque. Religious texts were available.
- Staff were confident they knew how to consider the needs of transgender patients. Patients who were transgender were accommodated on wards according to their gender presentation.

Listening to and learning from concerns and complaints

- The trust had received 63 complaints about the acute wards between July to December 2016. Bridge House and Ruskin on AL2 had received eight complaints, which were the highest recorded for a single ward. Gresham 1 had received six and AL3 was the only ward not to receive any complaints. The most common issues patients complained about were care and treatment, 19 complaints; and attitude and behaviour, 18 complaints. Others included concerns about detention under the Mental Health Act, admission and transfer arrangements, discharge and patients' property.
- The wards displayed information on the complaints process next to the ward entrances. They also provided information to patients as part of the welcome pack for new patients. Patients told us that they could feed back about the service at community meetings. Patients we spoke with said they knew how to complain and felt able to.
- Staff all spoke confidently about how they would manage complaints. They would try to address any concerns immediately and would actively support patients to access the formal complaints procedure if required. Staff could describe the complaints policy and how they dealt with concerns and complaints at a local level. Staff tried to address patients' concerns as they arose, informally.
- On Powell ward the ward manager held "drop in surgeries" for patients during which patients were able to meet with the managers and raise any complaints and concerns they had. All these complaints were recorded and followed up. On AL3 ward the ward manager held a compliments and complaints surgery.
- Staff responded to complaints and looked to identify learning from them. Staff discussion of and learning from complaints and feedback varied across the wards. On some wards such Nelson, Leo and Lambeth Triage, discussions about complaints formed part of the team business meeting agenda and were discussed weekly. On other wards complaints were not regularly discussed. The trust had just introduced a standard agenda for ward team business meetings including learning from complaints, but this was only just starting to be introduced. The trust had not yet fully embedded a system to ensure learning from complaints was shared with staff, and between wards, on a regular basis.

Psychiatric intensive care units

Access and discharge

- The PICUs had an average bed occupancy, in the six months before the inspection, of between 94% and 98%.
- The average length of stay for patients discharged from the wards in the 12 months before the inspection was 72 days on Croydon PICU, 48 days at Eden Ward, 185 days at ES1 and 60 days on Johnson Ward. Guidance from the national association of psychiatric intensive care and low secure units states length of stay should be kept to a minimum where possible, through effective

Are services responsive to people's needs?

Good

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

links with referring services, and would not normally exceed 6-8 weeks. This is around 56 days. The average length of stay for patients on ES1 exceeded this by 18 weeks.

- Patients were not moved between wards during their admission.
- The trust reported that transfers or discharges were rarely delayed from the wards. In the six months leading up to the inspection the trust reported one delayed discharge on Johnson Ward. During the inspection we saw that one patient on Johnson ward was experiencing a delay in their transfer for non-clinical reasons. Staff recorded their actions to find the most appropriate placement for this patient.

The facilities promote recovery, comfort, dignity and confidentiality

- Wards had a range of rooms available for patients, including lounges, dining rooms, individual bedrooms and activity rooms. Each ward had an extra care area with a bedroom, bathroom and living space. This was used for patients who would benefit from a space away from the main ward, but did not require seclusion. Croydon PICU was recently redesigned and also had a quiet room, an OT kitchen and office space off the ward. The OT Kitchen was accessible to patients with a member of staff and we saw cupboards were appropriately locked during the inspection.
- On two wards there were two bathrooms designated for ten patients. There were an additional two bathrooms available in the extra care areas and seclusion rooms. However, when these spaces were in use, the bathrooms were not accessible to other patients.
- The clinic rooms on Croydon PICU and Johnson did not have space for an examination couch. This meant examinations and tests where the patient was required to lie down had to take place in patient bedrooms, which was not ideal. On Johnson, work to make the clinic room larger to accommodate a bed was underway.
- Eden and Croydon PICU had a system in place so that patients could have telephone calls in private, providing them with the appropriate level of privacy and confidentiality. Cordless phones were available and staff said the personal alarms could also function as telephones and were used if necessary. On ES1 and Johnson patients were only aware of being able to use the payphone in the communal corridor outside the nursing office. One patient on Johnson said they felt uncomfortable that their phone calls could be overheard.
- All wards had a garden that patients could access throughout the day on request.
- Patients gave positive feedback about the food on the wards. Two patients on Johnson said although the food tasted good, there could be more variety in the food offered. Once a week patients were able to get takeaway food.
- Patients could request drinks and snacks throughout the day.
- Wards were clinical in their appearance and did not have a lot of decoration in communal spaces or bedrooms.
- Patients were able to store personal belongings in their bedroom or in secure storage spaces that staff accessed for them on request.
- Each ward had input from a full time occupational therapist (OT) who delivered a timetable of activities. Timetables were on display in the communal areas and included daily physical activity, art and music activities. On Croydon PICU, the OT developed an activities folder for activities over the weekend that support staff could lead. Patients were aware of the activities on offer and said they had a choice about whether to take part. On Johnson patients said the activities room was really good and there were always staff in there supporting patients to get involved in the activities such as music, video games and arts. Activity rooms were well equipped and used throughout the day by patients and staff.
- The trust took part in patient-led assessments of the care environment (PLACE) for all wards apart from Croydon PICU, which was newly opened. PLACE survey data showed scores of 93% - 100% for condition, appearance and maintenance.

