

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

## Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall trust quality rating

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

## Background to the trust

South West London and St George's Mental Health NHS Trust provides a range of mental health services in south west London. The trust serves a population of 1.2 million people across the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth and employs more than 2,000 staff who provide care and treatment to about 20,000 people from south west London and beyond. The trust has more than 100 clinical teams. The trust provides community and outpatient services in each of the five boroughs as well as many national services such as those for people with eating disorders, obsessive, compulsive disorder and national deaf services for children and adults. The trust has 391 inpatient beds across 25 wards, 30 of which are children's mental health beds.

The annual turnover of the trust is approximately £170 million.

The trust provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care unit
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Forensic inpatient/secure wards
- Mental health crisis services and health-based places of safety
- Community-based mental health services for older people
- Community-based mental health services for adults of working age
- Community services for people with learning disabilities or autism
- Specialist community mental health services for children and young people

The trust also provides the following specialist services:

- Specialist eating disorder services
- Substance misuse services
- National deaf services
- Other national specialist services

The trust operates from four registered locations: Springfield University Hospital; Tolworth Hospital; Queen Mary's Hospital in Roehampton; and the Trust Headquarters.

The trust has been inspected nine times since 2014. The last comprehensive inspections took place in January and February 2018 and well-led review in April 2018. At this inspection we rated the trust Good overall and good for all key questions – safe, effective, caring, responsive and well-led. Following that inspection, we rated all trust core services as

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Good** ● → ←

# Summary of findings

## What this trust does

South West London and St George's Mental Health NHS Trust provides mental health services in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. This includes a range of inpatient and community mental health services. The trust also provides specialist national services for adults, older people, children and young people, people with learning disabilities, and deaf children and adults.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five core and specialist services as part of our ongoing checks on the safety and quality of healthcare services. We carried out comprehensive inspections of four core and specialist services:

- Wards for older people with mental health problems
- Forensic inpatient/secure wards
- Mental health crisis services and health-based places of safety
- Specialist eating disorder services

In addition, we carried out a focused inspection of Acute wards for adults of working age and psychiatric intensive care unit. We inspected five of the trust's eight acute wards and the psychiatric intensive care unit. We looked at the key questions of safe and effective only.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led'

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated four of the five core and specialist services we inspected as good overall. Following the inspection 11 of the 12 core and specialist services in the trust were rated good overall.
- We rated well-led for the trust overall as good.

# Summary of findings

- There was good, effective leadership at all levels of the organisation. The trust senior leadership team was visible across the trust and modelled openness and transparency. Work had been carried out to co-produce a values and behaviours framework, which staff were positive about. The senior leadership team were compassionate and acted in accordance with the values. Since the last inspection the trust had completed work on a co-produced organisational strategy with defined strategic ambitions.
- There had been a number of recent appointments into permanent and temporary posts across the executive and non-executive teams. The team understood the plans for development both internally and externally and the size and complexity of the change agenda. Governance structures and processes had been strengthened throughout the organisation. The trust was well aware of the clinical areas they needed to improve, especially the quality and safety of care and leadership on the specialist eating disorder ward for children and young people.
- Since the last inspection in 2018 the trust had made improvements in a number of areas including in the physical health care of patients and the way patients were cared for after receiving rapid tranquilisation. Patients had good access to physical healthcare and were supported to live healthier lives.
- Services had enough staff with the right qualifications, skills, training and experience to keep patients safe and provide the care and treatment patients needed. Staff recruitment campaigns and efforts to retain staff were ongoing. The learning and development needs of staff were identified and prioritised through annual appraisals and regular clinical supervision. There were good opportunities for specialist training and professional development. Since the last inspection the trust had introduced a leadership development programme accessible to staff at all levels.
- Staff assessed and managed risks to patients well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. The trust was implementing a 'safety in motion' programme across inpatient wards, which had resulted in a significant reduction in the use of restraint and seclusion in the forensic wards.
- Managers investigated incidents and complaints and shared the lessons with staff to minimise the risk of them happening again. Since the last inspection the trust had involved patients and carers in improving the tone of complaint response letters, so that they were less corporate and conveyed empathy.
- Staff and service leaders understood their risks and were able to report them and escalate them when required. The board assurance framework was used actively by the board. The senior leadership recognised the need to do more to clearly link the framework to the strategic ambitions of the trust.
- Staff provided care that was personalised, holistic and recovery-oriented. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Staff were proactive in involving families and carers in patient care, when appropriate. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff from different disciplines worked well together to benefit patients. They provided a range of care and treatment interventions consistent with national guidance on best practice. Teams collaborated with each other and with external agencies. The trust worked well with partners, recognising the complexity of the local landscape and systems, developing work with the South London Partnership and volume of potential partners and meetings. The trust understood the need to continually risk assess areas of focus and priorities.
- The trust collected, analysed, managed and used information well to support all its activities. Managers had access to the information they needed to provide safe and effective care and used that information to good effect. The way information was presented to the board had been improved making it easier to confidently identify trends, expected variation and areas of declining performance.

# Summary of findings

- The trust engaged positively with service users and staff. The board and senior leadership team had involved service users, carers, staff and other stakeholders in the development of a trust strategy. The patient involvement team had increased the number of service users and carers on the involvement register. Service user and carer representatives were visible and valued contributors to board sub-committees and working groups.
- Work on equality and diversity had progressed since the last inspection. There had been an increase in the number of staff network groups. Plans to improve workforce race equality had been reviewed and re-energised.
- The trust had appropriate arrangements in place in relation to Mental Health Act administration and compliance. Staff understood their roles and responsibilities under the Act and discharged these well.
- The trust had made progress with its quality improvement programme. Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles. The trust was committed to improvement and innovation.

However:

- In the specialist eating disorder ward for young people staff did not always assess and manage environmental risks effectively and staff took an overly restrictive approach to the care of young people without clear rationale or individual risk assessment. Staff did not understand how the Mental Capacity Act 2005 applied to young people aged 16 and 17 or the principles of Gillick competence as they applied to those aged under 16. The leadership of the ward needed strengthening to bring about improvements in care.
- The trust operated in a complex and changing environment and was engaged in the delivery of a multi-million-pound estate modernisation programme and the transformation of local community mental health services. The board needed to continue to review the board assurance framework regularly and re-examine the alignment of the framework in line with the evolving strategy and strategic aims of the organisation. The size and complexity of the ongoing change agenda and recent and immanent changes at board level, meant that the trust needed to continue to monitor and evaluate the capacity and capability of the senior leadership to ensure the continued delivery of high-quality services.
- Although the trust had made considerable progress in addressing equality and diversity issues in a range of areas further work was needed ensure equality and diversity was integrated into all areas of work throughout the organisation.
- The trust had a relatively low number of clinical psychologists providing therapeutic input across services. The provision benchmarked poorly against other similar trusts. Similarly, there were small numbers of social workers available across the trust to complement the work of multidisciplinary teams. This had a negative impact in terms of patient access to appropriate services.

