South West London and St George's Mental Health NHS Trust

Quality Report

Trust Headquaters
Building 15, 2nd floor
Springfield University Hospital
61 Glenburne Road
London SW17 7DJ
Tel: 0203 513 5000
Website: www.swlstg-tr.nhs.uk

Date of inspection visit: 14 -18 March 2016
Date of publication: 16/06/2016

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Queen Mary's Hospital Springfield University Hospital Tolworth Hospital	RQY07 RQY01 RQY08
Forensic inpatient wards	Springfield University Hospital	RQY01
Child and adolescent mental health wards	Springfield University Hospital	RQY01
Wards for older people with mental health problems	Springfield University Hospital Tolworth Hospital	RQY01 RQY08
Rehabilitation mental health wards for working age adults	Springfield University Hospital Thrale Road Westmoor House	RQY01 RQY13 RQY14
Mental health crisis services and health-based places of safety	Trust HQ	RQYXX
Community based mental health services for adults of working age	Trust HQ	RQYXX
Community based mental health services for older people	Trust HQ	RQYXX

Summary of findings

Specialist community mental health services for children and young people	Trust HQ	RQYXX
Community mental health services for people with a learning disability or autism	Trust HQ	RQYXX

This report describes our judgement of the quality of care at this provider. It 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.

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 services at this Provider	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Good** 

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 have given an overall rating of **requires improvement** to South West London and St George's Mental Health NHS Trust.

We have rated three of the ten services that we inspected as requires improvement and seven as good. The services that require improvement are the community based mental health services for adults of working age and for older people and the rehabilitation mental health wards for working age adults.

The main areas for improvement were as follows:

- The trust had not ensured that the wards providing rehabilitation were supporting patients to achieve greater independence. The exception to this was Burntwood Villa where there was a well developed model of rehabilitation.
- In the forensic service and the child and adolescent mental health ward the trust was not recognising when they were secluding patients. This meant that the appropriate safeguards in terms of regular observations and medical review were not in place to keep people safe.
- Across a number of wards and teams staff were not being supported with regular one to one supervision. This often reflected the workload of the team and because some managers in the community were responsible for supervising too many staff.
- The trust had restructured the administrative support to teams in Kingston into a central hub. The implementation of this change was having ongoing negative consequences with patients not receiving appointment letters, delays in information reaching GPs and staff in the trust not being able to access patient information they needed for outpatient appointments. Whilst improvements were underway there were still more needed to ensure a safe service.
- The maintaining of up to date risk assessments across a number of teams needed to be improved. They also had to be stored consistently so they can be located when needed. This meant there was a risk of staff not safely supporting patients with their individual risks.
- There were significant challenges in the community services for working age adults, especially the recovery teams where staff morale was lower and staff were worried about meeting the complex needs of the patients on their caseloads.

Despite these areas for improvement there was much for the trust to be proud of as follows:

- The senior executive team were committed to improving services and providing a high standard of care for patients.
- Most staff said how much they enjoyed working for the trust and valued the leadership provided by the senior team. Many specifically mentioned the role played by the chief executive.
- Most staff we met were caring, professional and in manay cases innovative in their work.
- The culture of the trust was largely healthy with patients and staff feeling able to raise issues they felt needed to improve without fear of retribution.
- The trust board provided effective challenge and helped to ensure the trust met its strategic objectives.
- There were robust ward to board governance processes in place that supported managers throughout the trust to identify when improvements needed to take place.
- The trust was working with local communities to overcome the stigma of mental illness and make services more accessible.
- There had been significant improvements in the acute care pathway. Whilst demand was still very high and this presented a daily challenge, patients had an improved level of support to access the services they clinically needed.
- Staff had access to a wide range of opportunities for learning and development, which was helping many people to make progress with their career whilst also improving the care they delivered.

There were many areas of ongoing work within the trust. This included an active staff recruitment campaign. There were also other developments to improve patient and staff engagement. These will need time to progress but the inspection team agreed that the trust had the necessary leadership in place to take this forward.

Summary of findings

We will be working with the trust to agree an action plan to address the issues we found during our inspection.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** for the following reasons:

Forensic inpatient wards

- The time management practices being used on Halswell and Turner wards amounted to seclusion. However staff did not recognise this as being the case. They therefore had not put into place the safeguards for seclusion that are set out in the MHA Code of Practice.
- Patients on Halswell, Ruby and Turner wards reported that fresh air breaks did not take place regularly, and that on occasions leave was cancelled due to insufficient staff on duty. There was no evidence that this was being monitored or recorded by the staff.

Child and adolescent mental health wards

- A low stimulus room was used for seclusion. The policy needed to be clearer, to state that the use of this room did amount to seclusion and the safeguards within the Code of Practice must be applied.

Rehabilitation mental health ward

- Staff completed risk assessments for all patients. However, not all identified risks were addressed in care or management plans.
- Staff at Thrale Road were not carrying out one to one sessions with patients every two weeks as outlined in patient care plans and the reason for this was not recorded.

Summary of findings

Community based mental health services for older people

- Sutton, Merton and Richmond teams did not have adequate medicines management. Medication was not transported securely between the team's base and patients home, and medication stock levels were not being documented.
- Patient's risk assessments were not recorded consistently.

Community based mental health services for adults of working age

- In some teams staff did not update risk assessments to reflect current risks.
- Staff were not transporting medication safely.
- There were a high number of vacancies in most of the teams we visited. Vacant posts had been filled by agency staff or absorbed into team workloads but staff were concerned about meeting the needs of individual patients.
- At Central Wandsworth and West Battersea community team had a small number of patients being held by the team waiting to be allocated to a care co-ordinator.

However, staff knew how to support patients to mitigate the risks associated with ligature points across the trust. Staff knew how to report incidents and these were managed well to ensure they were appropriately investigated and learning took place as needed. The safeguarding procedures were robust and the trust was working with external partners. Restraint was used appropriately and where prone restraint took place the reasons for this were reviewed. On wards for older people the risks of falls and pressure ulcers were being well managed.

Are services effective?

Requires improvement 

We rated effective as **requires improvement** for the following reasons:

Summary of findings

Rehabilitation mental health ward

- Thrale Road, Westmoor House and Phoenix Ward did not clearly demonstrate how the recovery orientated approach to care was being implemented by the staff team. There was very limited evidence that patients were being fully supported to develop a range of independent living skills.
- Not all staff were receiving regular monthly supervision on Phoenix Ward and feedback from staff at Westmoor House meant it was unclear whether this was taking place on a monthly basis.
- Input from occupational therapists varied across the services and this meant some patients would benefit from more input to promote their rehabilitation.

Community based mental health services for adults of working age

- Some staff, especially from the Kingston and Richmond recovery support teams were not being supported with regular individual supervision.
- Electronic patient care records were not always regularly reviewed and updated and easy to locate.
- At Central Wandsworth and West Battersea community team and East Battersea community teams, some recently appointed staff were not having sufficient opportunities for individual support such as shadowing to help them manage complex caseloads.
- Whilst psychological therapies were available within each of the teams we visited, some patients who were ready for this therapy were having to wait for this.
- Staff were not confident in conducting Mental Capacity Act assessments and referred concerns regarding capacity to the medics in the team.

Summary of findings

Wards for older people with mental health problems

- The line manager on Crocus ward did not provide consistent 1:1 supervision to staff that they managed.
- Patients on Crocus ward did not have access to sufficient occupational therapy input.

Mental health crisis services and health based places of safety

- There was no formal individual supervision structure embedded across the services and some staff were not receiving regular individual supervision.
- Physical health checks of patients prior to commencing antipsychotic medications were being completed according to guidance, ensuring safe prescribing. However, supporting patients to have physical health checks was not done routinely for all patients on caseloads.
- The recording of care plans and risk assessments were not consistent and this could make it hard to find the current information.

However, the trust was carrying out a range of audits to monitor and improve standards of care. Staff felt well supported and able to access a range of training to develop their skills. There were many good examples of multi-disciplinary team working and of teams working with external agencies to meet the needs of patients. The Mental Health Act was well managed within the trust.

Are services caring?

Good

We rated caring as **good** for the following reasons:

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers, were usually involved in decisions about their care.

Summary of findings

- Opportunities were available for people to be involved in decisions about their services and improvements were taking place when concerns were raised.
- Work was taking place to improve patient involvement.
- Advocacy services were available and patients were supported to access these services.

However, there are a few wards where staff need to aware of their manner and approach to ensure their communication with patients is appropriate at all times. On Crocus older persons ward an effort must be made to ensure patients clothing does not get mixed up.

Are services responsive to people's needs?

Requires improvement

We rated response as **requires improvement** for the following reasons:

Rehabilitation mental health ward

- Patients, with the exception of Burntwood Villas, did not have access to the support to enable them to access the therapeutic activities to enhance their rehabilitation.
- At Thrale Road and Westmoor House staff were not fully supporting the needs of patients whose first language was not English and who required an interpreter.

Community based mental health services for adults of working age

- The Kingston recovery teams were struggling to reliably send out letters about appointments and reviews following changes in the administrative support to the team.
- At the Central Wandsworth and West Battersea community team more than 15% of patients were not attending their appointments. The team could not demonstrate that active steps were being taken to engage with patients who did not attend.
- For most teams, space was limited and staff had difficulties accessing interview rooms.
- Interview rooms were not soundproofed and discussions could be heard outside doors.

Summary of findings

Community based mental health services for older

people:

- The changes to the administration support for the Kingston team had led to patient's appointments being cancelled and staff unable to locate patient records.

However, there had been significant improvements in the management of access to acute beds across the trust and the acute care co-ordination centre was working well. Discharge co-ordinators on wards were helping to facilitate all the practical arrangements associated with each persons discharge. Most community teams were meeting their targets for assessing and treating people in a timely manner. This was particularly commended in the CAMHS teams where the service had gone through a period of change. Teams offered patients flexible appointments when needed to support their engagement with the service. The trust recognised the needs of people in terms of working towards providing services that met their needs in relation to their protected characteristics. There was some excellent work taking place with local communities to break down the stigma associated with mental illness. The trust was managing complaints in a timely manner and supporting people to raise concerns where needed.

Are services well-led?

Good

We rated well led as **good** for the following reasons:

- Teams across the trust recognised the visions and values and how these were applied in their day to day work.
- The trust had robust governance processes in place from ward to board and the quality of information enabled staff across the trust to know where improvements were needed.
- The trust board provided a high standard of challenge and held the executive team to account.
- The chief executive and senior executive team, despite going through a period of change, displayed a high level of commitment to ensuring high quality services for people using services provided by the trust.
- The trust in the main has a healthy culture and works hard to engage with people who use services and staff.

Summary of findings

However, the rehabilitation services need strong leadership to ensure they deliver their goals and support patients to achieve greater independence. Senior staff need to ensure that they regularly engage with staff working in community teams. Some staff in the adult community needs need support to have the correct management information. A couple of final fit and proper person checks need to be in place. The whistle-blowing process needs to be made more accessible for staff. Whilst plans were progressing across services on the acute care pathway and specialist services for accreditation with the quality improvement peer review schemes operated by the Royal College of Psychiatrists, this had not yet been fully implemented.

Summary of findings

Our inspection team

Our inspection team of **61** people was led by:

Chair: Kevan Taylor Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Jane Ray, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

Other members of the team included:

13 CQC inspectors

4 trainee CQC inspectors

1 assistant inspectors

1 inspection planner

2 analysts

6 Mental Health Act reviewers

11 nurses

2 psychiatrists

5 social workers

5 allied health professionals

2 CQC pharmacists

2 CQC policy team members

2 CQC observers

7 experts by experience (some were on site and other making phone-calls off site)

2 people with governance experience

Why we carried out this inspection

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

How we carried out this inspection

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Sought feedback from patients and carers through attending 4 user and carer groups and meetings.
- Received information from patients, carers and other groups through our website

During the announced inspection visit from the 14 March – 18 March 2016 and the unannounced inspections the following week, the inspection team:

- Visited **44** wards, teams and clinics
- Spoke with **173** patients and **27** relatives and carers who were using the service
- Collected feedback from **102** patients, carers and staff using comment cards
- Joined **12** service user meetings
- Spoke with **39** ward and team managers and **300** staff members
- Attended **18** focus groups attended by **302** staff
- Interviewed **24** senior staff and board members
- Attended and observed **36** hand-over meetings and multi-disciplinary meetings
- Joined care professionals for **13** home visits and clinic appointments
- Looked at **195** treatment records of patients
- Carried out a specific check of the medication management across a sample of wards and teams
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Requested and analysed further information from the trust to clarify what was found during the site visits

Summary of findings

- Observed a board meeting and a quality and safety assurance committee meeting

The team inspecting the mental health services at the trust inspected the following core services:

- Acute wards and the psychiatric intensive care unit
- Forensic inpatient wards including the high secure service
- Wards for older people with mental health problems
- Ward for children and adolescents with mental health problems
- Rehabilitation mental health wards for working age adults
- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people
- Specialist community mental health services for children and young people
- Community mental health services for people with a learning disability

We did not inspect substance misuse services or the specialist inpatient services including the eating disorder, services for deaf children and adults, eating disorder services, services for treatment of obsessive-compulsive and body-dysmorphic disorders.

There were no learning disability specific inpatient services.

Information about the provider

South West London and St George's Mental Health NHS Trust provides services to a population of over 1.1 million people. The trust supports adults, older people and children and young adults across the five London boroughs of Richmond, Wandsworth, Kingston, Merton and Sutton. They also provide a number of specialist services for people who are deaf, services for people who have obsessive compulsive disorders as well as forensic and eating disorder services. People using these services come from across the UK.

The trust employs over 2000 staff who provide inpatient and community care. Last year the trust had over 410,400 patient contacts.

The trust has 408 inpatient beds located on three main sites, Springfield University Hospital, Queen Mary's Roehampton and Tolworth Hospital. It has an annual budget of approximately £160 million.

The trust was organised into three borough based directorates, a CAMHS directorate and one specialist directorate and each had a clinical and service director.

At the time of the inspection the trust was in the application pipeline to be a foundation trust.

The trust was was inspected in March 2014 as a pilot for the Care Quality Commissions new inspection methodology. At this time trusts were not rated. In May 2015 a focused inspection took place across the acute and older person's inpatient services. This identified a number of areas of non-compliance at Springfield and Tolworth Hospital. This was followed up as part of this inspection and all the previous areas of non-compliance had been addressed. Just prior to the comprehensive inspection there was also a separate inspection of the specialist ward for deaf people and previous non-compliance had also been addressed on this ward.

What people who use the provider's services say

Before the inspection took place we met with **nine** different groups of patients, carers and other user representative groups as follows:

- Kingston Carers Group
- North Cheam – No Panic group
- No Panic user group – Sutton
- Merton Focus for 1 User Group
- Sutton 1 in 4 Network
- Sutton & Merton Carers Reference Group
- Sutton and Merton User Reference group
- Wandsworth Voicing Views
- Learning Disability focus group South West London and St George's

Summary of findings

Through these groups we heard from patients and carers. We also received feedback from two independent mental health advocacy services and three Healthwatch groups which provided us with general feedback and details of their enter and view visits.

During the inspection the teams spoke to 200 people using services or their relatives and carers, either in person or by phone. We received 102 completed comment cards of which most were positive.

We also had received 60 individual comments from people through our website or by phone in the six months leading up to the inspection. Of these 30 were specific complaints about the use of the Mental Health Act.