Meeting the needs of all people who use the service

- Wards were able to make adjustments and accommodate people requiring disabled access. PLACE

Are services responsive to people's needs?

Good

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

survey data showed scores for aspects of the environment related to accessibility for those with a disability were 67% on ES1 and 100% on Johnson and Eden.

- There was information about the service available for patients to see on the wards. This included information about patient's rights, access to advocates, how to complain and ward activities. On Croydon PICU staff had leaflets about gender, sexuality and sexual health available to patients as well.
- Information leaflets were available on the ward in English and staff could request these in a number of different languages if needed. We saw two patients with information leaflets in another language. However, these patients told us they would like to have the information explained verbally as well. Information leaflets in communal areas highlighted the different formats patients could request information in.
- Staff could access interpreters for patients who required them. Staff requested interpreters for patients during weekly ward rounds. Johnson staff said a member of the domestic staff helped to translate for one patient, which was not appropriate.
- The service was able to provide food meeting the requirements of religious and ethnic groups and patients were aware of what was available to them.
- Patients were able to access spiritual support. However, feedback from patients indicated staff did not always ask them about this or share information on how to do this. Three patients on Johnson ward and two on Eden ward said they did not know whether a multi faith room was available as staff had not discussed this with them. One patient on Johnson ward wanted to attend church but did not know how to do this. One patient on Croydon ward said he would like to practice his religion, but did not feel there was an appropriate place to do this on the ward.

Listening to and learning from concerns and complaints

- Most patients were aware of how to make a complaint or where to find information about this. However, some patients said they did not know how to make a complaint, and were not sure that they would not be listened to if they did complain. A patient on Eden ward said they had made a number of complaints and these were all dealt with verbally and informally, although they would have liked a written response.
- The trust collected information about the number of complaints on each ward that were made directly to the ward or through the patient advice and liaison service (PALS). Since April 2016 Croydon PICU had one formal complaint recorded. A further eight people contacted PALS for advice or feedback about the service. On ES1 and Eden there were three formal complaints between August 2016 and January 2017, with an additional 12 people contacting PALS with questions or feedback about ES1. Johnson ward received six complaints between June 2016 and December 2016.
- Staff kept compliments from patients and trainee staff. Johnson received two compliments in the six months before the inspection and Eden received one. This was on display in the nursing office.
- Staff knew how to support patients to make complaints.
- The trust put together reports about complaints for each ward manager that covered the content of the complaint and any outcomes from investigations. This could be shared with the wider team for learning.

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

- The trust had an aim to build relationships using five commitments: to be caring, kind and polite; to be prompt and value your time; to take time and listen to you; to be honest and direct with you; and to do what I say I'm going to do. The trust commitments were on display at each ward. Staff knew the commitments well and displayed an understanding of the trust values. We observed staff working in line with the commitments.
- Most staff said immediate managers and the heads of pathway were visible and staff felt able to approach them. For example, the new Croydon borough pathway lead for the acute clinical academic group visited the wards regularly. However, some staff felt the trust senior leadership team were remote and said they rarely saw members of the executive team or members of the trust board.