## Are services safe?

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

- At this inspection we rated four of the five core services that we inspected as good for safe. When these ratings were combined with other existing ratings from previous inspections, 11 trust services were rated good for safe and one was rated requires improvement.
- Since the last inspection in 2018 the trust had made improvements in the way patients were cared for after receiving rapid tranquilisation. Staff carried out post rapid tranquilisation physical health checks in line with national guidance and trust policy. Staff regularly monitored patients' vital signs and escalated any concerns identified in line with agreed protocols to protect patients from avoidable harm. They responded promptly to sudden deterioration in a patient's health.

# Summary of findings

- Wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Clinical premises where community patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- The services had enough nursing and medical staff, who knew patients and received statutory and mandatory training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams was not too high to prevent staff from giving each patient the time they needed.
- In most wards staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Restraint and seclusion were used only after attempts at de-escalation had failed. In forensic wards, the use of restraint had reduced significantly. Staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had access to the clinical information they needed, and it was easy for them to maintain high quality clinical records, whether paper-based or electronic.
- Services used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on patients' physical health.
- The trust had a good track record on safety. Services managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with individuals, teams and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- In the specialist eating disorder ward for young people staff did not always assess and manage environmental risks effectively and staff took an overly restrictive approach to the care of young people without clear rationale or individual risk assessment. Staff in the specialist eating disorder ward for adults needed to do more to ensure that potential deterioration in patients' physical health was acted upon or record clearly why action was not being taken.
- Although medicines were generally well managed in services across the trust staff on one ward staff did not always dispose of expired medicines in a timely way, or ensure medicines were always in the correct packaging or labelled. Staff on wards for older people with mental health problems did not always have clear written instructions on how to safely administer medicines authorised to be administered covertly.
- The trust was aware that a high proportion of patient restraints in the acute wards and psychiatric intensive care unit took place in the prone position. The trust was acting to address this through implementing the safety in motion programme, but more work was needed to reduce the number of prone restraints and consequent risk to patients' safety.
- Although the trust had guidance in place, ward staff we spoke with were not clear about what to do if a patient refused to leave in the event of a fire.

## Are services effective?

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

- At this inspection we rated four of the five core services that we inspected as good for effective. When these ratings were combined with other existing ratings from previous inspections, 11 trust services were rated as good and one as requires improvement.

# Summary of findings

- Staff assessed the physical and mental health of all patients. Staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected the patients' assessed needs, were personalised, holistic and recovery-oriented.
- Staff received regular supervision and an annual appraisal. The trust provided all new staff with an induction to their place of work and access to ongoing training and professional development.
- Staff from different disciplines worked together to benefit patients. They supported each other to make sure patients had no gaps in their care. The wards and teams had effective working relationships within the organisation and with relevant services outside the organisation.
- Staff provided a range of care and treatment interventions consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The trust had appropriate arrangements in place in relation to Mental Health Act administration and compliance. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- Most staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The trust employed a relatively small number of clinical psychologists across inpatient and community services and benchmarked poorly against other similar trusts in terms of the number of clinical psychologists per number of inpatient beds. The lack of resilience in the system and limited numbers of clinical psychologists led to increased internal waiting times for patients referred to specialist psychological services and lack of cover for staff absence.
- On the specialist eating disorder ward for young people staff did not always support patients to make decisions on their care for themselves proportionate to their competence. Staff on Wisteria Ward did not understand how the Mental Capacity Act 2005 applied to young people aged 16 and 17 or the principles of Gillick competence as they applied to those aged under 16. Staff across different core services did not have easy access to Mental Health Act documentation confirming the legal authority to administer medicines to detained patients at the point of administration.
- There was a need for improvement in terms of recording and documentation in some teams. Although home treatment team staff made sure patients had support for their physical health needs from their GP or community services and regularly discussed these needs, staff did not always clearly record who had oversight and managed patients' long-term physical health conditions. Staff on a ward for older people did not always record patients' needs in respect of incontinence and how this would be addressed.

## Are services caring?

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

- At this inspection we rated all the core services we inspected as good for caring. When these ratings were combined with the other existing ratings from previous inspections, all trust services were rated good for caring.
- Across all services staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

# Summary of findings

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. On one ward staff and patients had developed a one-page care plan at the request of patients to make care plans simpler. Staff ensured that patients had easy access to independent advocates.
- Staff were proactive in involving families and carers in patient care when appropriate. Staff in the wards for older people documented the support needs of carers and close family members and sought to address them. A social worker provided additional support to relatives in respect of social care issues.

## Are services responsive?

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

- At this inspection we rated three of the four core services we inspected as good for responsive. When these ratings were combined with the other existing ratings from previous inspections, 11 trust services were rated good and one requires improvement.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons. The trust worked with external partners to address barriers to discharge.
- The design, layout, and furnishings of services and premises supported patients' treatment, privacy and dignity.
- Staff met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Services treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider services.

However:

- The trust had only recently started to reliably record and audit how many times patients waited longer than 24 hours in the health-based place of safety and whether an extension to their length of stay had been authorised. The trust was working to improve the overall quality of data going forward and was monitoring this closely.
- On the specialist eating disorder ward staff and young people complained that the food was not of good quality and the menus repetitive. Staff had not escalated concerns to the external caterer effectively.

## Are services well-led?

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

- There was good, effective leadership at all levels of the organisation. We rated three of the four core services we inspected as good, for well-led. Eleven of the 12 core and specialist services were rated good or better for well-led. The trust leadership team was visible across the trust and modelled openness and transparency. It continued to develop with a number of recent appointments into permanent and temporary posts across the executive and non-executive teams. The team understood the plans for development both internally and externally and the size and complexity of the change agenda.
- The trust had continued to make good progress and considerable improvement since the last inspection in early 2018. Areas of improvement included establishing a trust strategy, implementing a leadership development programme, complying with the accessible information standard, improving the quality of complaint responses and improving staff access to occupational health.