Much of the feedback we received was very positive as follows:

- Kind staff, who are skilled, well managed and trained
- Positive opportunities for service users to participate in trust events, attend meetings and support improvement
- Good at providing support on wider issues – housing, finance, healthy living
- Recovery college is fantastic
- Improvements with food
- Inclusive community meetings on wards
- Medication – good explanation given

Some of the challenges we heard about were:

- High staff turnover
- Not enough staff at night and weekends – patients feel unsafe
- Not enough support for carers
- Care co-ordinators large caseloads – not picking up when patients are deteriorating
- Care plans not patient focused
- Poor discharge planning from inpatient services
- Physical health not adequately checked
- Need better communication between the trust and the GPs
- Complaints process – mixed feedback
- Mixed feedback about the crisis line – manner of staff could be improved, hard to get through
- Bed pressures – sent out of area
- Home visits very short
- Not enough access to therapy on acute wards
- Poor attitude especially of health care assistants – ward 2 and 3 and very mixed in some forensic wards
- Access to cigarettes especially just after admission
- Leave denied – acute wards Springfield
- Supporting patients to access advocacy – variable between wards
- Hard to get referred to the specialist learning disability teams
- Rehabilitation services – are they really supporting patients to be more independent

Good practice

Trust wide

- The virtual risk team provided support for teams across the trust where they were supporting patients with complex needs.
- The recovery college provided a wide range of courses valued by patients, carers and staff from inpatient and community services.
- The pharmacy provided support to patients to help them understand their medication and to answer any questions.
- The patient experience team spent time on wards giving people an opportunity to raise any concerns about the services.
- The Evolve BME staff network was helping to promote the race equality strategy in the organisation.

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

- The trust had an acute care co-ordination centre that operated 24 hours a day. This was very effective at ensuring beds were identified in a timely manner for patients who needed to be admitted.
- Wards had allocated discharge coordinators to facilitate communication between the staff team and local services. This meant that patient discharges from the wards usually took place in a timely way.
- Pharmacists met with patients to talk with them about their medicines and answer any concerns they had.

Summary of findings

- On Lavender ward there was a worker funded by partner organisations who supported patients' families and carers.
- Staff from the patient experience team, visited the wards on a weekly basis to support people who wanted to raise concerns or make a formal complaint.

Community mental health services for people with a learning disability or autism

- All people who used the service had accessible health passports which ensured that key needs and preferences where highlighted and shared with relevant healthcare professionals to benefit people who used the service.

Forensic inpatient wards

- The service had recently signed up to the restraint reduction network which worked at reducing the use of restraint through policy and practice.
- The service had a virtual court, where patients used video link and conferencing facilities for court and meetings. This meant that patients did not need to attend court. Resources and staff time required to support a patient to attend court were saved.
- The service had developed a physical health forum where patients participated in discussions and planned events to deliver physical health awareness.

Child and adolescent mental health wards

- There were facilities for parents to stay on site and young people could be given leave to stay with them at this accommodation.
- Specialist training was being provided to all staff in dialectical behavioural therapy.

Rehabilitation mental health wards

- Burntwood Villas provided a comprehensive timetable of rehabilitation focussed activities and several patients were using independent living skills, such as self-medication and self-catering. Several patients were involved in community activities, such as part time work and attending college. One patient had provided training to staff around self-harm and led a weekly activity for other patients.

Community based mental health services for older people

- There were systems for continuous improvement in the Kingston services. The psychiatrist had developed a tool for assessing patients with memory difficulties and this was implemented within the team. The admiral nurse, who is specially trained to work with carers, also developed a family assessment tool called the 'culturogram' which was being used by the team.
- The behaviour and communication service at the Wandsworth team had won three awards in service improvement, dementia care and mental health.
- The Wandsworth team produced their own staff bulletin which was circulated to the team via email. It shared good practice, commended individual staff and communicated updates within the team.

Specialist community mental health services for children and young people

- The 'what if' plan had been co-produced by head teachers, school counsellors, a health commissioner and members of the Sutton child and adolescent mental health service (CAMHS) along with young people from a Sutton secondary school. Young people who were accessing Tier 3 CAMHS could use this as part of the crisis planning process. Young people included information on the plan that was personal to them. These included top tips on how to keep well and the people they would want to be contacted should they become unwell.

Wards for older people with mental health problems

- On Jasmines ward the medical team had developed a one page discharge letter for patients and carers providing information on medication, ongoing treatment, names and contact details for ongoing support and what to do in a crisis.
- On Jasmines ward the occupational therapy team had developed a 'this is me' booklet that they prepared with patients and would go with them when they left the ward. The booklet contained information about the persons life and areas of interest and included photos.

Summary of findings

Mental health crisis services and health based places of safety

- Richmond home treatment team had set up a teaching session involving simulated learning using facilities at Springfield Hospital. The training session enabled staff from all disciplines and grades to take part in sessions working with scenarios, which represented common situations. It was an opportunity for staff to learn together and develop skills and competencies in assessment. The team planned to make this a regular event and repeat this again in the future.
- The home treatment team managers were engaged in a quality improvement process to review referral pathways into the service, aiming to improve response times and the experience of people using the service.
- In the Richmond and Wandsworth home treatment teams, an evaluation and audits of the effectiveness of the service and experience of patients were taking place.
- Merton home treatment team had achieved accreditation under the Home Treatment Accreditation Scheme (HTAS) run by the Royal College of Psychiatrists. They were the first team in the trust to achieve accreditation.

Areas for improvement

Action the provider MUST take to improve

Forensic inpatient wards

- The trust must ensure that the use of 'time out' and 'time management' plans are not used as defacto seclusion practices. Patients who are secluded must have all the safeguards in place as stated in the Mental Health Act code of practice.

Child and adolescent mental health wards

- The trust must ensure that the use of seclusion is correctly recognised and the necessary safeguards put into place.

Rehabilitation mental health wards

- The trust must ensure where a risk is identified in a risk assessment, there is a plan in place to address this.
- The trust must ensure all staff receive regular individual supervision.
- The trust must ensure that managers develop the leadership skills to implement a recovery orientated approach to care on all rehabilitation wards.
- The trust must ensure that patients are supported to access a programme of therapeutic activities to promote their rehabilitation.

Community based mental health services for older people

- The trust must ensure good medicines management practice, ensuring the safe transportation of medication between the team bases and patients homes and keeping a record of medicine stock levels.
- The trust must ensure the Kingston team have effective administration support. This is to ensure all letters are sent to patients and GPs in a timely manner, and information needed to deliver care is stored securely and available to staff when they need it.

Community based mental health services for adults of working age

- The trust must ensure that individual patient risk assessments are updated to reflect current risks.
- The trust must ensure that staff ensure there are safe systems for administration, storage and transportation of medication.
- The trust must ensure that staff especially from the Kingston and Richmond recovery teams are supported with access to regular individual supervision.
- The trust must ensure that effective administrative processes are in place so patients receive appointment details and information about their reviews in a timely manner.

Summary of findings

- The trust must ensure managers have the correct performance information that relates to their team and that this information is used to make improvements where needed.

Wards for older people with mental health problems

- The trust must ensure that staff on Crocus ward have access to consistent 1:1 supervision.

Mental health crisis services and health based places of safety

- The trust must ensure that an individual 1:1 supervision structure is embedded in the home treatment teams and that staff have access to regular individual supervision.

Action the provider SHOULD take to improve

Trust wide

- The trust should continue to progress its programme of staff recruitment.
- The trust should consider if the organisation of clinical and management audits would benefit from having staff to organise this work.
- The trust should continue to work with the local authorities to mitigate the impact on patients from the ending of the section 75 agreements.
- The trust should complete the last couple of fit and proper person checks.
- The trust should review the whistle blowing process to make it more accessible to staff and introduce a speak up champion.

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

- The trust should ensure that staff complete their progress towards meeting the trust mandatory training target.
- The trust should ensure that staff store and administer medications, including controlled drugs, in accordance with best practice and trust policy.
- The trust should ensure that, wherever possible, care plans reflect the preferences of each patient.
- The trust should ensure that staff discharge their duty to inform detained patients of legal rights as required by the Mental Health Act and Codes of Practice.
- The trust should ensure there is sufficient access to psychological therapies for patients in line with national guidance.
- The trust should ensure that staff, especially on Jupiter ward appropriately care for patients including undertaking regular interaction with them on the wards.
- The trust should ensure that ward facilities support patients' dignity, especially the toilet doors on Jupiter ward and the viewing panels in bedroom doors on Lavender ward.
- The trust should ensure sufficient activities are provided at the weekend.

Community mental health services for people with a learning disability or autism

- The trust should ensure that a permanent manager is recruited to each of the teams which ensures that local leadership is robust and supportive.
- The trust should ensure that succession planning is more formally embedded within the service. This is to ensure that there is scope for staff to develop within the service if they choose to.

Forensic inpatient wards

- The trust should ensure ligature risk assessments are regularly reviewed.
- The trust should ensure that fresh air breaks and leave are facilitated.
- The trust should monitor and record all cancelled leave.
- The trust should continue to ensure that poor staff attitude is addressed and that patients are treated with respect at all times.
- The trust should review the use of the ward telephone on Halswell ward to ensure the privacy of patients.

Child and adolescent mental health wards

- The trust should ensure that staff training is correctly recorded so training can be arranged as needed.

Summary of findings

- The trust should ensure that the use of the new care planning format is embedded.
- The trust should ensure that that staff supervision records and any other records about people employed to carry out regulated activity are stored appropriately.

Rehabilitation mental health wards

- The trust should ensure at Thrale Road that all patients receive their 1:1 sessions with staff in line with the trust policy available.
- The trust should ensure that equipment such as blood sugar monitors are calibrated and safe to use.
- The trust should ensure that at Thrale Road patients can access a bath or a shower within the same area as their bedroom.
- The trust should ensure that at Thrale Road an accurate record is kept of the medication fridge temperature and that if the temperature is too high that appropriate action is taken.
- The trust should ensure that the remaining nine staff on Phoenix ward complete their moving and handling training with the use of a hoist so they can safely support the patients with mobility issues on the ward. It was noted that there were plans progressing to support these patients to move to more appropriate environment.
- The trust should ensure that the teams on Thrale and Phoenix wards have the opportunity to discuss and learn from incidents across the trust and not just from their own service.
- The trust should ensure that care plans are reviewed especially when there is a change in the individuals needs and that updated care plans are implemented.
- The trust should ensure patients across the wards have access to sufficient occupational therapy input to support their rehabilitation.
- The trust should ensure all the staff on Phoenix Ward treat the patients with respect.
- The trust should ensure that records are always kept of the community meetings at Westmoor House so that agreed actions can be followed through.
- The trust should ensure patients have access to a phone they can use in private to make personal calls.
- The trust should ensure that if bedrooms are available on Phoenix ward for patients with mobility issues that other parts of the ward such as the kitchen and bathrooms are also accessible.
- The trust should ensure that all patients who require an interpreter are able to access one, in line with their care plan.

Community based mental health services for older people

- The trust should ensure the staff improve the consistency of the written individual patient risk assessments.
- The trust should ensure learning from incidents happens across all the teams and other parts of the trust.
- The trust shouldensure in Merton, Kingston and Wandsworth teams, that all patients are receiving regular physical health checks
- The trust should continue to review staff engagement processes across the teams to ensure staff feel involved in decisions and valued.

Specialist community mental health services for children and young people

- The trust should ensure that the changes in local protocols and policies around managing incidents of violence and aggression and lone working are fully implemented and fit for purpose.
- The teams should ensure that they give young people who are waiting for an assessment clear instructions about what to do if their health deteriorates.
- The trust should ensure that staff have a consistent approach across all teams to assessing, managing and monitoring young people who are identified as low risk.
- The trust should ensure that there is a consistent approach to recording information in the patient's care and treatment records so that information can be located where needed.

Summary of findings

- The teams should complete the outstanding mandatory training.
- The trust should ensure it keeps commissioners updated on the waiting times for psychology input so that this can be addressed.
- The trust should ensure that interview rooms at the Kingston team have adequate sound-proofing to ensure that confidential information cannot be overheard.
- The trust should ensure that the administrative staff receive ongoing support during the period of their roles being reviewed.

Community based mental health services for adults of working age

- The trust should continue to progress the recruitment of staff to fill vacancies.
- The trust should continue to ensure staff in the community mental health teams have completed their mandatory training.
- The trust should review the lone working procedure in Kingston to reflect the changed administrative arrangements.
- The trust should ensure that care plans are updated, reviewed and can be located by staff when needed.
- The trust should ensure that patients referred to the recovery teams are allocated to a care co-ordinator.
- The trust should ensure recently appointed staff are adequately supported to know how to work with patients who have complex needs.
- The trust should monitor waiting times for patients to access psychological therapies and work with commissioners where needed to address shortfalls.
- The trust should support staff to develop their confidence in using the MCA where needed.
- The trust should ensure patients havecopy of their care plan.
- The trust should ensure there are sufficient interview rooms available at team bases and that these are appropriately sound proofed.
- The trust should ensure patients especially from the Central Wandsworth and West Battersea community mental health team are supported to attend their appointments so the numbers of patients who do not attend are reduced.
- The trust should ensure that patients being cared for by the Wandsworth rehabilitation and recovery team are supported using a recovery orientated approach and are achieving outcomes that reflect the aims of the team.
- The trust should ensure that staff feel sufficiently supported by senior staff and that team managers have enough time to carry out their roles.

Wards for older people with mental health problems

- The trust should ensure that whilst disposable parts are replaced, equipment used for physical health observations is appropriately cleaned between use.
- The trust should review staffing levels on Jasmines ward to ensure there are sufficient staff at busy times such as in the morning when patients are getting up.
- The trust should continue to reduce the use of agency staff on Crocus ward to improve the consistency of care.
- The trust should ensure staff on both wards complete the training on moving and handling.
- The trust should ensure the staff improve the consistency of the written individual patient risk assessments.
- The trust should ensure that on Crocus ward internal doors are opened promptly for patients to enable them to access their bedrooms and single sex lounges where they wish to do so.
- The trust should review the occupational therapy input on Crocus ward to ensure the patients receive sufficient access to therapeutic activities.
- The trust should support the staff on Crocus ward to communicate effectively with patients and not just in relation to particular tasks.

Summary of findings

- The trust should ensure that patients on Crocus ward only wear their own clothes and that clothes are returned to the correct patient after being washed in the laundry.
- The trust should ensure that evening admissions to Crocus ward are avoided whenever possible.
- The trust should ensure Crocus ward has a more homely environment .
- The trust should continue to work to improve the staff morale on Crocus ward.
- The trust should ensure staff understand and know how to use the whistle-blowing process.

Mental health crisis services and health based places of safety

- The trust should ensure that the technology and systems used to obtain views of and feedback from people using the services work consistently and staff are able to use the mechanisms to obtain views and feedback.
- The trust should ensure that the home treatment team based in Richmond has sufficient space and access to equipment in the office base to carry out their role.
- The trust should ensure as much as possible,thatpatients who use the service receive support from the same staff in a continuous manner.
- The trust should ensure that records of care plans and risk assessments are stored consistently so they can be located when needed.

South West London and St George's Mental Health NHS Trust

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.
- The trust's systems supported the appropriate implementation of the Mental Health Act and its code of practice. The application of the Act was overseen by the mental health law governance group. This group met regularly to consider changes to policies, to review statistical reports of Mental Health Act activity and to identify and develop Mental Health Act projects such as report writing templates for mental health tribunals. Legal advice was available from the trust's solicitors, from the Mental Health Act manager and from the Mental Health Act office based at each hospital site.
- Training on the Mental Health Act and the Mental Capacity Act was part of the induction process for all staff. The Mental Health Act administrators trained ward staff to be authorised officers for the receipt and scrutiny of detention papers.A programme of training on the code of practice was still being rolled out to all doctors in the trust. We were informed that take up for training sessions in relation to the Mental Health Act was high. The aim was for 90% of the medical staff to have completed this training by April 2016.
- The Mental Health Act office sent out weekly electronic reminders to all teams in relation to detention renewals and consent to treatment provisions.The approved mental health professionals (AMHP) services were not managed by the trust but separately by the five individual local authorities.
- Trends in the use of the Mental Health Act over the past year were monitored by the director of social work and the Mental Health Act manager.These included an increase in the use of section 2 and a general increase in the use of the Mental Health Act resulting from Mental Capacity Act case law.
- During this inspection we completed ten Mental Health Act review visits pursuant to the CQC's duty under section 120 of the Act.
- We found evidence that detention paperwork was completed correctly, was up to date and was stored appropriately. However on one ward where a Mental Health Act review visit was completed, a section 5.2 had been applied before the end of a section 2 and a further section 5.2 had been applied when the first one had been deemed invalid.
- We found evidence that there was adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were attached to medication charts where applicable, although on one ward we visited the certificate of consent to treatment (T2) form on file was from a previous responsible clinician in a previous hospital, and on another ward both a certificate of second opinion (T3) and a T2 form were on the same medication chart leading to possible confusion.
- There was evidence that most people had their rights under the Mental Health Act explained to them.