Good governance

- During the inspection in September 2015 we found that trust governance processes were not sufficiently robust to identify where improvements needed to be made. At the current inspection we found that although a new governance structure had been put in place it was too early to determine how effective this would be in ensuring quality and safety in the acute care pathway. The trust had made changes to management and governance structures since the inspection of September 2015. In July 2016 the trust introduced the acute care clinical academic group (CAG) to oversee the provision of adult acute care inpatients, psychiatric intensive care units and home treatment teams. The acute care CAG management team were very new in post. They acknowledged that more time was needed to fully embed the changes that had been introduced to ensure the effective flow of information throughout the system and improve performance oversight. Most staff told us they felt the development of the new acute CAG was a positive move and led to a more cohesive pathway.
- There were a range of meetings that provided oversight of the acute wards. There were monthly acute CAG advisory group meetings, which included representation from service user consultants, carer consultants and service directors. This group met to discuss developments in the service. For example in January 2017, the group discussed the future of the triage wards and incidents on the wards. The acute care CAG clinical governance executive also met monthly. Fortnightly serious incidents panels were convened and were attended by consultants from the various wards. This group reviewed the incidents that had taken place.
- Senior managers used a quality, effectiveness, and safety trigger tool (QUESTT) to monitor ward performance and identify wards that needed additional support. The QUESTT results were reported at trust board meetings. Bridge House was rated red on the QUESTT monitoring results provided to the board at their meeting in January 2017. At the beginning of the inspection week the trust introduced a freeze on admissions to the ward because of concerns about staffing levels. The trust was planning to close the ward, moving some of the beds to a new ward at the Bethlem Royal Hospital.
- Ward managers had access to a range of information regarding the ward, but it did not always provide them with a clear overview of quality and safety. The trust had improved some information recently. For example, a new system for recording training had been introduced. However, this was not yet fully embedded. Ward managers told us that the data collected was usually incorrect. Managers did not have a full suite of information to provide a clear overview of quality on the wards. At Lambeth Hospital ward managers struggled to find information about the numbers of physical interventions such as restraint that had taken place. They also did not have easy access to data regarding safeguarding alerts and themes arising from these.
- The trust was developing a dashboard of key performance indicators for managers to help ensure they had easy and clear access to key data related to the performance of their ward. The dashboard would also allow a manager to benchmark their performance against other wards.
- Incidents, complaints and safeguarding were discussed at a trust and CAG level. However, comprehensive discussions of these did not routinely take place on all wards. On some wards this was covered as part of the

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.

ward business meeting, but on others it had not been discussed and opportunities to discuss trends, learn lessons and change practice may have been missed. The wards planned to start local clinical governance meetings. Once these started, they would provide a single forum for discussing quality on the wards. Standard agendas for team and business meetings were being introduced but were not yet implemented across the teams.

- 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. Lewisham Triage ward had clear action plans to address the areas of improvement identified as a result of these audits. On other wards the action plans were less clear. For example, on Wharton ward the audits of physical health checks on patients had identified that improvements were required. However, there were no clear action plans available showing how improvements would be made.
- The trust did not have effective systems in place to ensure all staff received regular formal one-to-one supervision. Few wards offered formal reflective practice meetings. Staff supervision rates were very low on a number of wards.
- The trust maintained a risk register at CAG level. Managers were able to raise concerns, which were escalated to the risk register. However, ward staff were not aware of the CAG risk register and how areas of risk were being addressed.

Leadership, morale and staff engagement

- Rates of staff sickness absence varied between wards but were generally low. All wards had a sickness rate below 9% except Wharton ward, 17%; Jim Birley Unit, 14%; and Clare ward, 10%. These three wards were all at the Ladywell Unit where general environmental conditions were poorer and some wards had high nurse vacancy rates. Five wards had sickness absence rates of less than 3.5%. Powell ward had the lowest rate of sickness at 2% and had the highest staff vacancy rate.
- Most ward managers were highly visible on the wards and staff said that they felt supported by them. Most staff told us they enjoyed their work and many were proud to work for the trust. Staff morale was good for most, although some staff told us that morale had been low. For example, five out of six members of staff we spoke with on Ruskin on AL2 told us morale amongst staff on the ward had been poor, due to the pressures resulting from the staffing vacancies. However, they felt things had improved with recent recruitment. Staff morale at Bridge House was also low. This ward was moving towards closure and staff felt they would have liked to be more engaged in the decision making about the ward closure. Staff also commented that it had taken too long from the point at which they were told the ward was closing to being offered alternative redeployment roles. A few very experienced staff had accepted jobs outside the trust in the meantime in order to guarantee job security. At the Bethlem Royal Hospital staff morale was generally good. Staff felt a strong connection to the team they worked with and felt well supported.
- The trust provided a number of leadership development programmes for staff including learning to manage, learning to lead and reach to inspire for different levels of manager development.
- Staff felt able to raise concerns about patient care and safety and were confident they would be listened to by senior staff and managers. Staff knew the trust had a whistleblowing procedure and what this meant. The trust freedom to speak up guardian gave a presentation to the trust board about their role and what this would mean for staff and the trust at a board meeting on 24 January 2017. Staff had opportunities to meet the chief executive and give feedback about services and other engagement opportunities. However, staff reported they were often unable to leave the ward to attend due to staffing pressures.

Commitment to quality improvement and innovation

- The trust had recently introduced a quality improvement programme. Some staff had already received training in quality improvement methods to support the development of quality improvement initiatives at ward and team level. The training was being rolled out across the trust. The trust committed further investment to the quality improvement programme at their board meeting in January 2017.
- The trust provided an innovation budget to support quality improvements. Staff on ES2 had piloted a new electronic observations system for physical

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.

observations. This system automatically prompted staff on the frequency of required observations and when an observation should prompt a response or escalation. They hoped to develop the system to cover all ward observations.