# Summary of findings

- The board and senior leadership team had set a clear strategy and staff were aware of what it was. Staff and service users had been engaged in the development of the strategy and their views had been incorporated. The board was aware of the immanent changes that may impact upon the strategy. Further work was to be completed to align the trust strategy with the developing health and social care system around it.
- The trust had a values-based culture, which was positive and open. There was a high degree of openness and transparency in the senior leadership team. Work had been done to co-produce a staff values and behaviours framework, which staff were aware of considered was useful.
- Work on equality and diversity had progressed since the last inspection. There had been an increase in the number of staff network groups. Plans to improve workforce race equality had been reviewed and re-energised.
- Governance structures and processes had been strengthened throughout the organisation. Committees demonstrated a responsive approach to what needed to be covered and agendas could be adjusted to accommodate these discussions. Items for escalation to the board were made clear in sub-committee meetings. The board had a clear structure for reviewing components of governance at meetings.
- The trust was well aware of the clinical areas they needed to improve, especially the quality and safety of care delivery and leadership on the specialist eating disorder ward for children and young people.
- The trust had improved its performance assurance processes. Risks were examined systematically, and detailed reviews of risk took place when required. Staff and service leaders understood their risks and were able to report them and escalate them when required. There was a board assurance framework (BAF), which was used actively by the board. The senior leadership recognised the need to do more to clearly link the BAF to the strategic ambitions of the trust.
- The trust engaged positively with service users and staff. Service users took part in staff recruitment and were active participants in board sub-committees and other decision-making meetings at all levels. Staff engagement was positive with a number of strategies to gain appropriate feedback. Staff focus group feedback at all levels was generally more positive than in previous years, recognising a changing culture with a focus on staff well-being and the modelling of trust values at a senior leadership level. However, positive outcomes of this work were yet to be demonstrated in staff survey results and other measures used by the trust.
- The trust collected, analysed, managed and used information well to support all its activities. Managers had access to the information they needed to provide safe and effective care and used that information to good effect. The way information was presented to the board had been improved making it easier to confidently identify trends, expected variation and areas of declining performance.
- The trust worked well with partners but understood there was further work to do on the risk assessment and governance of future partnerships that were developing, considering the complexity of the local landscape and systems, developing work with the South London Partnership and volume of potential partners and meetings.
- The trust was committed to delivering a quality improvement programme and had clearly invested in this across the organisation. Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles. The trust had a clear mortality review process and learning and support aligned to this. Learning was evident from recent work within the South London Partnership.

However:

- The trust operated in a complex and changing environment and was engaged in the delivery of a multi-million-pound estate modernisation programme and the transformation of local community mental health services. The board needed to continue to review the board assurance framework regularly and re-examine the alignment of the

# Summary of findings

framework in line with the evolving strategy and strategic aims of the organisation. The size and complexity of the ongoing change agenda and recent and immanent changes at board level, meant that the trust needed to continue to monitor and evaluate the capacity and capability of the senior leadership to ensure the continued delivery of high-quality services.

- Although the trust had made considerable progress in addressing equality and diversity issues in a range of areas, further work was needed ensure equality and diversity was integrated into all areas of work throughout the organisation. For example, the trust research strategy did not formally consider equality and diversity and access to psychological therapies was not monitored for equity.
- The trust had a relatively low number of clinical psychologists providing therapeutic input across services. The provision benchmarked poorly against other similar trusts. Similarly, there were small numbers of social workers available across the trust to complement the work of multidisciplinary teams. The importance of clinical psychologists and social workers to the delivery of high-quality care and treatment to patients was recognised and they were valued by staff in inpatient and community settings.
- Most teams and wards across the trust were well-managed and led by competent staff. Leadership on the wards for older people was particularly strong, ensuring the delivery of a high standard of care throughout. However, the leadership arrangements across the specialist eating disorder service needed strengthening to enable the delivery of high-quality care and treatment and to achieve the best clinical outcomes for children and young people.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in all five services we inspected:

- Wards for older people with mental health problems
- Forensic inpatient/secure wards
- Mental health crisis services and health-based places of safety
- Specialist eating disorder services
- Acute wards for adults of working age and psychiatric intensive care unit

For more information see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 11 Need for consent; Regulation 12 Safe care and treatment; Regulation 13 Safeguarding service users from abuse and improper treatment; Regulation 14 Meeting nutritional and hydration needs; and Regulation 17 Good Governance.

There were six things the trust must put right in relation to breaches of these five regulations. In addition, we found 30 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

# Summary of findings

For more information see the areas for improvement section of this report.

## Action we have taken

We issued requirement notices in respect of the five regulations that had been breached within one specialist service.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

### Trust wide

- The trust had set up an expert panel to look at the experience of black, Asian and minority ethnic (BAME) patients who were over-represented in in mental health services, particularly inpatients, and less likely to use talking therapies. The panel was chaired by an academic expert in the field. The expert panel was committed to developing a work programme to make trust services appropriate to BAME needs and ensure equitable, safe and effective mental health care. The co-production of services was central to the work of the panel. The trust catchment area is ethnically diverse with 28% of the population from a non-white background. The trust was working with local partners. The project was starting with an ethnicity audit of mental health care to identify the nature and extent of ethnic disparities in mental health care. This would be followed by the development a whole system intervention package to improve quality and safety in mental health care and address ethnic inequalities.
- The pharmacy team had written a successful business case for a project on medicines optimisation in care homes for people living with learning disabilities. Since the start of the project in January 2019, the trust had calculated a cost avoidance in excess of £60,000. The project had received praise from GPs and other stakeholders across the five boroughs.

### Wards for older people with mental health problems

- Staff provided excellent support to families and carers, considered their needs and were proactive in involving them in their relative's care. The social worker held a social care surgery every week, supporting carers in the consideration of future placements. Staff developed specific care plans for carers to ensure their own needs were met.
- Staff provided a very high standard of physical health care and treatment to patients. Records of physical health assessments and treatment were detailed. Staff proactively obtained and followed up physical health investigations and results to support the delivery of effective care. Doctors worked very well with specialists from other health care organisations to provide the best possible care to patients. Staff ensured that physical health monitoring of patients' vital signs was undertaken and recorded to a high standard, including after every use of rapid tranquilisation.

### Forensic inpatient/ secure wards

- The trust's 'safety in motion programme' was part of the provider's reducing restrictive interventions programme. Staff and patients were positive about the impact 'safety in motion' had had on the wards. Staff were committed to using the least restrictive practice and this was evident in the low usage of restraint, seclusion and rapid tranquilisation across the service.

### Mental health crisis services and health-based places of safety

# Summary of findings

- Lotus Suite and health-based place of safety staff took part in a rotational programme for nurses in partnership with local acute trust emergency department. Mental health nurses rotated with physical health nurses from the emergency department to share and build the skills and knowledge in respect of mental and physical health.
- In the Lotus Suite staff took part in wellbeing huddles, where they gathered for reflective practice and to encourage healthy living and appreciation for the work they did.

## Specialist eating disorder services

- On Avalon Ward, the occupational therapist developed a 'Your Group, Your Say' workshop where patients could make suggestions for new ward groups and then vote on what activities they wanted.