However on three of the wards we visited it was not clear that all patients had been regularly reminded of their rights and on one of the wards we visited patients were not aware of the availability of the Independent Mental Health Advocacy (IMHA) service.

- We found some concern in relation to the use of seclusion on two forensic wards, a rehabilitation ward and Aquarius ward for young people. In each case seclusion was not being recognised so that the appropriate safeguards such as regular observation could be put into place.
- An internal audit was carried out in September 2015 to review the processes in place at the trust to ensure compliance with the MHA, specifically Section 17 leave arrangements, consent to treatment and patients' rights. This had identified areas where improvements needed to be made and these had mostly been addressed.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on the Mental Capacity Act (MCA) was provided as part of the corporate induction. In addition the trust also provided a mandatory training course on consent to treatment which incorporated the Mental Capacity Act. This had been completed by 91% of the staff. In addition there was also a new e-learning training package. There had also been training delivered directly to teams and over 500 people had completed this training.
- The trust had Mental Capacity Act and Deprivation of Liberty Safeguard policies. These included flowcharts and vignettes to make it more accessible for staff. The trust had produced a consent and capacity electronic assessment and decision template to support staff to follow the correct steps where needed. There was a MCA lead in each directorate. Also the staff working in the MHA offices were being developed to offer support on the MCA.
- At the last inspection in 2015, we found the ability of the staff to apply the principles of the MCA was mixed. On Lilac acute ward the trust was non-compliant. At this inspection staff understanding and use of the MCA was much improved. Most capacity assessments were completed by the medical staff. We heard of examples of where best interest meetings were taking place. The patient records where appropriate, included capacity assessments and records of best interest meetings. These records were comprehensive. The exception to this was in the community recovery teams for adults. Here some staff did not feel confident in using the MCA. For example in the East Wandsworth community team some staff told us they had not completed sections of the initial assessment that addressed capacity due to their lack of confidence in the MCA. Sometimes locating the records was a challenge as they were not stored consistently.
- In the six months prior to the inspection there had been 16 authorized Deprivation of Liberty Safeguards (DoLS) across the trust. At the time of the inspection there were two patients on Crocus ward and two on Jasmines ward subject to an authorized DoLS. These were clearly recorded and the arrangements to minimize the restrictions were monitored.

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

Summary of findings

We rated safe as **requires improvement** for the following reasons:

Forensic inpatient wards

- The time management practices being used on Halswell and Turner wards amounted to seclusion. However staff did not recognise this as being the case. They therefore had not put into place the safeguards for seclusion that are set out in the MHA Code of Practice.
- Patients on Halswell, Ruby and Turner wards reported that fresh air breaks did not take place regularly, and that on occasions leave was cancelled due to insufficient staff on duty. There was no evidence that this was being monitored or recorded by the staff.

Child and adolescent mental health wards

- A low stimulus room was used for seclusion. The policy needed to be clearer, to state that the use of this room did amount to seclusion and the safeguards within the Code of Practice must be applied.

Rehabilitation mental health ward

- Staff completed risk assessments for all patients. However, not all identified risks were addressed in care or management plans.
- Staff at Thrale Road were not carrying out one to one sessions with patients every two weeks as outlined in patient care plans and the reason for this was not recorded.

Community based mental health services for older people

- Sutton, Merton and Richmond teams did not have adequate medicines management. Medication was not transported securely between the team's base and patients home, and medication stock levels were not being documented.
- Patient's risk assessments were not recorded consistently.

Community based mental health services for adults of working age

- In some teams staff did not update risk assessments to reflect current risks.
- Staff were not transporting medication safely.
- There were a high number of vacancies in most of the teams we visited. Vacant posts had been filled by agency staff or absorbed into team workloads but staff were concerned about meeting the needs of individual patients.
- At Central Wandsworth and West Battersea community team had a small number of patients being held by the team waiting to be allocated to a care co-ordinator.

However, staff knew how to support patients to mitigate the risks associated with ligature points across the trust. Staff knew how to report incidents and these were managed well to ensure they were appropriately investigated and learning took place as needed. The safeguarding procedures were robust and the trust was working with external partners. Restraint was used appropriately and where prone restraint took place the reasons for this were reviewed. On wards for older people the risks of falls and pressure ulcers were being well managed.

Requires improvement

Are services safe?

Our findings

Safe and Clean Environments

- The trust provided services from a very variable range of buildings. There were three main inpatient sites providing 408 beds. These were at Springfield University Hospital, Tolworth Hospital and Queen Mary's Hospital Roehampton. In addition there were 18 community sites and services were also provided from many more surgeries and community venues.
- The trust had an estates strategy looking at how best to modernise their entire estate. The estate modernisation programme (EMP) had been approved. Plans to redevelop Springfield and Tolworth were in place. It was hoped that the new facilities could be open by 2019. More immediately a new psychiatric decision unit was being developed at Springfield which would include a third 136 room and works were due to take place.
- Whilst recognising the challenge of providing care within buildings that are in need of modernisation, the inspection team did not have any significant concerns about the impact of the physical environment on the safety of patients being cared for in these wards.
- The trust has undertaken environmental risk assessments of ligature point risks in the mental health inpatient areas over the last year. This had identified wards which had been designated as high priority risk areas. Work was taking place across the wards to reduce fixtures and fittings that presented a ligature risk. Following a previous inspection in 2015 where Lilacs acute ward was found to be in breach of regulations regarding the management of ligature risks, steps had been taken to address this concern. For each ward there was an individual comprehensive document setting out the risks to patients due to the ward environment and how staff should mitigate the risks. Mitigation measures included individual risk management plans for each patient and ensuring that staff were regularly in ward areas where there were risks. In forensic services the inspection found that the ward risk management plans needed to be kept up to date. The trust was aware that the assessment and local management of ligature risk remained an area of ongoing work and this was on their risk register.
- The wards in the trust were either single sex or had arrangements in place for patients of different genders to maintain their privacy and safety by having separate bedroom and bathroom accommodation. At the previous inspection in 2015 the wards for older people were in breach of same sex accommodation. This had now been addressed by closing beds and making changes to the environment. There were still some potential risks, for example on Phoenix ward which was a mixed gender rehabilitation ward, the male and female sleeping areas were separate but the door between the areas was not always locked and so potentially patients could move between the two areas. The trust were aware that whilst the correct environments were now in place to offer same gender accommodation, there was still a potential risk if staff did not understand and apply the arrangements. This was an amber risk on the corporate risk register.
- The inspection highlighted a number of other areas for ongoing improvements in terms of the physical environment. For example the Richmond home treatment team were located in a very small office that made working arrangements very difficult. In a number of the adult community mental health teams the rooms used for interviews between staff and patients were not adequately sound proofed to maintain privacy and confidentiality.
- Equipment being used across the trust for a range of purposes including clinical examinations, emergency resuscitation and for moving and handling were mostly well maintained and regularly checked. At the previous inspection in 2015, there were a few items of equipment on the acute wards such as a nebulizer and machine to check the patients blood pressure that had not had a maintenance check. This had now been addressed. There were a few areas for improvement. For example on the rehabilitation wards it was found that the machines used to check the patients blood sugar readings had not all been calibrated which could mean that for patients with diabetes that the readings might be incorrect. Also on the wards for older people, some of the equipment used for physical health checks appeared in need of cleaning, although these machines did use disposable parts and so the risks to patients were minimal.
- The trust had a robust infection control policy. Staff received support from a a trust wide infection control advisor and each ward had an infection control lead.

There were governance processes in place through a trust wide infection control committee led by the director of nursing. Annual audits were taking place of infection control practices. Infection control training was mandatory for all staff. The inspection found that staff were following infection control procedures. Personal protective equipment such as gloves were available for staff to use where appropriate. The importance of all staff, patients and visitors cleaning their hands were publicized and hand wash and gels were readily available.

- In the 2015 Patient-Led Assessment of the Caring Environment (PLACE), the trust scored 97.4% for cleanliness which was similar to the national average for Mental Health and Learning Disability NHS trust sites. The environments that were inspected were all clean.

Safe Staffing

- At the time of the inspection the trust acknowledged that the recruitment and retention of staff, especially qualified nurses was one of the main challenges. The trust vacancy rate was 19%. The nurse vacancies were higher and had been 26% in December 2015. There was also the need to retain staff, especially in London where there were 10 other local trusts all recruiting from the same pool. From June to November 2015, 41 registered mental health nurses were recruited but 32 left. Staff turnover for all trust staff in December 2015 was 18%.
- In January the night time safe staffing figures were mainly met. Where there were slightly less qualified staff available additional unqualified staff were helping to provide cover. During the day the average registered nurse fill rate was 88%. Wards with the greatest shortfall in qualified staff during the day were three acute wards, Laurel ward at Queen Mary's (68%), Rose ward at Queen Mary's (85%) and Ward 3 at Springfield (84%).
- Overall there was a significant use of temporary staff including agency staff. The trust at the time of the inspection was spending 10% of its annual budget on agency registered nurses and had been issued a target by the trust development authority to reduce this to 6% by quarter 3 and then had a year-on-year target reduction to achieve 5% in 2016/17 and 3% 2017/18. The temporary staffing spend from April to December 2015 had been £10.5m on agency staff and £4.4m on bank staff.
- In addition it was recognised that the staffing levels on some wards needed to increase. The director of nursing had carried out a review of staff establishments and had identified the need to increase the staffing on 3 acute wards, Aquarius (CAMHS) and Avalon (eating disorder).
- The trust had a number of measures in place to promote safe staffing. Two new modern matrons had been recruited; one to oversee recruitment and retention and another to manage the roster and staffing.
- In terms of managing the roster and staffing levels, there were daily safe staffing check-ins with senior management. Managers had the discretion to book additional staff where needed. A temporary staffing team was in place to try and arrange staff. However, if staff were needed at short notice then it could still be hard to find temporary staff. The trust used an e-rostering system to make efficient use of staff and additional training was being provided in this. The trust had also done a pilot study looking at shift patterns for inpatient services. This had considered the introduction of long shifts and staff then working fewer days each week. The pilot had a very mixed response. At the time of the inspection it had been agreed that long shifts would not be imposed on staff teams, but individual staff would be able to choose their shift pattern. However, different wards had got different shift patterns in place. In addition the trust was also reviewing the start and end times of shifts. The trust had also introduced an in-house bank service a year ago. We heard from a number of staff that this did not always work well and that staff were leaving.
- The trust was seeking to recruit more staff and in particular more nurses. Five roles had been identified as roles that were difficult to recruit to. These included home treatment team staff, band 6 community nurses and band 7 community mental health team leaders. The trust had designed a social media campaign which had run since January 2016. This resulted in 139 mental health nursing posts being offered. Assessment centres were run three times a week and most recruitment took place centrally rather than being team based. Retired nurses were being encouraged to return to work. The trust was developing an employee benefits platform and employee recognition system to assist with staff retention. The trust was also looking at developing the

nurse practitioner role (band 4). The chief executive also met all new staff at the end of their probation to receive feedback on their experiences to identify areas for improvement.

- Recruitment and retention and safe staffing was reviewed at each board meeting and there were governance processes in place to monitor the effectiveness of the initiatives being used to address staffing issues.
- In terms of the impact of staffing challenges the inspection teams found that the greatest pressures were in the community services, rather than in inpatient services. This had also been recognised by the trust. In the community based mental health services for adults the case loads were a reasonable size. However, patients told us about how they were seeing different staff from the home treatment teams. They found this lack of staff consistency distressing. The inspection also found that staff were struggling to keep important records updated such as risk assessments or managers were struggling to complete regular supervision with members of their team. These all reflected the pressures within the community teams linked in many cases to high levels of staff vacancies.
- For inpatient services there were occassions where there was an impact from staffing challenges. For example in the forensic services patients told us that escorted leave was occasionally cancelled and fresh air breaks were not always facilitated due to staffing shortages. There were no records of this so it was not possible to say how often this was happening. On Jasmines ward for older people, staff said they found it very challenging to meet each persons needs at busy times of the day, such as when people are getting up and would welcome more staff input at these times. On Crocus ward for older people, the higher use of agency staff was impacting on the consistency of care.
- We reviewed the personnel records of eight trust employees. Records showed that checks had been carried out on staff before they started working for the trust, to confirm that they were suitable to work with vulnerable adults and children. These checks included enhanced criminal record checks with the disclosure and barring service (DBS) for those staff working directly with patients. The trust obtained at least two references from previous employers. References covered a minimum of the last three years. Prospective staff provided photographic proof of identity. For all records we checked the reasons for any gaps in the employment history of the prospective employee were explained in their application form. The service checked the professional registration of clinical staff before they were employed and monitored this on an on-going basis. If any positive disclosures were obtained from the DBS a panel was set up to consider the seriousness of the concerns identified in the context of the person's overall application and role applied for.
- Throughout the trust there was usually sufficient medical cover to support people with their physical and mental health clinical needs. This was a challenge at night in Kingston and Richmond where the medical cover worked across two inpatient sites. The ward staff understood the arrangements and if they needed urgent medical input would if needed call emergency services. In terms of medical revalidation, at the end of March 2016, 132 out of 139 medical staff had completed their revalidation.
- The trust was making good progress towards meeting its target of 95% for mandatory training. At the time of the inspection the completion rate was 81%. A new learning management system had gone live in June 2015, but ensuring that the recording of training was accurate was still work in progress. The low completion of some training such as basic life support training for staff in inpatient services represented a risk to the trust and patients. However, additional training sessions had been arranged. There had also been difficulties with access to some on-line training such as food hygiene. There had been significant shortfalls in staff completing fire safety awareness training for in-patients. The trust had commissioned three more training days that would cover 240 staff and bring the area into compliance. The trust have said that fire safety training in May 2016 had reached 72%. Similarly additional safeguarding children level 3 had been commissioned to enable all staff that required this training to attend. Other actions were in place to meet mandatory training targets. This included a weekly email to operations managers to highlight who needed to complete which training, face to face training overbooked to ensure places were all taken if people did not arrive and an analysis of staff who did not attend for training to address the reasons for this.

Requires improvement

Are services safe?

- The inspection found that in most services, the completion of mandatory training was satisfactory. There were a few areas where this appeared to need more work, but in order to ensure this took place when needed the accuracy of the data also had to improve.