- The trust had developed the garden for ES2 as a therapeutic space. This involved developing planning and seating areas. Staff had designed the garden so that all plants were edible and could be used in patient cooking activities.
- Medical staff undertook research projects regularly. Medical staff we spoke with felt the trust supported them in undertaking this work.
- A 'four steps to safety' quality improvement programme had been implemented on all the Lambeth Hospital acute wards except for Bridge House. This aimed to reduce incidents of violence and aggression through better management of challenging behaviour. Staff told us that use of restraint had reduced as a result of fewer incidents of violence and aggression. On Nelson ward a project to improve communication had also led to a reduction in incidents of restraint.
- Ruskin on AL2, AL3 and Jim Birley Unit had achieved accreditation with the Royal College of Psychiatrists' 'Accreditation for Inpatient Mental Health Services' programme.

Psychiatric intensive care units

Vision and values

- Information about the trust's five commitments were on display on the wards.
- Staff on Croydon PICU felt engaged with the most senior managers of the trust who had visited the ward, but this was not the case on all wards.

Good governance

- To embed a more effective governance system the trust had changed the senior management structure a few months before the inspection. The trust planned to create better systems and information available to ward managers in relation to key performance indicators. For example, at the time of inspection ward managers could not easily access information about restraint and seclusion rates without requesting reports centrally. The training record system was being updated at the time of inspection and not all staff were on the system yet.
- The trust did not always gather information robustly. This resulted in some inconsistencies in information reported centrally from the trust and on the ward during the inspection. For example, average supervision rates reported by the trust were different to those on the units and the trust recorded that ES1 received two complaints since August 2016, whereas information provided on the day of inspection stated this was three.
- The trust did not have effective systems in place to share information consistently across wards. For example, wards appeared to have different information available about what constituted a ligature risk. The trust had introduced methods to increase consistent actions on wards, such as set meeting agendas, and had plans to introduce clinical governance meetings.
- Staff carried out audits but did not always develop actions plans to address issues raised. We saw that repeated audits identified the same issues occurring over time.
- Managers at ward level ensured staff were supported through regular debriefs, supervision and appraisals.
- A risk register was held at the clinical academic group level. Ward managers could escalate concerns to senior managers within the trust.

Leadership, morale and staff engagement

- Sickness rates were between 1.3% on Croydon PICU and 22% on Johnson.
- Staff did not report any instances of bullying within their teams.
- Staff said they felt able to raise concerns or make suggestions within their team about improvements.
- Staff said they enjoyed their jobs but recognised that at times it could be a stressful environment to work in. Two staff said the trust was supportive in allowing flexibility due to childcare commitments.
- Staff said they were supported well by their colleagues and direct line managers, but said that they felt less supported by more senior managers within the trust.

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.

Staff on Eden said the new ward manager was a very good role model. Staff on Croydon PICU said the manager was very supportive and approachable. Medical staff at Croydon PICU and ES1 said they felt very well supported by the management team. Health care assistants and nursing staff said multidisciplinary staff were approachable and open to feedback and discussion. Staff on Croydon PICU said there was very good communication between team members. Staff who were in training felt managers gave them very good support.

- Some staff said that although the trust had been supportive in leadership development, more training and encouragement could be offered.

Commitment to quality improvement and innovation

- All the PICUs were registered with the national association of psychiatric intensive care units and low secure units (NAPICU).
- Wards were involved in research carried out by the trust and piloted behavioural and medical interventions. For example, the wards had piloted and embedded the four steps to safety programme. ES1 was piloting the use of one medicine administered through inhalation rather than by injection. Johnson was piloting the use of electronic recording of physical observations. Staff on the unit gave very positive feedback about this.

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 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 service users.** **Staff on the psychiatric intensive care units did not always identify possible ligature anchor points and therefore could not put plans in place to manage the risks safely and effectively.** **There had been more than 360 incidents of the restraint of service users in the prone position in the last seven months. This put service users at increased risk of avoidable harm.** **Information about fire safety and evacuation procedures was not up to date on all wards.** **This was a breach of Regulation 12(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes established to investigate allegations of abuse were not always effective.** **Staff on some wards did not recognise safeguarding incidents and therefore follow trust safeguarding procedures.** **This was a breach of Regulation 13(3)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Systems or processes in place to ensure the acute wards and psychiatric intensive care units were compliant with the regulations were not effective. This was a breach of Regulation 17(1)(2)(a)(b)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 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 were deployed. Some acute wards had significant staff shortages, which had an impact on the care and quality of experience of service users. Not all staff received regular managerial and clinical supervision. This was a breach of Regulation 18 (1)