## Acute wards for adults of working age and psychiatric intensive care unit

- The trust had introduced the 'safety in motion' programme on the acute wards and PICU. The programme involved the introduction of eight evidence-based interventions aimed at reducing violence and aggression on the wards. The interventions had been gradually introduced on the acute wards since May 2019 following a successful pilot. As part of the implementation of 'safety in motion,' ward staff had co-produced with patients a set of clear mutual expectations these were individual to each ward. Mutual expectations helped clarify expected behaviours on wards and address lack of consistency between staff.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

### Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with legal requirements. These six actions related to one specialist service.

#### Specialist eating disorder services

- The trust must ensure that in the eating disorder service information about patients' physical health care is recorded accurately and that the information is transferred promptly on to patients' electronic records so that it can be followed up quickly when concerns are identified. Where decisions have been made not to escalate concerns these should be clearly recorded in patient care plans. **Regulation 12 (1)(a)(b)**
- The trust must ensure that all staff in the eating disorder service know where potential ligature points are throughout the ward and how the risks are mitigated. All staff, including temporary staff must be aware of where the ligature cutters are located. The induction pack for new staff must include where the ligature points and ligature cutters are on the ward, especially on Wisteria Ward. **Regulation 12 (1)(a)(b)**
- The trust must ensure they review the use of overly restrictive blanket restrictions on Wisteria Ward to ensure that they are appropriately applied and based on patients' individual needs and risks. **Regulation 13(4)(b)**
- The trust must ensure that staff working with children and young people on Wisteria Ward understand the issues of competence and consent to treatment in this age group. The trust must ensure staff follow the guidance of Gillick competence. **Regulation 11 (1)(2)**

# Summary of findings

- The trust must ensure that systems in place to assess, monitor and improve the quality of service in Wisteria Ward are effective. The trust must ensure that audits are of good quality and address all necessary areas of practice. Where shortfalls or gaps are identified, a clear time limited action plan with named people responsible for implementation is in place and monitored. **Regulation 17 (1)(2)(a)(b)**
- The trust must ensure that food on Wisteria Ward is of good quality and suitable for young people with an eating disorder. **Regulation 14 (1)(4)(a)(c)**

Action the trust **SHOULD** take to improve

We told the trust that it should take action to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These are the 30 actions related to the whole trust and five core and specialist services.

## Trust wide

- The trust should ensure that, in a complex and changing environment, the board assurance framework is regularly reviewed to confirm the board's assurance needs and re-examine the framework in the light of the evolving strategy of the organisation.
- The trust should continue to be proactive in reviewing the capability and capacity of the board to deliver a complex agenda, in response to internal and external changes.
- The trust should review multidisciplinary involvement in all wards and teams, particularly the provision of clinical psychology and social work, to improve access for patients.
- The trust should ensure equality, diversity and human rights is an integral part of all trust strategies and developments.
- The trust should continue to implement the work needed to deliver better workforce race equality standard outcomes and overall staff satisfaction and engagement.
- The trust should continue to make improvements in the timeliness of IT support provided to staff.

## Wards for older people with mental health problems

- The trust should ensure that staff are trained in how to check and maintain correct pressure for individual patients using pressure relieving mattresses, to ensure that this is effective.
- The trust should ensure all Mental Health Act consent to treatment documents are easily accessible to nursing staff at the point of medicines administration.
- The trust should ensure that staff have clear instructions on the medicines administration recording system on the safe administration of each medicine authorised to be administered covertly, to ensure that this is carried out appropriately.
- The trust should ensure that staff record patients' needs in respect of incontinence and how this will be addressed.
- The trust should review the use of care plans, particularly on Jasmines Ward, to ensure that they provide essential information, and ensure that care plans are accessible to patients, particularly those with cognitive impairment.

## Forensic inpatients/secure wards

- The trust should ensure all expired medicines are disposed of in accordance with trust policy and all individual patient medicines are labelled so that they can be identified accurately at Burntwood Villas.

# Summary of findings

- The trust should ensure that all blood glucose monitoring equipment is calibrated and tested in accordance with the manufacturer's instructions.
- The trust should ensure that local procedures, as well as trust policy, are clear on what action staff should take if a person refuses to leave the ward and/or unit in the event of a fire.
- The trust should ensure that issues raised by patients in community meetings are followed up promptly.

## **Mental health crisis services and health-based places of safety**

- The trust should ensure that staff in the home treatment teams clearly record how patients' ongoing physical health needs, including long-term physical health conditions, are being managed and by which team or primary care practitioner.
- The trust should ensure staff keep patients updated about changes to their appointments at Wandsworth home treatment team.
- The trust should continue with its work to consider the multidisciplinary make-up of the home treatment teams
- The trust should ensure that curtains around reclining chairs in the Lotus Suite fully protect patients' privacy and dignity.
- The trust should continue to collect reliable data on performance in the health-based place of safety and ensure that patients remain for no longer than 24 hours unless an extension is authorised and recorded.

## **Specialist eating disorder services**

- The trust should ensure activities for young people are provided at the weekend, especially on Wisteria Ward.
- The trust should review the restriction of locking away young peoples' care plans on Wisteria Ward.
- The trust should ensure staff on Wisteria Ward actively record young people's feedback from the community meetings. Staff should make clear the action they take in response to this feedback.
- The trust should ensure that staff can easily access consent to treatment forms and that staff can check that they have the legal authority to administer medicines before they are administered.
- The trust should continue to address cultural issues, such as low staff morale and lack of multidisciplinary leadership, on Wisteria Ward so that young people achieve the best clinical outcomes possible.
- The trust should ensure there are sufficient experienced and substantive registered nurses on Wisteria Ward before safely reopening the ward for new admissions.

## **Acute wards for adults of working age and psychiatric intensive care unit**

- The trust should ensure staff have clear guidance on what to do if a patient refuses to leave the building in the event of a fire.
- The trust should continue to work on reducing the number of incidents of prone restraint.
- The trust should ensure there is sufficient capacity to provide support and cover for clinical psychologists, should they be on extended leave, and maintain the provision of psychology input to the acute wards at all times.
- The trust should ensure that the relevant legal documentation of consent to treatment is available to staff when administering medicines to patients detained under the Mental Health Act.