Assessing and managing risk to patients and staff

- Just prior to the inspection the trust had carried out some audits of how it carried out the completion of risk assessments across a number of community teams. These audits found that risk assessments were regularly not being completed in the first 72 hours, the quality of the risk assessments varied, the risk summary did not signpost the reader to the risk management plan. The inspection found that in many services risk was managed well. Examples of good practice were noted in the home treatment teams, acute and forensic wards. In all these services, there were opportunities for teams to regularly discuss and update records in relation to individual risk. For example in the home treatment teams individuals were prioritised and a clear colour coded system meant that team members immediately knew who needed more support. In some of the recovery teams and rehabilitation wards there were examples of risk assessments not being updated to reflect new areas of risk. In the community based mental health services for older people and CAMHS teams the risk assessments were found to not be recorded consistently. This could cause difficulties for staff in locating the most recent document.
- The trust had a virtual risk team. This consisted of around 12 experienced practitioners. They were available for staff to access when supporting a patient with complex needs. They would also be available to offer support for patients where there had been a serious incident or multiple incidents. Where needed members of the team could go and spend time directly with the patient and staff to offer guidance. We heard from staff that this was a very highly valued resource.
- The trust had safeguarding processes in place, although there were some local variations based on the individual boroughs. The operational lead for safeguarding was the head of social care. There was an adult and children's lead. At the time of the inspection 88% of staff had completed the mandatory level 1 safeguarding vulnerable adults raining. Level 2 and 3 training was mainly provided to local authority staff. Level 1 safeguarding children training was delivered to all staff as part of their induction. At the time of the inspection 91% of staff working with children had received level 2 training. Level 3 training was in place for staff involved in safeguarding investigations. All five boroughs had signed up to the pan-London safeguarding agreement. Each borough had a safeguarding lead and there were also leads in wards and teams. The trust service director attended the safeguarding board in each borough. In October 2015 there were 48 alerts reported. The trust executive lead was the medical director and reports on adult and children's safeguarding were presented to the board. The inspection found that staff across the trust had a good knowledge of safeguarding and this was well managed across the services. There was a user friendly patient information booklet produced by the trust on safeguarding adults. The safeguarding leads felt that they had made good progress in raising staff awareness and encouraging staff to 'think family' when considering safeguarding concerns. They realised there was more to do in terms of getting the thresholds right for raising alerts, raising awareness for patients and also to ensure safeguarding processes are supportive to the service users.
- The trust had a policy on the prevention and therapeutic management of violence and aggression. Training was provided to support staff in the use of physical interventions. The training was tailored to the needs of specific groups of patients. Staff were very aware that physical interventions should only be used as a last resort. The inspectors saw several examples during the inspection of staff supporting patients in a very appropriate manner and using their skills to defuse potentially challenging situations. The use of restraint fluctuated each month. For example in December 2015 there were only 15 incidents of restraint and in February 2016 there were 42. The trust had a zero target for prone restraint and one prone restraint had been reported in December 2015. All prone restraint was followed up by the trusts proactive physical intervention lead. The inspection found that staff were clear about reporting incidents of restraint. Forensic services had recently signed up to the restraint reduction network which worked at reducing the use of restraint through policy and practice. Each of the directorates reviewed the use of restraint as part of their clinical governance process.

Requires improvement

Are services safe?

- The trust had a seclusion policy. The number of incidents of recorded seclusion was low with 8 incidents in December 2015 mainly on acute or PICU wards. We were concerned that in a few areas the use of seclusion was not being recognised. This meant that the necessary safeguards such as monitoring the patients and recording the observations was not in place. This was found in the forensic wards, where on Halswell and Turner wards patients were confined to their bedrooms for 'time out'. On Phoenix rehabilitation ward staff were confining patients in a de-escalation room although the trust confirmed they had stopped this practice immediately after the inspection. On Aquarius a child and adolescent ward there was a low stimulus area where young people were taken when rapid tranquillization was being administered. Although young people were accompanied by staff the practice was seclusion and regular checks needed to take place. After the inspection we were told that the trust had taken the immediate steps of closing the de-escalation room on Phoenix rehabilitation ward and they were carrying out a full review and implementation plan for the seclusion policy.
- The inspection did not find many cases of blanket restrictions. In most procedures, such as carrying out a search when patients returned from leave was based on the type of service or the specific needs of the patients. For example, on Aquarius ward for young people, the bathrooms and toilets were kept locked. This was based on the needs of the people using the service but meant that young people had to ask staff to open the doors when they needed to use the facilities.
- On the wards for older people, both wards had made the decision to restrict access to the bedroom areas. This was to ensure male patients did not wander into female bedroom areas. On Jasmines ward staff were very observant about when patients wanted access to their bedrooms and opened up the door promptly. On Crocus ward, which had five more patients and was much busier staff did not appear to notice when patients may want to return to their bedrooms. For example we saw a couple of patients falling asleep in hard dining room chairs, where it may have been appropriate to support them to have a rest on their bed.
- The trust was monitoring the numbers of patients who were absent without leave. Patients fell into three groups. The first was patients who absconded from escorted leave. In January 2016 there were three patients where this occurred. The second was patients who failed to return from leave. In January 2016 this occurred with two patients. The third was patients absconding directly from the wards. In January 2016 there were three patients who were absent in this way. The trends in patients who were absent without leave were being monitored and opportunities to reduce this happening were being reviewed in the services concerned.
- At the time of the inspection, the trust had acknowledged that there had been an increase in patient on patient assaults. This was monitored on a monthly basis, although the latest figures had been increased by one particular patient. They recognise that the acuity of patients has increased.
- On the wards for older people the trust had recognised that the greatest risk was of patients having a fall. All the patients were assessed for the risks of falls and appropriate measures put into place. This included seeking advice from care professionals such as the physiotherapist, adaptions to the environment, individual walking aids and safe footwear. The trust also recognised there was a risk in terms of the patients pressure care. All patients had a waterlow assessment on admission and this was also repeated at regular intervals. If a raised risk was identified then measures were put into place such as using pressure relieving equipment to prevent the development of an ulcer. At the time of the inspection a couple of patients had a pressure ulcer which had been acquired prior to their admission and the ward were treating the patient as needed. The wards also had access to tissue viability advice when required. The wards were not an outlier in terms of the NHS safety thermometer for falls or pressure care.
- The inspectors looked at the arrangements for lone working across the teams, especially for staff working in community teams and going into patients homes. These were generally working well. For example in the home treatment teams staff had regular access to trust mobile phones to communicate when working in the community. Two home treatment teams had recently introduced a mobile alarm system, which staff carried with them on home visits. The system was connected to a central call centre. Each home treatment team used a system for staff to record their movements from the home treatment team base to visits. This enabled staff

to know where colleagues were in community. Where there were concerns around safety joint working and joint home visits took place as an alternative to lone working. In the Kingston community recovery teams there was a system where staff gave their whereabouts to the administrative team, but this needed to be reviewed to reflect recently changed administrative arrangements. In CAMHS, some appointments took place after 5pm in the team bases, but the alarm systems were not always robust if staff needed to call for assistance. For example in the Merton office, if the alarm was sounded it did not show where help was needed.

- The trust had as a quality priority for 2014-15 for patients to have a crisis plan. The target was achieved with 72% of people on CPA (care planning approach) and 48% of non CPA patients now having a collaboratively developed crisis plan . Of these 94% of crisis plans are now being rated as 'adequate' or above in quality, with 71% of these being rated as 'good' or 'excellent' in quality. The inspection found that most people had a crisis plan in place. In the home treatment teams these plans included information about the individual warning signs of deterioration in health, positive support factors and contact numbers of services and how to access help and support in future.

- There were safe and effective arrangements in place for medicines in most of the areas we inspected. The trust Pharmacy dispensary was based at Springfield University Hospital and was open from Monday to Friday, 9am to 5pm. An on-call pharmacist was contactable out of hours and staff had access to an emergency drug cupboard. Medicines were couriered to Tolworth Hospital and Queen Mary Hospital twice a day. There were systems in place to ensure that there were adequate medicines supplies on the wards and in community clinics. This meant that patients had access to medicines when they needed them. The exception to this was on Aquarius ward where a fridge to store medication had been broken for several weeks and staff had to go to another ward to access these medications including rapid tranquillisation where needed. This was addressed immediately after the inspection. Some wards and home treatment teams were visited by pharmacists daily, whilst other wards and community teams received less frequent visits depending on patient turnover. The community based teams had pharmacist input on a monthly basis. We noted issues with stock control at the Merton and Richmond community based mental health services for older people.

- Medicines were stored safely and securely within most areas that we visited. However some community teams were not adhering to the trust policy on the secure transportation of medicines to patients' homes and medicines were being carried in unsecured personal bags. The trust said after the inspection that lockable rucksacks had been ordered. Emergency medicines and resuscitation equipment were easily accessible in clinical areas. They were tamper evident, in date and we saw evidence that they were checked regularly. Smart cards were used to access patient summary care records which meant that pharmacists were able to provide quality advice about medicines use. Medicines reconciliation occurred for each patient admitted to a ward. Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP.

- All prescriptions were clearly written and included information about allergies, weight, MHA status (the appropriate documentation regarding legal authority to administer medicines to individual patients' were readily available), date of birth, ECG and blood tests. In some cases photographs were included with the charts to aid the identification of patients. Appropriate codes were used to note medicines refusals and we saw that clinical staff discussed treatment options to encourage people to take their medicines. Nutritional supplements and fluid thickeners were prescribed and used in accordance with dieticians' advice. Medicines for physical health were prescribed and monitored appropriately.

- Nurses completed an annual medicines management update. Doctors that were new to the trust received at least 45 mins of medicines related training. In addition to this, the doctors were instructed to visit the pharmacy dispensary to ensure that they could see the patient impact on the receipt of late prescriptions. E-learning packages were also used to deliver medicines training to various staff groups in the trust.

Requires improvement

Are services safe?

Track record on safety

- We analysed data about safety incidents from three sources; incidents reported by the trust to the national reporting and learning system (NRLS) and to the strategic executive information system (STEIS) and serious incidents reported by staff to the trust's own incident reporting system (SIRI). These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources.
- Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The average time taken by the trust to report incidents to NRLS was 19 days. This meant that the trust was considered a consistent reporter of incidents.
- The trust reported a total of 3,141 incidents to the NRLS between 1 January 2015 – 31 December 2015. When benchmarked the trust was in the middle 50% of reporters of incidents when compared with similar trusts. Of these about two thirds of incidents reported to NRLS resulted in no harm, about a third were reported as resulting in low harm, 2.2% (69) in moderate harm, 1.1% (36) in severe harm and 0.51% (16) in death.
- Trusts are required to report serious incidents to STEIS. These include 'never events' (serious patient safety incidents that are wholly preventable**).** The trust reported 37 serious incidents between 1 October 2014 – 2 October 2015. None of these were never events.
- The trust monitored the number of incidents each month and identified trends. The medical director had commissioned an internal review as there were a number of unexpected deaths in late October/early November 2015. This was reviewing the referral process, assessments, identified risks and the treatment and care provided to the patients. The findings would be reviewed by the mortality committee and outcomes reported. In January 2016 there were 6 serious incidents, 3 suspected suicides and 3 unexpected deaths.

Reporting on incidents and learning from when things go wrong

- The trust had a serious incidence governance group that met weekly. This was multi-disciplinary and looked at all incidents to identify the level of investigation that was needed. This also generated a weekly 'risk intelligence report' that was sent to executive directors.
- Where an investigation was required the trust used a root cause analysis (RCA) methodology. The trust had met the 45 day or 60 day timeframe for investigation consistently since December 2012. At the time of the inspection only one investigation was outside the timeframe. An extension in the timeframe had been agreed with the commissioners to allow an external investigation.
- The trust had a reporting investigating and learning from serious incidents policy. Monthly learning themes are reviewed and included in a monthly and then quarterly report that was presented to the integrated governance group. The trust also had a mortality review group which identified areas for learning. Where needed changes in policies and training took place. For example the risk assessment training and education course included how staff needed to learn from incidents and make changes in practice.
- Urgent learning from incidents was disseminated using email risk alerts. Feedback was also through monthly learning bulletins, directorate governance groups to wards and teams and learning events that were held during the year. An intranet page was being set up as a forum for staff to share their learning experiences.
- The inspection found that staff were confident about reporting incidents, knew about incidents that had occurred in their service and were mostly having opportunities to discuss learning from incidents as part of team meetings. Some teams had less opportunity to hear about incidents from other teams especially between boroughs or from other parts of the trust. This was particularly evident in Thrale and Phoenix rehabilitation wards and the community teams for older people.
- A quarterly medicines incident report was produced. There were governance structures within each directorate for the handling of medicine related incidents. The medicines safety officer for the trust was a pharmacist who managed the investigation of all medicines related incidents in the trust. There were

examples of shared learning from medicines related incidents, such as a clozapine learning event for all trust staff. Risk alerts were placed on a designated area on the trust intranet as a learning resource for all. An example of a risk alert was an article on look-alike and sound-alike medicines. If a drug alert required action on the wards, it was dealt with by members of the pharmacy team. Information relating to drug alerts was disseminated in a variety of ways including a discussed at the safe medicines practice committee and drugs and therapeutics committee meetings, published via the pharmacy newsletter and amendments were made to local standard operating procedures if necessary.

- The inspectors looked at four root cause analysis reports from serious incidents and these were completed in a thorough manner with clear action plans and timescales.

Duty of candour

- The inspection found that staff working across the trust had a good understanding of the duty of candour.
- All incidents were recorded on an electronic system. This included making a record that the duty of candour had been applied. There was an expectation that staff would contact relatives and carers within 10 days of an incidents and ideally meet them face to face. The completion of this record allowed the application of the duty of candour to be monitored and there had been no breaches in December 2015.

Anticipation and planning of risk

- Teams and directorates completed local risk registers and these fed into the corporate risk register. The top four risks in January 2016 were risks from bed pressures, failure to modernise the estate impacting on care, failure to secure the contracts for the CAMHS tier 4 services and forensic services in a tendering process as this would lead to a loss of income. This risk register was presented monthly to the board.
- The trust has an emergency preparedness, resilience and response assurance process. This showed that the trust was 95% fully compliant with the NHS England assurance framework and this was accepted by the board in January 2016. The assurance process included the work the trust does with other local stakeholders to deliver this plan.

Requires improvement

Are services effective?

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.

Summary of findings

We rated effective as **requires improvement** for the following reasons:

Rehabilitation mental health ward

- Thrale Road, Westmoor House and Phoenix Ward did not clearly demonstrate how the recovery orientated approach to care was being implemented by the staff team. There was very limited evidence that patients were being fully supported to develop a range of independent living skills.
- Not all staff were receiving regular monthly supervision on Phoenix Ward and feedback from staff at Westmoor House meant it was unclear whether this was taking place on a monthly basis.
- Input from occupational therapists varied across the services and this meant some patients would benefit from more input to promote their rehabilitation.

Community based mental health services for adults of working age

- Some staff, especially from the Kingston and Richmond recovery support teams were not being supported with regular individual supervision.
- Electronic patient care records were not always regularly reviewed and updated and easy to locate.
- At Central Wandsworth and West Battersea community team and East Battersea community teams, some recently appointed staff were not having sufficient opportunities for individual support such as shadowing to help them manage complex caseloads.
- Whilst psychological therapies were available within each of the teams we visited, some patients who were ready for this therapy were having to wait for this.
- Staff were not confident in conducting Mental Capacity Act assessments and referred concerns regarding capacity to the medics in the team.

Wards for older people with mental health problems

- The line manager on Crocus ward did not provide consistent 1:1 supervision to staff that they managed.
- Patients on Crocus ward did not have access to sufficient occupational therapy input.

Mental health crisis services and health based places of safety

- There was no formal individual supervision structure embedded across the services and some staff were not receiving regular individual supervision.
- Physical health checks of patients prior to commencing antipsychotic medications were being completed according to guidance, ensuring safe prescribing. However, supporting patients to have physical health checks was not done routinely for all patients on caseloads.
- The recording of care plans and risk assessments were not consistent and this could make it hard to find the current information.

However, the trust was carrying out a range of audits to monitor and improve standards of care. Staff felt well supported and able to access a range of training to develop their skills. There were many good examples of multi-disciplinary team working and of teams working with external agencies to meet the needs of patients. The Mental Health Act was well managed within the trust.

Our findings

Assessment of needs and planning of care

- Staff in most of the areas we visited completed comprehensive assessments for the people they were supporting. The assessments varied depending on the needs of the individuals. For example on the wards for older people the assessments included pressure care,

risk of falls and continence. For inpatient services there was always a completed physical health assessment. The home treatment teams were introducing a standard assessment format across all the teams.

- The quality of care plans varied between services and teams. Where the services had a longer period of involvement with the patients, the care plans were generally more comprehensive and holistic. For example in the forensic services they had recently implemented a recovery model of care called 'my shared pathway'. This involved patients and staff working together on care planning so that patients had more choice, responsibility and involvement in their care. Patients told us they were aware of their care plans and had been involved in their development and review. The care plans were in the main personalised and recovery focussed. This contrasted with the acute wards where the written care plans were more varied and most showed less input from patients.
- Some care plans that were shared with patients were printed off the electronic patient record system. Others were in a more accessible format. For example in the community services for people with a learning disability, people who used services were able to access easy read care plans and plans which were developed according to the specific communication needs and preferences of people. We saw that people had been involved in the planning and reviewing of their care and the language in the care plans we saw reflected the needs and preferences of people who used the service.
- Most care plans were being regularly reviewed, however there were a few areas where care plans were not being regularly updated to reflect the changes in peoples needs. This was noted as more of an issue in the rehabilitation services. It was also observed across the home treatment teams, CAMHS and the adult recovery teams that there was a lack of consistency in terms of where care plans were stored, which could make it hard for the current records to be located and used by staff in the team.

Best practice in treatment and care

- The trust had a wide range of measures in place agreed with commissioners and other stakeholders such as NHS England with the aim of improving the outcomes of people who use their services. These included the measures agreed in the annual quality account. The commissioning for quality and innovation (CQUIN) framework had incentivised the trust to deliver improvement. A number of national and local targets were set. These included national CQUINs for improving physical healthcare and local or specialist ones, for example active engagement for patients using forensic services and carer involvement strategies. Each directorate governance group was monitoring their progress and this was reported to the quality and safety assurance committee and then to the board as part of the monthly performance dashboard and performance and quality report. At the time of the inspection, the trust had identified that they were falling behind in meeting a couple of targets including the completion of carers assessments and were identifying how this could be addressed.
- The trust was working towards ensuring it maintained the care it provided and associated procedures in line with the latest guidance. Findings from a recent audit of the trusts operational and clinical policies identified that policies were not routinely referencing relevant national institute for health and care excellence (NICE) guidance. In response to this a dedicated NICE/clinical audit group had been established, chaired by the medical director. All clinical policies had been reviewed and the appropriate NICE guidance referenced. The clinical effectiveness manager was responsible for reviewing and disseminating published national institute guidance. New NICE updates were also added to the trust wide NICE database published on the trust intranet clinical effectiveness pages. Clinical directors are responsible for disseminating new guidance through their directorate clinical governance groups for action by local teams.
- During the inspection we saw staff referring to NICE guidance and demonstrating a high awareness of how services were meeting the guidance. For example in the specialist community mental health services for children and young people clinicians considered NICE guidance when prescribing medication and used it to inform treatment pathways, particularly the use of psychological therapies. Doctors offered young people antipsychotic medication in conjunction with psychological interventions. We also saw that clinicians were skilled in explaining medication to young people in a way that was age appropriate and relevant to the person. The inspectors found individual services

updating their practice to reflect new guidance. Many of the mental health services had access to a range of psychological therapies in line with the guidance although there were areas where more input was needed including the acute wards and some of the adult recovery teams.

- The trust was reviewing how it it was improving patients health by monitoring whether they received a physical health check during admission. In December 2015, the target of 95% of patients having a physical health assessment within 48 hours of admission was being met. Although in January 2016 the trust said that there was a risk of it missing its CQUIN target of completing cardio metabolic assessments for 90% of inpatients and 80% of patients accessing the early intervention service. There was some good practice in terms of ensuring patients had their physical healthcare needs met. All the wards were using the national early warning scores to identify if a patients physical health was deterioriating. On the acute wards we saw that staff undertook a full physical examination of patients on admission and monitored the physical health of patients on a daily basis. We observed good communication between staff in handovers, weekly ward rounds and MDTs which covered the physical needs of patients. Staff and patients reported good access to other physical health services such as dentists. One patient confirmed a planned operation went ahead while they were a patient on the ward. The trust provided a smoking cessation programme for all patients who wanted it. On the wards for older people the patients were having physical health observations carried out on a daily basis. In the forensic service they had developed a physical health forum which provided physical health awareness events for patients and staff. Successful events on oral hygiene, coronary heart disease, obesity and heart disease had taken place and been well received by the patients.
- In the community mental health services, access to physical health checks was more variable. The trust had a target of 75% for all community patients receiving an annual physical health check. In most teams the physical health check would be carried out by the GP, but staff had not ensured that patients had received these checks or followed up the results. For example in the Merton, Kingston and Wandsworth teams for older people, the teams performance dashboard highlighted that patients had not had an annual physical health check with their GP but this had not been addressed. In the adult community recovery teams, all the teams with the exception of the Mitcham recovery support team were not meeting this target. There was also some good practice. For example the Wimbledon recovery support team had a physical health lead who had introduced initiatives to promote physical health. This included a physical health day, introduction of equipment so nurses could monitor blood pressure and weight checks as well as training two staff in phlebotomy. The team also held regular liaison meetings with local GPs. More recently the team had aligned individual practitioners with GP practices and expected them to contact the practice each month and chase up patients who required physical health checks with the GP. Despite this, staff were not clear for some patients who attended the clozapine clinic if they had received a physical health check. Good practice was noted in the community teams for people with a learning disability. Here the service used health passports to ensure that people were able to share information about their needs both in terms of the physical health needs but also emotional and psychological needs with other health professionals. Staff and people who used the service gave us examples of where these health passports had been used to facilitate a more person-centred hospital admission or discharge meaning that information had been shared beneficially.
- The trust took part in number of national audits. This had included the national audit of schizophrenia. Whilst the audit was now several years old there were ongoing recommendations in relation to improving the physical health of patients receiving community services. They also took part if the national audit of psychological therapies. This has led to work around improving access for different religious and cultural groups, for people over the age of 65 and improving the number and choice of sessions. The most recent national audit which was published in 2014 was the prescribing observatory for mental health (POMH-UK), a national audit-based quality improvement programme to improve prescribing practice in mental health. Three audits had been carried out looking at the prescribing of anti-dementia drugs, prescribing anti-psychotics for children and adolescents and prescribing for alcohol detoxification. Where the results showed a need for

improvement, action plans had been implemented and the inspectors saw this being put into practice in services for older people and services for children and adolescents.

- The trust recognised that clinical audit was an essential part of improving quality.The effectiveness team oversaw the work on clinical audit but there was not a dedicated clinical audit department. At the time of the inspection there were 115 registered audits and others taking place that were not registered. The clinical audits checked compliance with targets set by commissioners such as audits of physical health checks and the completion of discharge summaries to GPs. They also checked compliance with internal procedures such as compliance with NICE guidance, patient safety alerts, infection control and hand hygiene. They had also been developed to address areas of priority, for example the audits looking at access to psychological therapies and support with accessing employment. The audits were completed by internal staff but an external company was also used to complete some audit work. The learning was disseminated through an annual audit award day, a newsletter, the intranet, clinical governance meetings, learning events and training. The inspection team saw the results of audits being used in teams to reflect on and improve performance. For example the staff at Burntwood Villa a rehabilitation service had developed a dental audit in December 2015 and also developed a footcare audit at the same time, as staff felt a focus on this would benefit their patients physical health.
- The trust undertook a number of medicines related audits to assess quality and to assist in the identification of areas for improvement. These included audits of missed doses, dispensing errors, medicines reconciliation, safe storage of medicines, controlled drugs, pharmacy related interventions and use of rapid tranquillisation. We saw how the results of the audits had been used to make improvements in medicines management and the audit results had steadily improved. We saw examples of positive clinical input by pharmacists who gave advice to both staff and patients to improve medicines optimisation. Patients were able to access information related to the medicines in a variety of ways including a dedicated patient medicines information line that was contactable Monday to Friday, 9am – 5pm, from the choice and medication website, from easy-read leaflets on wards and medicines information in braille a variety of languages. The trust had a number of medicines optimisation initiatives in place including; a recently designed application to assist patient who were on lithium to manage their treatment and their blood tests, a pharmacy led project to help staff improve the quality of medicines information on discharge letters, new medicines trolleys in some wards which had been shown to reduce medicines errors.
- In terms of measuring outcomes for individuals the trust was also using the paired health of the nation outcome scales to measure the health and social functioning of people with a severe mental illness and over time the patient outcomes. At the time of the inspection this had been completed for over 90% of patients. Services also used a wide range of other outcome measures dependent on the needs of the individual to see how patients were progressing. For example in the community teams for older people the Merton team used the quality and outcome framework for physical health activity. The behaviour and communication team in Wandsworth and the challenging behaviour team in Sutton and Merton used a recognised 'challenging behaviour' scale to ascertain the progress made by patients and the effectiveness of their treatment. In the teams for people with a learning disability they used a variant of the health of the nations outcome scales which were specific for learning disabilities services. In addition to this, staff specifically used a modified behaviour and mood score which a psychiatrist in the Merton and Sutton team had adapted for the service. The trust had also started work on introducing patient reported outcome measures but this was still at an early stage.

Skilled staff to deliver care

- Most teams had access to the full range of mental health disciplines required. There were however a few notable areas where having staff with the appropriate skills needed to be improved. The first was psychology input, especially for patients accessing crisis services and the acute care pathway and the adult community recovery teams. The second was occupational therapy input, especially for patients using the rehabilitation services and patients on Crocus ward for older people where the limited occupational therapy input was impacting on the quality of their care.

Requires improvement

Are services effective?

- The trust provided a two day corporate induction for all staff every two months. This was attended by the chief executive. We heard from a range of staff that this training was very useful. In addition staff received a local induction that supported them to understand their specific role in the services. We heard in most areas that this was very good.
- The trust offered over 11,000 hours of continuing professional development every year. Staff talked positively about the range of training opportunities available, although some said it was hard to find the time to complete the training. This was provided through a combination of internal and external training. We heard about how teams benefitted from reflective practice and also from learning from each other in structured learning sessions. Some other specific learning we were told about included the CAMHS team in Kingston who said they had received training from the Tavistock and Portman NHS Foundation Trust around supporting young people who identified as being transgender. The CAMHS team in Wandsworth had worked with the local community to improve their understanding of female genital mutilation. Staff on Aquaruis ward for children and young people had received specialist training including a psycho-social interventions course and training on the Children Act. On the wards for older people staff had completed a days training to improve their knowledge about how to care for people with dementia and we heard this had been useful. The trust had introduced learning disability clinical leads to ensure staff had the knowledge or access to advice if they were supporting a person with a learning disability across any of the trusts services.
- A recurring theme on this inspection was that a number of staff across services were not having access to 1:1 supervision on a regular basis. At the last inspection in 2015, staff on the acute wards were not all receiving regular supervision. This time we found that regular supervision was taking place on the acute wards but not on some of the rehabilitation wards, in the Merton community team for older people, in the Kingston and Richmond recovery teams, on Crocus ward for older people and in most of the home treatment teams. The trust had an expectation that staff should receive individual supervision at least every six weeks. In some cases, especially in the community teams, managers had line management responsibility for large numbers of staff and delivering supervision to all these people was not possible. We were told by the trust that they are reviewing the supervision arrangements. It was also noted on Aquarius ward for young people that supervision records were not stored in a manner that maintained the confidentiality of the staff member. The trust did offer other opportunities to support staff including reflective practice, group supervision facilitated by psychologists and supervision as part of multi-disciplinary team working.
- In December 2015 the percentage of non-medical staff at the trust who had an appraisal in the last 12 months was 77%. This was improving in most services at the time of the inspection.
- Staff had access to regular team meetings.
- Where managers were working to address staff performance issues, they felt adequately supported by the human resources team with this work.

Multi-disciplinary and inter-agency team working

- Staff spoke favourably about internal multi-disciplinary work. We also observed a number of multi-disciplinary meetings and staff handovers. This reflected some good practice and we saw staff working well together in a respectful manner making the most of each others skills and experience. Meetings took place with appropriate frequency and displayed a good understanding of each patients needs. For example on the acute ward we observed some handover meetings. These were well organised and covered a range of areas including risks, physical health, medication, activities, leave and details of each persons MHA status. Staff followed and completed a check list to ensure that the handover covered all necessary matters.
- Relationships and joint working between other internal trust services also generally worked well. For example the home treatment teams were attending the local adult community recovery team weekly zoning meetings, enabling regular discussion and joint working, to enhance the referral process between the teams. Patients who had been supported by the team for a sustained period of time (14–28 days) were reviewed jointly with a care coordinator where possible to help facilitate discharge.
- There were also many examples of teams from the trust working with teams from other agencies. For example the specialist trust learning disability teams had links

with local community teams for people with learning disabilities as well as adult social care teams. In Merton and Sutton, the consultant psychologist based in the team had spent 18 months seconded to the community team for people with learning disabilities. This had facilitated strong working relationships with these teams and ensured that the teams worked well together. They also provided supervision for psychologists based in these teams. Another example was in meeting the educational needs of the young people cared for in the trusts inpatient services which was managed in partnership with the Wandsworth Hospital and Home Tuition Service (WHHTS) through its on-site school, which is provided by Wandsworth Council. Ofsted had graded all aspects of the provision offered by the WHHTS as 'outstanding'.

- There were also examples of recently introduced schemes working in an innovative manner to meet peoples needs. For example the trust had introduced a street triage scheme in Richmond and Wandsworth. The trust was working with the police and the charity Together for Mental Well-being to provide practitioners based in police stations and court to identify, screen and assess people with mental health problems and help to arrange housing and finances if needed. The trust had been working with the police, local authority and other agencies to develop effective policies and protocols for the use of the places of safety to ensure the principles of the crisis care concordat work were firmly implemented.

- At the time of the inspection section 75 agreements were being dissolved between the trust and their partner local authorities. This meant that teams that had previously included staff employed by health and social services were now being separated. This was presenting challenges for the trust teams who needed to access social care input for the patients they were supporting. In Wandsworth we heard that requests for support required a written request and was very bureaucratic and time consuming. In other boroughs the arrangements were working better. The inspection felt the trust could do more to ensure these arrangements worked as well as possible.
- The arrangements for working with GPs also varied between boroughs. Managers and consultants in the Kingston recovery support team, Mitcham recovery support team and Wimbledon recovery support team had worked to develop links with GPs. At Wimbledon recovery support team, individual practitioners had been aligned with GP practices and were expected to visit the surgery each month to discuss patients who needed input for their physical health. In other boroughs the joint working was not as well developed.

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

- The trust's systems supported the appropriate implementation of the Mental Health Act and its code of practice. The application of the Act was overseen by the mental health law governance group. This group met regularly to consider changes to policies, to review statistical reports of Mental Health Act activity and to identify and develop Mental Health Act projects such as report writing templates for mental health tribunals. Legal advice was available from the trust's solicitors, from the Mental Health Act manager and from the Mental Health Act office based at each hospital site.

- Training on the Mental Health Act was part of the induction process for all staff. In addition the trust provided a mandatory training course on consent to treatment which also incorporated training on the Mental Health Act. The Mental Health Act administrators trained ward staff to be authorised officers for the receipt and scrutiny of detention papers. A programme of training on the code of practice was still being rolled out to all doctors in the trust. We were informed that take up for training sessions in relation to the Mental Health Act was high. The aim was for 90% of the medical staff to have completed this training by April 2016.

- The Mental Health Act office sent out weekly electronic reminders to all teams in relation to detention renewals and consent to treatment provisions. The approved mental health professionals (AMHP) services were not managed by the trust but separately by the five individual local authorities.

- Trends in the use of the Mental Health Act over the past year were monitored by the director of social work and the Mental Health Act manager. These included an increase in the use of section 2 and a general increase in the use of the Mental Health Act resulting from Mental Capacity Act case law.

Requires improvement

Are services effective?

- During this inspection we completed ten Mental Health Act review visits pursuant to the CQC's duty under section 120 of the Act.
- We found evidence that detention paperwork was completed correctly, was up to date and was stored appropriately. However on one ward where a Mental Health Act review visit was completed, a section 5.2 had been applied before the end of a section 2 and a further section 5.2 had been applied when the first one had been deemed invalid.
- We found evidence that there was adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were attached to medication charts where applicable, although on one ward we visited the certificate of consent to treatment (T2) form on file was from a previous responsible clinician in a previous hospital, and on another ward both a certificate of second opinion (T3) and a T2 form were on the same medication chart leading to possible confusion.
- There was evidence that most people had their rights under the Mental Health Act explained to them. However on three of the wards we visited it was not clear that all patients had been regularly reminded of their rights and on one of the wards we visited patients were not aware of the availability of the Independent Mental Health Advocacy (IMHA) service.
- We found some concern in relation to the use of seclusion on two forensic wards, a rehabilitation ward and Aquarius ward for young people. In each case seclusion was not being recognised so that the appropriate safeguards such as regular observation could be put into place.
- A majority of the care plans we reviewed were comprehensive and individualised. On two wards we visited we found inconsistent evidence of patient involvement and the recording of patients' views in relation to their care and treatment in line with the Code of Practice.
- An internal audit was carried out in September 2015 to review the processes in place at the trust to ensure compliance with the MHA, specifically Section 17 leave arrangements, consent to treatment and patients' rights. This had identified areas where improvements needed to be made and these had mostly been addressed.