# Summary of findings

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

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

- The trust had continued to make good progress and considerable improvement since the last inspection in early 2018. Areas of improvement included establishing a trust strategy, implementing a leadership development programme, complying with the accessible information standard, improving the quality of complaint responses and improving staff access to occupational health.
- There was good, effective leadership at all levels of the organisation. We rated three of the four core services we inspected as good, for well-led. Eleven of the 12 core and specialist services were rated good or better for well-led. The trust leadership team was visible across the trust and modelled openness and transparency. It continued to develop with a number of recent appointments into permanent and temporary posts across the executive and non-executive teams. The team understood the plans for development both internally and externally and the size and complexity of the change agenda.
- The board and senior leadership team had set a clear strategy and staff were aware of what it was. Staff and service users had been engaged in the development of the strategy and their views had been incorporated. The board was aware of changes that may impact upon the strategy and the need to align the trust strategy with the developing health and social care system around it.
- The trust had a values-based culture, which was positive and open. There was a high degree of openness and transparency in the senior leadership team. Work had been done to co-produce a staff values and behaviours framework, which staff were aware of and considered useful.
- Work on equality and diversity had progressed since the last inspection. There had been an increase in the number of staff network groups. Plans to improve workforce race equality had been reviewed and re-energised.
- Governance structures and processes had been strengthened throughout the organisation. Committees demonstrated a responsive approach to what needed to be covered and agendas could be adjusted to accommodate these discussions. Items for escalation to the board were made clear in sub-committee meetings. The board had a clear structure for reviewing components of governance at meetings.
- The trust was well aware of the clinical areas they needed to improve, especially the quality and safety of care delivery and leadership on the specialist eating disorder ward for children and young people.
- The trust had improved its performance assurance processes. Risks were examined systematically, and detailed reviews of risk took place when required. Staff and service leaders understood their risks and were able to report them and escalate them when required. There was a board assurance framework (BAF), which was used actively by the board. The senior leadership recognised the need to do more to clearly link the BAF to the strategic ambitions of the trust.
- The trust engaged positively with service users and staff. This included engagement in service design and development and co-production work. Service users took part in staff recruitment and were active participants in board sub-committees and other decision-making meetings at all levels. Staff engagement was positive with a

# Summary of findings

number of strategies to gain appropriate feedback. Staff focus group feedback at all levels was generally more positive than in previous years, recognising a changing culture with a focus on staff well-being and the modelling of trust values at a senior leadership level. However, positive outcomes of this work were yet to be demonstrated in staff survey results.

- The trust collected, analysed, managed and used information well to support all its activities. Managers had access to the information they needed to provide safe and effective care and used that information to good effect. The way information was presented to the board had been improved making it easier to confidently identify trends, expected variation and areas of declining performance.
- The trust worked well with partners but understood there was further work to do on the risk assessment and governance of future partnerships that were developing, considering the complexity of the local landscape and systems, developing work with the South London Partnership and volume of potential partners and meetings.
- The trust was committed to delivering a quality improvement programme and had invested in this across the organisation. Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles. The trust had a clear mortality review process with learning and support aligned to this. Learning was evident from recent work within the South London Partnership.

However:

- The trust operated in a complex and changing environment and was engaged in the delivery of a multi-million-pound estate modernisation programme and the transformation of local community mental health services. The board needed to continue to review the board assurance framework regularly and re-examine the alignment of the framework in line with the evolving strategy and strategic aims of the organisation. The size and complexity of the ongoing change agenda and recent and immanent changes at board level, meant that the trust needed to continue to monitor and evaluate the capacity and capability of the senior leadership to ensure the continued delivery of high-quality services.
- Although the trust had made considerable progress in addressing equality and diversity issues in a range of areas, further work was needed ensure equality and diversity was integrated into all areas of work throughout the organisation. For example, the trust research strategy did not consider equality and diversity and access to psychological therapies was not monitored for equity.
- The trust had a relatively low number of clinical psychologists providing therapeutic input across services. The provision benchmarked poorly against other similar trusts. Similarly, there were small numbers of social workers in trust services to complement the work of multidisciplinary teams. This had a negative impact in terms of patient access to appropriate services. The importance of clinical psychologists and social workers to the delivery of high-quality care and treatment to patients was recognised and they were valued by staff, patients and family members in inpatient and community settings.



## Ratings tables

| Key to tables                           |           |               |                      |                 |                  |
|---|-----------|---------------|----------------------|-----------------|------------------|
| Ratings                                 | Not rated | Inadequate    | Requires improvement | Good            | Outstanding      |
| Rating change since last inspection     | Same      | Up one rating | Up two ratings       | Down one rating | Down two ratings |
| Symbol *                                | ↔         | ↑             | ↑↑                   | ↓               | ↓↓               |
| Month Year = Date last rating published |           |               |                      |                 |                  |

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

| Safe                  | Effective             | Caring                | Responsive            | Well-led              | Overall               |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Good<br>↔<br>Dec 2019 | Good<br>↔<br>Dec 2019 | Good<br>↔<br>Dec 2019 | Good<br>↔<br>Dec 2019 | Good<br>↔<br>Dec 2019 | Good<br>↔<br>Dec 2019 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Ratings for mental health services

|  | Safe                                   | Effective                             | Caring                 | Responsive                            | Well-led                              | Overall                               |
|--|--|---------------------------------------|------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Acute wards for adults of working age and psychiatric intensive care units       | Good<br>↑<br>Dec 2019                  | Good<br>→←<br>Dec 2019                | Good<br>May 2018       | Good<br>May 2018                      | Good<br>May 2018                      | Good<br>→←<br>Dec 2019                |
| Long-stay or rehabilitation mental health wards for working age adults           | Good<br>May 2018                       | Good<br>May 2018                      | Good<br>May 2018       | Good<br>May 2018                      | Good<br>May 2018                      | Good<br>May 2018                      |
| Forensic inpatient or secure wards   | Good<br>↑<br>Dec 2019                  | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019 | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                |
| Child and adolescent mental health wards   | Good<br>May 2018                       | Good<br>May 2018                      | Good<br>May 2018       | Good<br>May 2018                      | Good<br>May 2018                      | Good<br>May 2018                      |
| Wards for older people with mental health problems                               | Good<br>→←<br>Dec 2019                 | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019 | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                |
| Community-based mental health services for adults of working age                 | Good<br>May 2018                       | Good<br>May 2018                      | Good<br>May 2018       | Good<br>May 2018                      | Good<br>May 2018                      | Good<br>May 2018                      |
| Mental health crisis services and health-based places of safety                  | Good<br>→←<br>Dec 2019                 | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019 | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                |
| Specialist community mental health services for children and young people        | Good<br>May 2018                       | Good<br>May 2018                      | Good<br>May 2018       | Good<br>May 2018                      | Good<br>May 2018                      | Good<br>May 2018                      |
| Community-based mental health services for older people                          | Good<br>Dec 2016                       | Good<br>Dec 2016                      | Good<br>Dec 2016       | Good<br>Dec 2016                      | Good<br>Dec 2016                      | Good<br>Dec 2016                      |
| Community mental health services for people with a learning disability or autism | Good<br>Jun 2016                       | Good<br>Jun 2016                      | Good<br>Jun 2016       | Good<br>Jun 2016                      | Good<br>Jun 2016                      | Good<br>Jun 2016                      |
| Substance misuse services  | Good<br>May 2018                       | Good<br>May 2018                      | Good<br>May 2018       | Good<br>May 2018                      | Good<br>May 2018                      | Good<br>May 2018                      |
| Specialist eating disorders service  | Requires improvement<br>→←<br>Dec 2019 | Requires improvement<br>↓<br>Dec 2019 | Good<br>→←<br>Dec 2019 | Requires improvement<br>↓<br>Dec 2019 | Requires improvement<br>↓<br>Dec 2019 | Requires improvement<br>↓<br>Dec 2019 |
| <b>Overall</b>   | Good<br>→←<br>Dec 2019                 | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019 | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                | Good<br>→←<br>Dec 2019                |