Good practice in applying the Mental Capacity Act

- Training on the Mental Capacity Act (MCA) was provided as part of the corporate induction. In addition the trust also provided a mandatory training course on consent to treatment which incorporated the Mental Capacity Act. This had been completed by 91% of the staff. In addition there was also a new e-learning training package. There had also been training delivered directly to teams and over 500 people had completed this training.
- Trust had Mental Capacity Act and Deprivation of Liberty Safeguard policies. These included flowcharts and vignettes to make it more accessible for staff. The trust had produced a consent and capacity electronic assessment and decision template to support staff to follow the correct steps where needed. There was a MCA lead in each directorate. Also the staff working in the MHA offices were being developed to offer support on the MCA.
- At the last inspection in 2015, staffs ability to use the MCA was mixed. On Lilac acute ward the trust was non-compliant. At this inspection staff understanding and use of the MCA was much improved. Most capacity assessments were completed by the medical staff. We heard of examples of where best interest meetings were taking place. The patient records where appropriate, included capacity assessments and records of best interest meetings. These records were comprehensive. The exception to this was in the community recovery teams for adults. Here some staff did not feel confident in using the MCA. For example in the East Wandsworth community team some staff told us they had not completed sections of the initial assessment that addressed capacity due to their lack of confidence in the MCA. Sometimes locating the records was a challenge as they were not stored consistently.
- In the six months prior to the inspection there had been 16 authorized Deprivation of Liberty Safeguards (DoLS) across the trust. At the time of the inspection there were two patients on Crocus ward and two on Jasmine ward subject to an authorized DoLS. These were clearly recorded and the arrangements to minimize the restrictions were monitored.
- The Mental Capacity Act does not apply to young people aged 16 and under. For children under the age of 16,

Requires improvement

Are services effective?

staff in the CAMHS teams applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions themselves.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** for the following reasons:

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers, were usually involved in decisions about their care.
- Opportunities were available for people to be involved in decisions about their services and improvements were taking place when concerns were raised.
- Work was taking place to improve patient involvement.
- Advocacy services were available and patients were supported to access these services.

However, there are a few wards where staff need to aware of their manner and approach to ensure their communication with patients is appropriate at all times. On Crocus older persons ward an effort must be made to ensure patients clothing does not get mixed up.

Our findings

Kindness, dignity, respect and support

- The inspection found that caring was good across all the core services that were inspected. The staff we spoke to across the trust were very hard working and committed to their work and wanted to provide high quality care to people who were using the services. Staff showed considerable passion, pride and enthusiasm for the many imrpovements that were taking place.
- We observed many positive examples of positive interactions between staff and patients throughout the inspection visit. For example on Jasmines ward for older people, the staff knew the patients very well including small but important details such as whether they preferred to spend some time in their bedrooms rather than always being in the communal areas. We also saw many other examples of where staff really knew the patients and their carers well and were attentive to their individual needs.
- There were a few examples of where we heard or observed care where there was room for improvement. For example in the forensic services some patients told us that a few members of staff had a poor professional attitude towards the patients and spoke in their own language. On Crocus ward for older people, the staff were extremely busy and were struggling to support all the patients. We observed that staff communication with patients was very task focused. One relative told us on Crocus ward that the person they were visiting was wearing someone else's clothing. On Phoenix rehabilitation ward some patients said the staff spent lots of time in the office and were not always respectful or polite. On Jupiter acute ward it was also observed that staff could improve their interactions with patients.
- The feedback from various surveys about the quality of care was also slightly mixed. In the patient family and friends test in November 2015, 72% of respondents said they would recommend the trust if they needed similar care or treatment. This figure was below the England average of 87%. Also 29% of patients said they would not recommend the trust which is also worse than the England average of 5%. However, the completion rates for this test were low. In contrast the Care Quality Commission survey of patients using community services for 2015 showed an improvement in how patients rated their overall experience with an average score of 7.5 out of 10, which was the highest in London. The trust also collected real time feedback for patients using inpatient and community services. In January 2016 the trend for the year to date was an improvement in satisfaction for inpatient services and a continued high level of satisfaction for patients using community services.

Involvement of people in the care they receive

- Throughout the inspection there were many examples of patients and their carers being involved in assessments, care plan reviews and decisions about their care. In most cases patients and carers were

invited to be part of meetings where their care was discussed. For example on Aquarius ward for young people, families and carers were very involved in care and treatment. Up to half of the therapeutic work that took place with each young person involved their family through family therapy and developing strategies for problems to be resolved together.

- At the last inspection it was found on an acute ward that patients were not involved in the development of their care plan and that these documents did not reflect peoples preferences. At this inspection most patients on the acute wards that we spoke to said they had received a copy of their care plan. Many confirmed that they had discussed their care plan with staff and also that family members were involved in their care and treatment. At Burntwood Villas which is a rehabilitation service, staff helped patients on admission write their care plan and all staff were eager to involve patients in their care as much as possible. Patients we spoke with said they were involved in their care plans and were able to speak to staff about them. One patient was aware of a discharge plan for them to live independently. A few patients being supported by the community recovery teams said they had not received a copy of their care plan.
- On most of the wards there were regular community meetings taking place which enabled patients to have some involvement in the services they were receiving. On most of the wards a record was kept of these meetings and it was possible to see that suggestions had been followed through. At Westmoor House a rehabilitation ward, records of the community meetings needed to be kept. In forensic services the Voice peer support group had won an award in the 'breaking down barriers' catergory of the national service user awards. An ex-service user returned each week to facilitate the group.
- Some wards also had meetings dedicated to supporting the involvement of families and carers. This included a weekly session on the Laurels ward between the psychiatrist and patients' families. On Lavender ward there was a carers recovery worker funded by Richmond health and social services. The worker's role was to ensure there was effective communication between families and carers and the multidisciplinary team in relation to the patient's treatment and discharge. The trust had a target that 60% carers of patients on a care programme approach will be offered a carers assessment. The trust were struggling to meet this target but had identified this as an area for improvement.
- Advocacy services were available across the trust website. Different boroughs had local advocacy services. Services had information displayed about advocacy services and staff mostly knew about how to access services.
- The inpatient services we visited had arrangements in place to introduce patients arriving on the ward in a thoughtful manner. We saw that leaflets were also available giving people essential information about the ward. Information was also available or being developed for the community services. For example a patient information leaflet had been developed in Kingston home treatment team and this was clear, informative and easy to read. It included information on how the team worked, how to access services in an emergency and support helplines. This leaflet was provided to people who had been referred to the service, and families or carers.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated response as **requires improvement** for the following reasons:

Rehabilitation mental health ward

- Patients, with the exception of Burntwood Villas, did not have access to the support to enable them to access the therapeutic activities to enhance their rehabilitation.
- At Thrale Road and Westmoor House staff were not fully supporting the needs of patients whose first language was not English and who required an interpreter.

Community based mental health services for adults of working age

- The Kingston recovery teams were struggling to reliably send out letters about appointments and reviews following changes in the administrative support to the team.
- At the Central Wandsworth and West Battersea community team more than 15% of patients were not attending their appointments. The team could not demonstrate that active steps were being taken to engage with patients who did not attend.
- For most teams, space was limited and staff had difficulties accessing interview rooms.
- Interview rooms were not soundproofed and discussions could be heard outside doors.

Community based mental health services for older people

- The changes to the administration support for the Kingston team had led to patient's appointments being cancelled and staff unable to locate patient records.

However, there had been significant improvements in the management of access to acute beds across the trust and the acute care co-ordination centre was working well. Discharge co-ordinators on wards were helping to facilitate all the practical arrangements associated with each persons discharge. Most community teams were meeting their targets for assessing and treating people in a timely manner. This was particularly commended in the CAMHS teams where the service had gone through a period of change. Teams offered patients flexible appointments when needed to support their engagement with the service. The trust recognised the needs of people in terms of working towards providing services that met their needs in relation to their protected characteristics. There was some excellent work taking place with local communities to break down the stigma associated with mental illness. The trust was managing complaints in a timely manner and supporting people to raise concerns where needed.

Our findings

Service planning

- Stakeholders said that the trust worked with clinical commissioning groups, local authorities, Healthwatch, health and well being boards and overview and scrutiny committees, four acute trusts who are all in deficit, GPs and other local providers to understand and meet the needs of the people in the five boroughs where local mental health services were provided. The trust also provided specialist services where patients came from across the London and other parts of the country to receive care. They worked with specialist commissioners to meet the needs of these patients.
- The trust recognised the complexity of the stakeholder engagement and had an engagement programme in place throughout 2016 onwards.
- At the time of the inspection the trust was organised based on boroughs, CAMHS and specialist services. They were considering if a re-organisation on service lines could promote further improvements in services as they recognised there are variations between boroughs that do not just relate to differences in commissioning.

Requires improvement

Are services responsive to people's needs?

Access and discharge

- Overall the trust was working to make the access and discharge arrangements work as well as possible. Whilst there were specific challenges they were in discussion with commissioners to find solutions. There were also some variations between boroughs in terms of how services were commissioned that impacted on how arrangements worked in practice.
- The area of greatest improvement for the trust has been in terms of access to mental health services in a crisis including an acute bed where needed. This had been very challenging as the average bed occupancy across the acute wards in a six month period between June 2015 and November 2015 was 111%. The ward with the highest occupancy rate during that period was Ward 2 at 129%. The lowest was Lavender at 103%. In addition readmissions at the time of the inspection were 8%. At the previous inspections there was non-compliance associated with acutely unwell patients being placed on wards including services for older people and services for deaf people. This was potentially placing vulnerable patients at risk and not providing the most appropriate service for the patients. At this inspection the trust was still having to cope with very high bed occupancy but had developed the acute care co-ordination centre which operated 24 hours a day and managed the demand for beds on a daily basis. The trust was monitoring and ensuring patients were placed in wards which were clinically appropriate.
- The trust had also recognised that they needed more acute beds. When benchmarked against other trusts they were in the lower quartile in terms of their acute beds per 100,000 population. In this financial year up to January 2016 the trust had placed 71 acute patients in beds outside the trust. In response to this they had arranged a contract for 10 beds with East London Foundation Trust and were planning to open 12 beds on Ellis ward at Springfield in April 2016. The trust have said that since the inspection Ellis ward had opened. They were aiming to end the arrangement with East London Foundation Trust once local beds were available. In December 2015 the trust had also opened another 5 beds on Laurel and Lilac acute ward to help manage the bed pressures. The board had approved a new clinical admission protocol to help manage the decision making process about where acute patients would be placed. This included the provision of support for carers and relatives if patients were placed in beds away from their local services. Whilst still very stretched on a daily basis these arrangements were helping to ensure that where a bed was clinically needed that this would be found.
- The trust was also looking at innovative ideas going forward to support patients using the urgent care pathway. This included the introduction of a psychiatric decision unit which would be located alongside the health based place of safety, crisis house and cafes, additional staff for the home treatment teams and specialist housing discharge co-ordinators. At the time of the inspection some funding had been approved to start taking these proposals forward.
- When patients returned from leave in the community the bed they previously occupied was not always available. This was due to bed pressures across the trust. When this happened a bed was found for the patient on another ward or on the same ward but a different room. However, because patients usually did not go on home leave overnight this occurred very rarely.
- Staff rarely moved patients between the wards after admission unless this was for clinical reasons. Also as the catchment area of the trust was large covering several boroughs patients from that area could be admitted to a service that was some distance from their home. Therefore, if a patient asked to move to a different service closer to their home after admission and staff identified that it was in the patient's best interests to move them to an available bed then they did this.
- Where required, a bed on a psychiatric intensive care unit (PICU) was available in the trust for male patients on Ward 1 at Springfield hospital. This was normally available the same day or the next day. For example, on the day of the inspection, a patient on Laurels ward moved to the PICU following an incident which had occurred the previous night. Where a female patient required a PICU bed, the trust had commissioned two female PICU beds. These beds were located on Shannon Ward based at St Charles Hospital (Central and North West London NHS Foundation Trust). In addition to this resource the trust spot purchased female PICU beds. Due to the demand for these services across London there was sometimes a delay in finding a bed. Staff managed these delays keeping unwell patients under close observation until a bed was available.

Requires improvement

Are services responsive to people's needs?

- The trust was also working hard to ensure that patients were being discharged in a timely manner. In January 2016, the trust reported that there were 12 delayed transfers of care due to housing, transfers to another NHS setting or nursing homes. Each ward had a dedicated discharge co-ordinator who helped to ensure the discharge arrangements for each person were in place. The trust was also reviewing delayed discharges on a weekly basis. Despite this work it was noted at the time of the inspection that the lengths of stay, especially on the acute wards were increasing.
- Another area where the trust needed to review discharges was in the rehabilitation services. Some patients were experiencing very long periods of time in the services, in a few cases, several years and this did not reflect the aims of the services to provide rehabilitation.
- For patients in the community there was access to telephone support 24 hours a day. There was an additional mental health support line which operated from 9pm – 5am on weekdays and 24 hours a day at the weekend and on bank holidays providing an access point for people in crisis. This service provided advice and signposting, if required. When people were identified as requiring an urgent mental health assessment, staff advised people to attend a local accident and emergency department where they would be assessed by the psychiatric liaison team. The feedback about this service was mixed with some people saying it could take while to get through. The inspectors saw that all calls were recorded and monitored including response times. The staff working on the support line were not qualified but had received bespoke training and could access support from the nurses working in the urgent care co-ordination centre which was located at night in an adjoining room.
- In Wandsworth, Sutton and Richmond there were street triage services where staff from the trust worked with the police and helped to identify people who needed mental health services and arranged for them to access the health based place of safety. There were commissioning plans in Kingston and Merton.
- Each borough had a home treatment team that operated with varying shift patterns 24 hours a day. Referrals were triaged by a shift co-ordinator supported by the team manager. The teams had a target time of 2 hours for urgent cases from referral to assessment. This target was being met across the home treatment teams and the response time from referral to initial assessment was good. For all referrals the assessments were arranged within 24 hours and prioritised according to the presenting risk. Each of the teams had a gatekeeping function where assessments for an inpatient hospital admission would be conducted by the home treatment team to review whether home treatment could be provided as an alternative to hospital admission. The home treatment teams also followed up patients after discharge. For patients on a care programme approach 95% were being followed up within 7 days of their discharge.
- Other community services were experiencing pressures which was impacting on access to services. For example the memory assessment services had long waits in Wandsworth, Kingston and Sutton due to an increase in referrals. Extra funding for additional staff had been agreed with commissioners in Wandsworth and Sutton and a meeting was arranged with the Kingston commissioners to address this challenge.
- The tier 3 CAMHS had worked to improve access. Four of the five CAMHS teams had introduced a single point of referral. A target of urgent referrals being assessed in 7 days was being met. The target for tier 3 CAMHS clients to be assessed in 8 weeks had been achieved in November and December 2015, which was an improvement as the target had previously been missed. There were also pressures in terms of referral to treatment times in the CAMHS teams where there was an 18 week target. The main reason for this target being breached was the long waiting lists for the neurodevelopmental service but this has been raised with commissioners and the service was now almost meeting the target. The CAMHS teams maintained contact with young people who were waiting for treatment. There was a waiting list for psychological therapies in all services. The Sutton service had 49 young people waiting for a psychology appointment. These young people had been waiting for up to 24 weeks. Whilst these young people waited they were given ongoing psychiatric support.
- For the specialist community learning disability teams provided by the trust in Wandsworth, Merton and Sutton, the main concern raised by patients and carers was how hard it was to meet the criteria to be referred to the team. Once patients were referred they were assessed and treated promptly.

Requires improvement

Are services responsive to people's needs?

- There were trust wide targets to respond to referrals to adult community teams, which were to assess 80% of non-urgent referrals in 28 days and 80% of urgent referrals in 7 days. At the time of the inspection, performance against the 28 day target was 93% in the Central Wandsworth and West Battersea community team and 87% in the East Wandsworth community team. Performance against the seven day target was 80% in the Central Wandsworth and West Battersea community team, which had dropped from 90% in January and 100% in the East Wandsworth community team. Staff attributed the drop in the Central Wandsworth and West Battersea community team to the absence of the triage worker. The manager and deputy manager were covering the post. The trust had agreed with Wandsworth the development of a single point of entry commencing in September 2016 to improve responsiveness. The trust had set a target for teams to offer at least 92% of patients four appointments within 18 weeks from referral to treatment. This was mostly being achieved.
- At the time of the inspection the Central Wandsworth and West Battersea community team had classified 143 patients as "waiters". These patients had completed an initial triage assessment and were waiting for further assessments, appointments, treatment, care co-ordinator allocation or discharge. The circumstances of these patients were overseen and understood by the managers and triage staff.
- Across the trust appointments generally ran on time and when staff cancelled, they offered an explanation to patients. The teams recognised that some patients were hard to engage and tried to be flexible to meet their specific needs. For example in the Wandsworth community team for older people, staff called patients or carers prior to appointments to remind them. If patient did not attend an appointment twice, the doctor or nurse would arrange to see the patient at home. There were examples in other teams of where staff met patients in GP surgeries where they were reluctant to attend appointments at mental health settings. The trust monitored patients who did not attend (DNA) appointments. If the target for the team was missed an action plan was put in place.
- In Kingston there had been a re-organisation of the administrative support to a centralised team. At the time of the inspection, whilst the service was starting to improve there were still lots of teething problems. This was having an impact in particular on the community teams working in the borough. Ongoing problems being described by large numbers of staff included appointment letters not being sent out, delays in information being sent to GPs. This was potentially a risk for the patients concerned. For example, when we visited the older persons team in Kingston, the doctor could not find patient care plans on the system ahead of an appointment at the memory clinic. The administration hub had failed to prepare them. The doctor had to spend time contacting the administration hub to access the information that was needed. In the adult community team staff felt this led to problems in booking follow up appointments and reviews. The trust had recognised that this was an issue and had begun to implement measures to improve the arrangements but this was still a work in progress. A number of measures had been put into place including the use of a digital transcription software to speed up the production of letters. The trust have said that at the time of the inspection, the longest delay for a letter from the Kingston adult recovery support team was 10 days.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust provided services from a range of buildings. Most inpatient services had access to a range of facilities including quiet lounges, rooms for therapeutic activities and outside space. In some areas there had been considerable thought given to making the environment as pleasant and comfortable as possible. An example of this was on Aquarius ward for young people where in the main communal area of the ward there were sofas and bean bags, along with books, board games and a television. The atmosphere on the ward felt welcoming and relaxed. On the wards for older people there were attractive enclosed gardens with outside seating ares. On Wards 2 and 3 and Lilacs ward patients also had areas for gardening and growing vegetables.
- The wards tried to afford patients with privacy and dignity. Overall the patient led assessment of care (PLACE) score for privacy, dignity and well-being was 92% which was just above the national average. However, not all facilities promoted patient dignity and privacy. On Lavender acute ward there were panels set into bedroom doors to allow staff to observe patients in

their rooms. But patients were unable to open or close the panels from inside and some panels had been left open, potentially compromising patients' privacy. This contrasted with the other acute wards were patients were able to close the same panels on their doors. On Jupiter acute ward patients complained individually and during their community meeting that there was a gap between the door and the wall on both male and female toilets. We inspected these facilities and saw that a gap of approximately a centimetre existed between the door and the wall. When asked staff explained that this gap was necessary to permit the doors, which were thick, to close. However, these gaps made it possible when standing close to see into part of each toilet compromising the privacy of patients.

- In some of the community teams for adults and the Kingston CAMHS base, it was noted that the meeting rooms did not provide sufficient soundproofing meaning the confidential discussions could be heard in adjoining rooms. This sould compromise people's privacy.
- On most wards patients could use their own mobile phone or had access to a ward phone. On Phoenix Ward which was a rehabilitation service, the ward phone was in a main corridor and meant patients could not have conversations in private.
- Most of the wards had somewhere secure for patients to store their personal possessions or people were able to lock their bedroom door.
- Most of the patients were positive about the quality and variety of food. The PLACE score for food was 87% again just above the national average. For example on the wards for older people patients were asked earlier in the day for their meal choice. Additional meals were also provided incase patients changed their mind once the food was served. A sandwich could be provided if people did not like the meals. Where needed there was access to dietary supplements, a soft diet and other specific dietary needs. Staff were aware of where patients needed encouragement to eat or needed additional support. The food was presented well and the tables were laid with access to drinks and condiments. The wards could also make toast or a sandwich, although one member of staff on Crocus ward said on occassions that the bread, milk and butter could run out. On the rehabilitation wards there was also positive feedback about the food. Patients at Burntwood Villas were self-catering and bought and prepared their own food. On all wards hot drinks and snacks were available although arrangements for how these were accessed varied.
- Access to therapeutic activities were generally very good for people using inpatient services. For example on the forensic wards There was a good range of activities and groups available to patients on all of the wards throughout the week. Patients told us that fewer activities took place at the weekends and staff on the wards did not always facilitate groups. Both recreational and therapeutic activities were on offer, for example music, art therapy, horticulture, further education, meal preparation and health and fitness. Patients spoke highly of the occupational therapy service and the sessions provided. One to one sessions were provided for those patients who were unable to leave the ward to attend group sessions. Some patients on Hume ward attended the Recovery College which was on the hospital site. There was a patient run café which was available two days of the week. Patients prepared and cooked food which was then sold at the café. Where possible patients used seasonal vegetables that had been grown on the onsite allotment/horticulture area. This enabled patients to engage in meaningful activity and gain work experience. On Aquarius ward the young people attended an on-site school during the week. Other recreational, physical and creative activities took place on the ward. However, the provision of an activities co-ordinator had been reduced from full-time to 15 hours per week. This has meant that activities including the daily planning group and mindfulness walking group had, at times, been cancelled, especially when nurses had to prioritise patient observations and manage a heightened risk level. On the acute wards the therapeutic activites were felt to be a good quality but patients said they would like to have access to more activites at the weekends.
- In the rehabilitation services access to therapeutic activities to promote peoples recovery needed to improve. Here with the exception of Burntwood Villas there was little evidence of patients being supported to access a programme of activities that promoted the development of skills so they could live more independently.
- The well established recovery college provided educational courses for patients , staff and carers/

relatives. The college had venues across the five boroughs and at Springfield hospital. Further modules were being developed after input from staff, service users and carers.
- The trust also worked in partnership with other third sector providers to support patients back into employment and employment opportunities were provided by the trust such as peer support workers.

Meeting the needs of all people who use the service

- The trust was aware of the make-up of the local population. Twenty five per cent of the population in the five London boroughs served by the trust came from black, Asian and minority ethnic groups. More than 100 languages were spoken locally with the most common being Polish, Bengali and Gujarati. The proportion of the population for whom English was not their first language was 15%.
- The trust equality strategy for 2016-2020 had been approved by the board in February 2016. The strategy included an action plan and equality objectives. The strategy says how the trust will work in partnership with patients, carers and staff to improve equality of access, experience and opportunity. The trust had an equality and diversity lead. It wants to have a trust lead for each of the protected characteristics.
- The trust was aware of the make-up of the workforce in terms of seven of the nine protected characteristics. The trust collected information about staff as part of its general equality duty' as set out in the Equality Act 2010. Information was used to improve equality of opportunity between people who shared a relevant protected characteristic and those who did not.
- Trust-wide spiritual and pastoral care offered chaplains at Tolworth, Queen Mary's and Springfield Hospitals. At least one chaplain was always available from Sunday to Friday. We also heard how individual services supported patients to spend time with faith leaders where they requested this support. The estates strategy included having more multi-faith rooms which was identified as being important through feedback from staff. The trust had worked with many faith communities, to support people to access psychological therapies and also to address the stigma of mental health.
- The trust had a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care were reasonably adjusted to meet the health needs of these patients. The trust provided readily available and comprehensible information to patients with learning disabilities. The trust was providing training on easy read and plain English for a core group of staff as part of 'making health & social care information accessible'. A network of learning disability champions had been recruited.
- Interpreting services were readily available.
- Deaf staff told us the trust had encouraged them to undertake nurse training. The trust provided British sign language interpreters to help deaf staff participate in staff focus groups during the inspection.
- Occupational therapists had received disability awareness training and acted as specialist disability champions in their particular ward or team.

Listening to and learning from concerns and complaints

- Information about how to complain was displayed on posters in inpatient areas and in community services. 'Comments, complaints and compliments' leaflets were also located across the trust. Feedback leaflets had a gummed strip so they could be returned to the complaints team in confidence, although a stamp was needed. Leaflets could be supplied in any language or braille by telephoning the number on the back of the standard version. The trust website contained information about how to complain, the complaints process and how to get help to make a complaint. The website also contained a British Sign Language video about how to give feedback or complain. Separate Patient Advice and Liaison Service (PALS) feedback leaflets were also available.
- People who we spoke with across the trust generally knew how to make a complaint. Complaints were welcomed in writing, verbally or via feedback leaflets. The PALS phone line was manned during weekdays and messages could be left at other times. PALS also held routine surgeries on inpatient wards, as did members of the patient experience team, in order to gather feedback. In addition to this, feedback surgeries could be requested by ward managers when they felt they might be necessary. The trust was working towards

finding a similar feedback vehicle for community services. Staff had recently gathered feedback from community patients using computer tablets and some community hubs had permanent feedback stands.

- During the period 1 March 2015 to 29 February 2016, 511 complaints were received by the trust. Of these, 199 were upheld (120 partially) and five were referred to the Parliamentary and Health Service Ombudsman (PHSO). During the same period 1291 compliments were received. There were 15 concerns received by PALS in November 2015, a decrease by two on the previous month. Of these, 85% were resolved within 5 days, which remained above target. The Richmond mood and anxiety community mental health team received 29 complaints, which was the highest number by location in that timescale. Also, 22 complaints were received about Lilacs ward, 20 about Jupiter ward, and 19 about Ward Two (all acute wards for adults) during the same period.
- The trust aimed to acknowledge formal complaints within 3 working days and responded to them within 25 days. The patient experience department consistently achieved this target and all key performance indicators around timeliness had been met over the past few years. Formal complaint responses since February 2016 were signed by the chief executive.
- All informal and formal feedback was fed into a central database which was used to inform the integrated governance group, which fed into the board. Service user experience group meeting minutes also went to the integrated governance group. Themes and specific learning areas were identified by the integrated governance group and clinical leads could access their findings and feed back to front line staff. The most common complaint categories identified were treatment, values and behaviours, and communications.
- We reviewed 10 complaint files and responses provided to complainants by the trust. Investigation notes were included in the files and we could clearly see how responses had been reached by the investigator. Complaints were consistently acknowledged within three working days. We found evidence that face to face meetings with complainants had taken place so the process could be clearly set out in the most appropriate way. Only one of the complaints we reviewed was responded to after more than 25 days. This was because a root cause analysis was necessary, which could take up to 45 working days to complete. The expected delay was clearly communicated with the complainant at the beginning of the process.
- Responses followed a consistent format that included numbered summaries. The points raised in the initial complaint were numbered and then addressed consecutively and details of the PHSO were routinely supplied. Of the complaints we reviewed, two were withdrawn. One of the files clearly documented a conversation with the complainant where they had said they did not wish to receive a withdrawal letter from the patient experience team. The other complaint was marked as having been withdrawn, but there was no evidence of a withdrawal letter being sent to the complainant.
- One of the responses we reviewed stated that the complaint had been referred as a safeguarding concern, but it did not follow the normal response format where the points raised were reiterated and addressed chronologically in a compassionate way.
- A complaints satisfaction survey was launched in March 2016 and there had been no returns at the time of the inspection. If a complainant was dissatisfied with the process their complaint could be logged again for a different patient experience lead to reconsider the points made. Complainants could also meet with the serious incident lead and relevant clinical lead if they were not satisfied with the complaints process in order to find a solution. The patient experience team could refer people to the PHSO and clearly set out the ombudsman principles when necessary.

Good

Are services well-led?

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.

Summary of findings

We rated well led as **good** for the following reasons:

- Teams across the trust recognised the visions and values and how these were applied in their day to day work.
- The trust had robust governance processes in place from ward to board and the quality of information enabled staff across the trust to know where improvements were needed.
- The trust board provided a high standard of challenge and held the executive team to account.
- The chief executive and senior executive team, despite going through a period of change, displayed a high level of commitment to ensuring high quality services for people using services provided by the trust.
- The trust in the main has a healthy culture and works hard to engage with people who use services and staff.

However, the rehabilitation services need strong leadership to ensure they deliver their goals and support patients to achieve greater independence. Senior staff need to ensure that they regularly engage with staff working in community teams. Some staff in the adult community needs need support to have the correct management information. A couple of final fit and proper person checks need to be in place. The whistle-blowing process needs to be made more accessible for staff. Whilst plans were progressing across services on the acute care pathway and specialist services for accreditation with the quality improvement peer review schemes operated by the Royal College of Psychiatrists, this had not yet been fully implemented.

Our findings

Vision, values and strategy

- The mission of the trust was 'making life better together'. Their vision was to 'aspire to be a cost effective centre of excellence, a place where patients choose to be treated, where clinicians want to train and work, and where stakeholders want to work with us'.
- The trust had six values which were developed from a number of staff listening into action events and these were to be open, respectful, collaborative, compassionate and consistent.
- Staff throughout the trust had a good understanding of the trusts vision and values and how these were applied in the services where they worked.
- The trust had a five year strategy document which detailed quality objectives and the measures the trust will use to regularly evaluate progress. Its objectives were to improve quality and value, improve partnership working, improve coproduction, improve recovery, improve innovation, improve leadership and talent. The trust had a clinical strategy linked to a quality strategy and this detailed the delivery of recovery, co-production and partnership working.
- At the time of the inspection the trust was expecting an end of year surplus of £3m and they recgonised the area where the most control on costs was needed was agency staff spending.

Good governance

- The trust had a very robust governance structure. This meant that from ward to board there was a good understanding of the key challenges facing the trust.
- The trust governance structure operated at three levels. Firstly there was assurance through the board assurance framework and the quality and safety assurance committee. Secondly through scrutiny at the directorate level clinical governance committees and finally through monthly directorate performance review meetings to monitor delivery.

Good

Are services well-led?

- The trust had a board performance and quality report. This was broken into the five domains used by the Care Quality Commission. This expanded on key performance data and showed trends and described how they were being addressed. A summary of this was provided in a performance quality dashboard. These were comprehensive documents and provided assurance to the board.
- There were five committees that fed into the board, quality and safety assurance, finance and investment, audit, renumeration and the executive management committee. Sitting under the quality and safety assurance committee there are other groups covering health and safety, clinical practice, serious incidents, information governance, mental health law (MHA and MCA), service user experience and safeguarding children and adults.
- The trust was divided into directorates. These were borough based and there was a separate directorate for CAMHS and specialist services. Each directorate had a clinical governance group and these each had access to a quality and performance dashboard.
- Wards and teams had access to a system that provided them with management information and also enabled them to provide data for the board performance and quality report. We heard that wards and teams had team meetings arranged where feedback and learning from incidents and complaints could be shared. In most cases, we heard that managers were using these systems to inform the improvements they needed to make in their services. In the adult community teams there were a few teams where the information was not being used. In the Central Wandsworth and West Battersea community team, East Wandsworth community team, Kingston recovery support team and Richmond recovery support team, the trust had not updated the system to reflect current team configurations. The merger of teams meant that managers had difficulty in monitoring KPIs and had to review multiple dashboards that were categorised under pre-merger names. This meant that managers might not address areas for improvement.
- All the teams could also access the risk register and add items of concern. These then fed into the directorate and corporate risk registers. Most of the team risk registers were up to place and issues were appropriately escalated.
- Where needed individual services were identified for additional support. At the time of the inspection Ward 2 (acute Springfield) had an executive led action plan in place to respond to a number of concerns.