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Specialist eating disorders service

Requires improvement  

## Key facts and figures

The team that inspected the specialist eating disorders wards consisted of two CQC inspectors, a Mental Health Act reviewer, an inspection planner and one specialist advisor, with experience working in eating disorders services.

Before the inspection, we reviewed information that we held about the trust and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

- spoke with the managers of both wards
- spoke with one service manager and the matron
- spoke with 20 staff members including consultant psychiatrists, clinical psychologists, nurses, social workers and support workers
- looked at the quality of the environment on each ward
- reviewed nine care and treatment records
- spoke with seven patients and young people and two parents
- reviewed 13 medicines administration charts
- observed a community meeting and a multidisciplinary team meeting

Avalon Ward is a 20-bed national, specialist service providing care and treatment for male and female patients over the age of 18, experiencing severe eating disorders. The usual length of admission is three to four months.

Wisteria Ward is 12-bed ward for male and female young people between the ages of 11 and 18 with severe eating disorders and weight loss related to mental health problems. It is a national service and accepts referrals from across the country. At the time of the inspection, the ward was closed to admissions and had four young people admitted to the ward. Each young person had been on the ward for six to twelve months.

In addition, the trust operates an Eating Disorders Day Unit as a five-day a week service. It operates Monday to Friday during office hours and can accommodate up to ten male and female patients over the age of 18 years. The service is for patients with a diagnosed eating disorder and who require a more intensive treatment programme of care and treatment than could be offered by the community mental health teams. We did not inspect this service.

South West London St Georges Mental Health NHS Trust specialist eating disorders services were last inspected in March 2017, when the overall rating for the service was Good. Safe was rated as Requires Improvement, and Effective, Caring, Responsive and Well Led were rated as Good. At that inspection we identified breaches of Regulation 12: safe care and treatment.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

# Specialist eating disorders service

- We found a mixed picture on the two wards in terms of the quality and safety of the care provided. While on Avalon Ward, the eating disorder ward for adults, we found that care and treatment had improved since our last inspection, we identified several areas of concern regarding the care provided to the young people on Wisteria Ward. The trust had identified and highlighted concerns to us following a serious incident on Wisteria Ward before our inspection and had stopped admissions until they were satisfied that they could provide safe and effective care.
- Bedrooms on Wisteria Ward had ligature points, which were not included in the ward ligature risk audit. Three staff we spoke with on Wisteria Ward were not aware of the potential ligature risks in the bedrooms. Two temporary staff did not know where the ligature cutters were kept. The trust took immediate action to update the ligature risk audit and ensure all temporary staff were informed about the location of the ligature cutters during their induction. Where young people were assessed as at risk of self-harm staff took action to protect them by increasing levels of observation, risk assessments were of good quality on both wards.
- Some practices on Wisteria Ward were overly restrictive. Staff locked young people's bedroom doors for long periods throughout the week and were unable to explain the rationale for these restrictions. Restrictions were not based on individual needs. Staff locked away young peoples' care plans, explaining they were protecting patient confidentiality, but this meant that young people's involvement in their care was not promoted.
- Staff on Wisteria Ward did not fully understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff did not follow good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff on Wisteria Ward were not always responsive to young people's feedback. Staff and young people complained that food was not always of good quality. This had not been escalated to catering services. Although following a similar complaint from patients on Avalon Ward, staff had raised their concerns with the caterers and were taking steps to make improvements. Staff on Wisteria Ward did not keep a record of the weekly community meetings. This meant that any feedback the young people gave could not be followed up with an identified action.
- Although governance arrangements worked well on Avalon Ward and supported the delivery of high-quality care, Wisteria Ward needed to make improvements to their systems and processes to ensure they were well led. The trust had taken action to strengthen governance systems on Wisteria Ward since a serious incident earlier in the year, but these still needed further embedding. The team's local recovery plan did not include some of the risks and ineffective practice we found during this inspection. Audits of assessments of competence in under 16s had not been completed, although they were part of the ward recovery plan.
- Although staff had made improvements in monitoring and recording patients and young people's vital signs since the last inspection, in March 2017, we found that when staff decided not to escalate concerns about patients with elevated scores on the modified early warning score charts, they did not always record why action was not being taken. Information on physical health monitoring scores was stored in three different parts of the patient records, which could lead to errors in transferring data or in finding accurate information when needed. The trust took immediate steps to address this with staff and ensure decisions not to escalate certain scores were recorded in patients' care plans or progress notes. There was no evidence that patients came to harm as a result.
- Staff morale on Wisteria Ward was low, there was a lack of clear leadership on the ward and the multidisciplinary team needed to work better together to ensure young people achieved the best outcomes.
- There was high use of bank staff, particularly on Wisteria Ward, some of whom lacked experience of eating disorders. The ward had an on-going recruitment programme to fill all their vacancies.

However:

# Specialist eating disorders service

- The trust had made improvements to the recording of patient and young peoples' risk management plans since our last inspection in March 2017. Staff completed detailed risk assessments for patients and updated them after incidents. Risk management plans contained information specific to patients' physical and mental health needs. Staff knew what safety incidents to report and how to report them.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance for eating disorders. Staff on Avalon Ward supported patients with particular physical health conditions well.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness. On Avalon Ward, they actively involved patients and families and carers in care decisions. Staff and patients had co-produced a welcome video for patients and staff to orientate them to the ward. The manager hoped to start using this video soon for new patients. The occupational therapist had developed a voting system for patients to have a say about what groups and activities they would like on the ward.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, staff worked with community services and acute care health specialists to optimise the care pathway for patients with an eating disorder.

## Is the service safe?

**Requires improvement** ● → ←

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

- Although staff on Avalon Ward had made improvements since our last inspection and provided safe care to patients, we identified some safety concerns on Wisteria Ward, the majority of which the trust was aware of.
- Although staff had made improvements in monitoring and recording patients and young people's vital signs since the last inspection, in March 2017, we found that when staff decided not to escalate concerns about patients with elevated scores on the modified early warning score charts, they did not always record why action was not being taken. Information on physical health monitoring scores was stored in three different parts of the patient records, which could lead to errors in transferring data or in finding accurate information when needed. The trust took immediate steps to address this with staff and ensure decisions not to escalate certain scores were recorded in patients' care plans or progress notes. There was no evidence that patients came to harm as a result.
- Bedrooms on Wisteria Ward had ligature points, which were not included in the ward ligature risk audit. Three staff we spoke with on Wisteria Ward were not aware of the potential ligature risks in the bedrooms. Two temporary staff did not know where the ligature cutters were kept. The trust took immediate action to update the ligature risk audit and ensure all temporary staff were informed about the location of the ligature cutters during their induction. Where young people were assessed as at risk of self-harm staff took action to protect them by increasing levels of observation and risk assessments were of good quality on both wards
- Some practices on Wisteria Ward were overly restrictive. Staff locked young people's bedroom doors for long periods throughout the week and were unable to explain the rationale for these restrictions. Restrictions were not based on individual needs.

# Specialist eating disorders service

- Wisteria Ward was closed to admissions and had only four patients at the time of the inspection. The ward was using high numbers of bank registered nurses, some of whom did not have experience in eating disorders. The ward would need more experienced and substantive registered nurses in order to safely re-open to admissions.

However:

- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. The trust had made improvements to the monitoring of medicines fridge temperatures since our last inspection in March 2017.
- The trust had made improvements to the records of patient and young people's risk since our last inspection in March 2017. Staff completed detailed risk assessments for patients and updated them after incidents. Risk management plans contained information specific to patients' physical and mental health needs. Staff knew what safety incidents to report and how to report them.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

**Requires improvement** ● ↓

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not always support patients to make decisions on their care for themselves, proportionate to their competence. Staff on Wisteria Ward did not understand how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16.
- Staff did not have easy access to Mental Health Act documentation, confirming the legal authority to administer medicines to detained patients, at the point of medicines administration

However:

- Avalon Ward had an effective and full multidisciplinary team working together to achieve better outcomes for patients' recoveries. On both wards a full range of healthcare professionals met every two weeks to discuss each patient's care and treatment. This included the patient, family members and school staff where appropriate. The dietitian, in collaboration with the multidisciplinary team, ensured staff supported the nutritional needs of patients and provided guidance regarding safe refeeding protocols.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on eating disorders. Staff supported patients to live healthier lives.
- Staff received an annual appraisal of their work performance and regular supervision.
- Nursing staff received training in the safe insertion of nasogastric tubes and completing physical health checks on patients.
- Staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised, holistic and recovery oriented.

# Specialist eating disorders service

## Is the service caring?

**Good** ● → ←

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. On Avalon Ward, staff and patients had co-produced a welcome video for patients and staff to orientate them to the ward. The manager hoped to start using this video soon for new patients. The occupational therapist had developed a voting system for patients to have a say about what groups and activities they would like on the ward.
- Staff informed and involved families and carers appropriately. On Avalon Ward, families and carers could access a skills workshop to support loved ones with an eating disorder.

However:

- Staff on Wisteria Ward did not keep a record of the weekly community meetings. This meant that any feedback the young people gave could not be followed up with an identified action.
- Staff locked away copies of young peoples' care plans in lockers, which only staff had the key to. They said they did this to protect young people's confidentiality, but this hindered young peoples' involvement in their care and treatment. Following our inspection of the ward the trust to immediate action to ensure young people had copies of their care plans.

## Is the service responsive?

**Requires improvement** ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- On Wisteria Ward, staff and young people complained that the food was not good quality. Staff had not escalated concerns to the external caterer. Conversely, following a similar complaint from patients on Avalon Ward, staff had raised their concerns with the caterers and were taking steps to make improvements.
- Activities on Wisteria Ward at the weekend were limited. This meant staff did not promote young people's specific needs.

However:

- Staff worked with community services and acute care health specialists to optimise the care pathway for patients with an eating disorder.
- Staff facilitated young people's access to high quality education throughout their time on Wisteria Ward.
- The wards met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

# Specialist eating disorders service

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Oversight of Wisteria Ward had not alerted the trust to systemic issues on the ward that resulted in a poor quality service for young people, until a serious incident had occurred. Since that time the trust had been proactive in referring the ward to the local safeguarding team and implementing a recovery programme. The trust had taken steps to stop further admissions to the ward until they considered it was safe to accept new patients.
- Although we found effective governance systems were in place on Avalon Ward, ensuring high-quality care was delivered to patients, Wisteria Ward needed to make improvements to their systems and processes to ensure there was strong collaborative leadership in place. Governance systems had improved on Wisteria Ward following changes made by the trust, but these still needed to further embed. The team's local recovery plan did not include some of the risks and ineffective practice in the service that we found during this inspection. An audit of assessment of competence in under 16s had not been completed.
- Staff morale on Wisteria Ward was low, there was a lack of cohesive leadership on the ward and the multidisciplinary team needed to work better together to ensure young people achieved the best outcomes.

However:

- Senior leaders on Avalon Ward had the skills, knowledge and experience to perform their roles and had a good understanding of managing an eating disorders service. Senior managers were visible in the service and approachable for patients and staff.
- Managers had access to range of dashboards, which outlined individual team performance. This meant that they could identify both good and poor performance easily.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt able to raise concerns and knew about the whistleblowing policy. Staff morale on Avalon Ward was high.
- The trust had a clear sight of the concerns on Wisteria Ward and the steps they needed to take to address them.

## Outstanding practice

- On Avalon Ward, the occupational therapist developed a 'Your Group, Your Say' workshop where patients could make suggestions for new ward groups and then vote on what activities they wanted.