Fit and proper persons test

- The trust was in the process of meeting the fit and proper persons requirement (FPPR) to comply with Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors of health service bodies are fit and proper persons to carry out their role.
- The trust was using the NHS Confederation assurance form and policy to implement its fit and proper person checks. The process for existing directors was self-declarations. For new substantive directors it is done via the recruitment process on appointment.
- We reviewed six personnel files which included three executive directors and three non-executive directors; the majority of whom had been in post prior to the FPPR coming into force in November 2014.
- Self-declarations for executive directors were included in the files which included a section on occupational health. A talk between non-executive directors and the chief executive officer about occupational health was also recorded. Photographic identification and certificates to prove professional qualifications and competencies were included in all of the files we reviewed. Insolvency and bankruptcy checks were recorded as having been undertaken, although evidence of the results from these checks was not included in the files. Detailed employment histories were generally included, often as part of the initial application form or CV, however there was no record of employment history for one of the non-executive director files we reviewed. References from substantive employers were not included in the files for the three non-executive directors.
- One of the executive director files did not contain a criminal record check, although the check had been marked as complete at the front of the file. The other files that we reviewed contained up to date DBS checks. Two of the non-executive director files contained recent application forms for DBS checks that were pending.

Good

Are services well-led?

Leadership and culture

- The trust had a recent history of some instability at a senior level. The current chief executive had been in post for four years but there had been two interim directors of nursing over the last year. The current interim director of nursing was well received and a permanent appointment had been made and the new post holder was starting after the inspection. At the time of the inspection the director of finance was on long term sick leave and an interim arrangement was in place. Staff working for the trust welcomed the leadership provided by the senior executive team, especially the chief executive.
- The chair joined the trust in 2011. There were six non-executive directors including the chair. The non-executive directors had expertise and experience that was relevant to the leadership of the trust. Four of the board members had originally trained as care professionals even if their careers had taken a different direction since then. This was reflected in the high quality of challenge and debate at the board meeting. The trust had recognised that it wanted to support more board board members from a BME background. At the time of the inspection a trainee non-executive director from a BME background selected through work with the NHS Leadership Academy was participating in board and quality& safety assurance meetings.
- At a team or ward level there were 11 vacant posts at the time of the inspection, but interim managers were in place. There were two areas where the inspection found that leadership skills needed improvement. The first was in the management of the rehabilitation services, where with the exception of Burntwood Villas the managers were not leading the services to promote the rehabilitation of people. The second was at the Central Wandsworth and West Battersea community team where the use of an interim manager was impacting on the smooth delivery of the service. In the specialist learning disability teams it was also noted that one manager had been covering two teams for a year while a permanent manager for one team was being recruited which was a long time.This was not impacting on the quality of care.
- External stakeholders felt the trust had improved in terms of its communication and its openness and transparency. Clinical commissioning groups said they appreciated the open and frank discussions they had been able to have with the trust leadership team and at the clinical quality review group. They felt the trust had responded to their challenges quickly and clearly when we had sought further clarification or had expressed concerns.
- The trust demonstrated that it was promoting a healthy culture. During the inspection staff were mostly very positive about working for the trust and said this was a good experience, even though they highlighted areas where they would like to see improvement. The staff sickness across the organisation was at 4.2% which was very average. The NHS staff survey 2015 which was published just before the inspection showed a small reduction in staff satisfaction from the previous year, where the results had been very positive. In the survey 48% of staff said they would recommend the trust as a place to work. This was below the average score for a mental health trust of 56%.
- Staff told us that they strongly valued the team working and mutual support. Staff did not feel bullied. We heard that staff felt able to raise concerns without fear of victimisation and many were able to give examples of where they were able to do this. Staff described a 'no blame' culture. Staff said they felt able to raise concerns through their line manager. The survey of medical trainees in the trust carried out in 2015 by the General Medical Council found no concerns about bullying. The NHS staff survey for 2015 found that the that the scores for staff experiencing harassment, bullying or abuse from patients, relatives or the public and staff was very similar to the national average.
- In this inspection we looked at how the trust recognised the diverse needs of the workforce and actively promotes equality and diversity. We undertook a pilot inspection of the implementation of the Workforce Race Equality Standard (WRES). The WRES is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation. We inspected how the trust had implemented the WRES, and the Equality Delivery System 2 (EDS2), which trusts must complete to demonstrate compliance with all protected characteristics in the Equality Act 2010, in all our inspections from April 2016. The trust held

detailed information on the equality characteristics of its workforce. This was acknowledged in its most recent WRES report, which was shared with the board in June 2015, along with an accompanying action plan. Key findings from the WRES report showed that 17.4% of BME staff held senior management positions (band 8a and above for non medical staff) compared with the overall workforce which was 44.5% BME, the ratio of BME staff compared with white staff being shortlisted for posts was 0.09 compared to 0.2. BME staff were 3.75 times more likely to enter disciplinary proceedings than white staff. The human resources department held overall responsibility for the delivery of the action plan. The trust had also appointed one whole time equivalent equality and diversity lead for a twelve month period to assist with delivery. The department had experienced changes at senior management level, which had impacted negatively on the delivery of the plan. More than nine actions in the report had not been delivered by the stated October 2015 target. Staff responsible for delivering the plan acknowledged that it had been over ambitious in terms of time scales and limited resources. Work continued to achieve the WRES goals and this was a priority for the trust. The trust had identified four staff members who had were participating in the Academy's Ready Now leadership programme and intended to utilise the learning from the group to support the comprehensive inclusion of staff from a BME background.

- The trust had delivered a programme of unconscious bias training to all recruiting managers (over 50 staff members of staff), which had been made mandatory for all recruiting managers since January 2016. Unconscious bias refers to a bias that people are unaware of, and which happens outside of their control. It happens automatically and is influenced by people's background, cultural environment and personal experiences.

- Much of drive behind the race equality strategy in the organisation came from the established, active and open to all, BME staff network called Evolve. This group had independently established an inclusive leadership mentoring programme for BME staff in the trust, which was in its' third year. Funding had been secured to train and accredit staff as mentors. Staff feedback showed that 80% of mentees had achieved what they stated at the start of their mentoring. Evolve also ran mentoring schemes within the local community to tackle the stigma surrounding mental health conditions for young people aged 16 to 25. They provided regular networking events and an annual conference with evidence based workshops targeted to encourage and support BME staff into senior posts. Members of Evolve that we spoke with felt the work they had undertaken was not well recognised across the trust, although they appreciated the support of the chief executive, who was the patron of the Evolve BME staff network.

- The inspection team met with BME staff from across the trust in a focus group. Staff acknowledged that there had been improvements in the trusts' approach to inclusion and equality. However, some staff felt that there were still occasions when senior staff demonstrated non-inclusive behaviours. White and BME staff had almost identical access to non-mandatory training and promotion. However, some BME staff felt that it was difficult to gain promotion within the trust. One staff described the experience as having 'sticky floors and a glass ceiling'. Whereas another staff member had a much better experience and had been supported to move up through the grades quickly. Having BME managers on the recruitment panel increased staff confidence in the fairness of the process.
- There had been no internal whistle blowing in the trust in the last 12 months. There had been 4 whistle-blowing concerns raised with the Care Quality Commission in the six months prior to the inspection about specific services, which showed that a few staff do want to access support outside their line management structure. The trust had not yet appointed a speak up guardian. Freedom to speak up guardianshelp raise the profile of raising concerns in their organisation andprovide confidential advice and support to staffin relation toconcerns they have about patient safety and/or the way their concern has been handled. However, there were staff support advisors in place and the adult safeguarding lead had let staff know that they were available to talk confidentially about staff concerns. The whistle blowing procedure was quite complicated and signposted staff to a number of routes. A whistle blowing helpline number was not displayed throughout the trust.
- The trust recognised the importance of staff engagement. The main methodology used for this work

was 'listening into action' which had led to a number of initiatives. The trust was also using 'back to the floor initiatives' where senior managers were working in teams or wards.

- The trust was also using a number of measures to communicate with staff. This included the chief executives weekly message, team brief and the CEO open sessions. There was also a monthly conference for 150 senior leaders across the trust supported by a leadership briefing system. In the NHS staff survey 2015, 31% of staff surveyed reported good communication between senior management and staff which was below the national average of 40%.
- The inspection found that most staff working in inpatient services knew the senior managers in the trust and felt they had regular contact with managers. The community teams for adults and older people gave more mixed feedback and would benefit from more contact, especially at times of organisational change. It was also noted that the morale on Crocus ward for older people needed to improve.

Engaging with the public and with people who use services

- The trust had a shadow council of governors. This group met four times a year and consisted of service users, carers, staff and local representatives such as councillors. The governors felt valued and had contributed to thinking about the trust strategy. Governors were also asked to help with in-house inspections and other engagement activities. They would like meetings to be minuted with agreed actions. Some members say they had received training (often through other roles) and some would like training to support them to perform this role.
- The trust had recently aimed to enage with the public through a series of mental health seminars led by clinicians open to people. Also a co-produced involvement event took place with service users, carers and local communities in attendance to agree a framework going forward for co-production work.
- The trust has recently established a patient quality forum chaired by the medical director which had met four times and was still developing its terms of reference. The service users who were on this group had been offered a leadership development programme which had been greatly valued. So far 11 out of 18 places on the forum had been filled. The trust also had a carers, friends and family reference group.
- The trust has protocols in place to encourage the representation of people with learning disabilities and their family carers. A learning disability workshop for staff included service user stories. Staff and people using the specialist learning disability community team services provided by the trust, felt that more could be done to ensure people with learning disabilities were engaged fully in the work of the trust.
- External stakeholders said the trust was committed to hearing the patient voice throughout the organisation and carers and users of the service were represented at a number of internal and external meetings. For example there was a carer and user representative on the quality and safety assurance committee and we observed that they participated fully in the meeting.
- There were numerous mental health service user groups and user led organisations across South West London, including forums set up within the trust to provide feedback and foster involvement in local trust services. These included, for instance, the Sutton and Merton User Reference Group which met bi-monthly with trust senior and operational managers.
- Training workshops took place for service users and carers so they could help with staff recruitment.
- Service users and carers were encouraged to give feedback and this was through the patient opinion website, real time feedback using kiosks and tablets in wards and teams, the friends and family test and talking to PALS. We did hear that the tablets for real time feedback did not always work very well away from the team base and the technology around this needs to improve.

Quality improvement, innovation and sustainability

- The trust provided several management and leadership courses for staff. The courses helped equip managers with the skills they needed to develop their teams, such as, spotting early signs of poor performance and coaching skills. The trust ran a six month development programme for band 6 nurses. Five nurses who

Good

Are services well-led?

completed this programme subsequently moved into management roles. The trust held a monthly band 7 development day to improve the knowledge and skills of ward and team managers.

- The trust supported staff to attend leadership courses including Masters level courses and a paired learning programme run by Health Education England. The trust had formed a link with the local acute trust. Six nurses from the acute trust came to work in the trust for a fixed period to broaden their skills. The trust intended to reciprocate and send six nurses to work in accident and emergency, paediatrics and medical wards in order to improve their knowledge and skills in respect of physical health care.
- The trust has been very successful in supporting health care support workers to become qualified nurses. Ten staff had followed this route recently and were undertaking nurse training at a university.
- Other leadership initiatives had included an executive team development programme, supported attendance at the NHS leadership academy top leaders programme and Kings Fund leadership courses, providing coaching for managers.
- The trust participated in research and development through a 'clinical and academic hub'. There were two discrete clinical research units, the psychiatry of old age and neuropsychiatry (started autumn 2013) and the general psychiatry and allied disciplines (started November 2014). They carried out a wide range of mental health research. For example researchers had been awarded a £1.95m grant to pilot and trial peer worker intervention for patients being discharged from inpatient to community mental health care. The trust also had the highest recruitment rates in the country for its 'impact of illness in schizophrenia study'.
- The trust was developing opportunities to extend the use of technology in delivering care and treatment. For example a project in using skype for outpatient appointments had gone well and was going to be extended. The pharmacy team had developed an app that will be available to help with the safe prescribing, administering and monitoring of lithium.
- The trust had very few services accredited with schemes operated by the Royal College of Psychiatrists centre for quality improvement. At the time of the inspection the ECT services at Springfield were accredited and the Merton home treatment team. Also the psychiatric liaison team at St Georges and a CAMHS inpatient service were accredited. A few other services in forensic and child and adolescent care were participating but not yet accredited. The trust said it hoped to further develop this work going forward.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Forensic inpatient wards** Service users were not protected from abuse and improper treatment because the provider operated restrictive practice with the use of time management practices, which had not been recognised as seclusion practices. Patients subject to these practices did not meet the safeguards set out in the MHA Code of Practice. **Child and adolescent mental health wards** Service users were not protected from abuse and improper treatment because the provider operated practices, which had not been recognised as seclusion practices. Patients subject to these practices did not meet the safeguards set out in the MHA Code of Practice. This was a breach of 13(5)(7)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way and the trust done all that was reasonably practicable to mitigate the risks. **Rehabilitation mental health wards** The trust had not ensured that all risks identified in risk assessments had associated plans to mitigate this risk. **Community based mental health services for older people** Care and treatment should be provided in a safe way for patients. There must be the proper and safe management of medicines.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
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 **Rehabilitation mental health wards** The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed and that they had the appropriate supervision and support to enable them to carry out their duties they are employed to perform. The trust had not ensured that staff were receiving regular supervision to enable them to carry out their role. The trust had not supported the managers to be effective leaders to implement a recovery-orientated approach across all the rehabilitation services. **Community based mental health services for adults of working age** Staff need to receive appropriate support , training and supervision to enable them to carry out the duties they are employed to perform The trust had not ensured that staff were receiving regular supervision to enable them to carry out their role. Medication at Sutton, Merton and Richmond was not stored, administered and transported in a safe manner at all times. **Community based mental health services for adults of working age** Care and treatment must be provided in a safe way for patients The trust did not ensure that individual patient risk assessments were updated to reflect surrent risk. The trust did not ensure there are safe systems for the administration, storage and transportation of medication. This was a breach of Regulation 12 (2)

This section is primarily information for the provider

Requirement notices

Wards for older people with mental health problems
The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed and that they had the appropriate supervision and support to enable them to carry out their duties they are employed to perform.

The trust had not ensured that staff on Crocus ward were receiving regular 1:1 supervision.

Mental health crisis services
The trust had not ensured that staff had the appropriate supervision and support to enable them to carry out their duties they are employed to perform.

The trust had not ensured that staff were receiving regular supervision to enable them to carry out their role.

This was a breach of Regulation 18 (2)(a)

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

Rehabilitation mental health wards
On some wards patients were not receiving appropriate care to support their recovery and rehabilitation and meet their needs

The trust did not ensure that the operational policies promoting rehabilitation were implemented on all the wards. This included providing a range of therapeutic activities that supported people with their rehabilitation.

This was a breach of Regulation 9(1)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Community based mental health services for older people

Systems or processes must be established and operated effectively to ensure compliance.

In the Kingston team administration support was not working well and letters were not reaching patients and GPs in a timely manner, and information needed to deliver care was not always available to staff when they needed it.

Community based mental health services for adults of working age

Systems or processes must be established and operated effectively

In the Kingston team administration support was not working well and letters were not reaching patients and GPs in a timely manner which could also impact on patients receiving details of their next appointment.

Changes in the configuration of teams, meant that team mamagers were not always receiving performance informance that related correctly to their current team.

This was a breach of regulation 17(1)