## Areas for improvement

Action the provider must take to improve:

- The trust must ensure that in the eating disorder services information about patients' physical health care is recorded accurately and that the information is transferred promptly on to patients' electronic records so that it can be followed up quickly when concerns are identified. Where decisions have been made not to escalate concerns these should be clearly recorded in patient care plans. Regulation 12 (1)(a)(b)



# Specialist eating disorders service

- The trust must ensure that all staff in the eating disorder services know where potential ligature points are throughout the ward and how the risks are mitigated. All staff, including temporary staff must be aware of where the ligature cutters are located. The induction pack for new staff must include where the ligature points and ligature cutters are on the ward, especially on Wisteria Ward. Regulation 12 (1)(a)(b)
- The trust must ensure they review the use of overly restrictive blanket restrictions on Wisteria Ward to ensure that they are appropriately applied and based on patients' individual needs and risks. Regulation 13(4)(b)
- The trust must ensure that staff working with children and young people on Wisteria Ward understand the issues of competence and consent to treatment in this age group. The trust must ensure staff follow the guidance of Gillick competence. Regulation 11 (1)(2)
- The trust must ensure that systems in place to assess, monitor and improve the quality of service on Wisteria Ward are effective. The trust must ensure that audits are of good quality and address all necessary areas of practice. Where shortfalls or gaps are identified a clear time limited action plan with named people responsible for implementation is in place and monitored. Regulation 17 (1)(2)(a)(b)
- The trust must ensure that food on Wisteria Ward is of good quality and suitable for young people with an eating disorder. Regulation 14 (1)(4)(a)(c)

Action the provider should take to improve:

- The trust should ensure activities for young people are provided at the weekend, especially on Wisteria Ward.
- The trust should review the restriction of locking away young peoples' care plans on Wisteria Ward.
- The trust should ensure staff on Wisteria Ward actively record young people's feedback from the community meetings. Staff should make clear the action they take in response to this feedback.
- The trust should ensure that staff can easily access consent to treatment forms and that staff can check that they have the legal authority to administer medicines before they are administered.
- The trust should continue to address cultural issues, such as low staff morale and lack of multidisciplinary leadership, on Wisteria Ward so that young people achieve the best clinical outcomes possible.
- The trust should ensure there are sufficient experienced and substantive registered nurses on Wisteria Ward before safely reopening the ward for new admissions.

# Wards for older people with mental health problems

Good   

## Key facts and figures

The service is comprised of:

- Crocus Ward at Springfield University Hospital: a 19 bed mixed gender ward for patients over the age of 65 with mental health problems and dementia.
- Jasmines Ward at Tolworth Hospital: a 16 bed mixed sex ward for patients over the age of 65 with mental health problems and dementia.

The last comprehensive inspection of this service took place in March 2016. We rated the service as good overall. We rated effective as requires improvement and safe, caring, responsive and well-led as good. We issued a requirement notice for one regulation:

- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We conducted an unannounced focussed inspection of Crocus Ward in September 2016 following which Effective was re-rated as Good.

The current inspection was unannounced in line with CQC guidance.

During the inspection visit, the inspection team:

- spoke with a ward manager, an acting ward manager, and a service matron
- spoke with 20 members of staff including doctors, registered and non-registered nurses, student nurses, pharmacists, occupational therapists, activities coordinators, a speech and language therapist, and a social worker
- spoke with 11 patients
- spoke with an advocate who worked with clients on both wards
- observed a community meeting, staff handover, and discharge meeting
- observed lunchtime on both wards
- conducted observations of staff-patient interactions (short observation framework of inspection) on both wards, and observed group activities
- reviewed 10 patient care records
- completed tours of the ward areas
- reviewed both clinic rooms
- reviewed 15 medication charts
- reviewed nine staff supervision files
- reviewed physical health records

Following the inspection visit, we spoke with eight relatives/carers of patients on the wards.

# Wards for older people with mental health problems

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- We rated this service as good for safe, effective, caring, responsive and well-led.
- Leaders at all levels were compassionate, inclusive and effective. They demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Leaders demonstrated good leadership and motivated their teams to ensure high quality care was delivered in all areas. Excellent, collaborative, multidisciplinary team working ensured patients' holistic needs were met.
- Leaders had the skills, knowledge and experience to perform their roles to a high level, were visible in the service and approachable for patients and staff. The service treated concerns and complaints seriously, investigated them and learned lessons from the results.
- Staff provided excellent support to families and carers, considered their needs and were proactive in involving them in their relative's care. The social worker held a social care surgery every week, supporting carers in the consideration of future placements.
- Staff ensured that physical health monitoring of patients' vital signs was undertaken and recorded to a high standard, including after every use of rapid tranquilisation. There was excellent medical provision on the wards, with good access to doctors at all times. Doctors worked very well with specialists from other health care organisations to provide the best possible care to patients. Staff carried out detailed assessments of the physical and mental health of all patients on admission.
- Staff engaged actively in local and national quality improvement activities. Staff were involved in a quality improvement initiative to reduce falls on the wards.
- Since the previous inspection in March 2016, the number of staff working on each ward had been increased during busy times, and the use of agency staff members had reduced. There were also improvements in the quality of recording of risk assessments for patients, and records of cleaning clinical equipment. Staff had received more training in moving and handling patients with mobility needs, including the use of hoists. There had been an improvement in staff morale, and interactions with patients on Crocus Ward, so that these were less task focussed. The décor, furnishings and layout on Crocus Ward had been upgraded to provide a more comfortable and dementia friendly environment. Occupational therapy support on both wards had increased, ensuring that patients had access to a range of appropriate activities to meet their needs
- Wards were safe, clean, well-equipped, and well maintained, with sufficient trained and skilled staff to support patients safely. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, and de-escalating, challenging behaviour. Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so.
- The wards had a good track record on safety. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They held weekly physical health clinics, made timely referrals to specialist healthcare teams, and supported patients to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff had regular individual supervision sessions and annual appraisals and described good opportunities for professional development within the trust.

# Wards for older people with mental health problems

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- Staff ensured that patients had easy access to independent advocates, and provided weekly 'Know your rights,' and 'Know your medicines,' sessions for individual patients.
- Staff managed beds well, ensuring that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Staff worked creatively to prevent delayed discharges and avoided evening admissions.

However:

- Although care plans, particularly on Crocus Ward, were patient centred and holistic, on Jasmines Ward care plans did not always include the detailed plans of care that were recorded in the progress notes. In a small number of cases patient records did not always include the management of incontinence and how this would be addressed.
- Care plans were not user-friendly and accessible to patients, particularly those with cognitive impairment.
- Further staff training was needed in how to check and maintain the correct pressure for individual patients using a pressure relieving mattresses, to ensure that this was effective.
- Staff across different core services did not have easy access to Mental Health Act documentation confirming the legal authority to administer medicines to detained patients at the point of administration. The trust had plans to change the electronic prescribing system to address this. Staff did not always have clear instructions on how to safely administer medicines authorised to be administered covertly.

## Is the service safe?

Good   

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

- Since the inspection in March 2016 the number of staff working on each ward had been reviewed with an additional staff member provided at busy times. The use of agency staff had also reduced following an improvement in recruitment to staff vacancies and retention of staff on the wards.
- Since the inspection in March 2016 there were improvements in the quality of recording of risk assessments for patients, and these were reviewed regularly. There were also improvements in the recording of cleaning clinical equipment between patients.
- Since the inspection in March 2016 staff had undertaken further training in moving and handling patients with mobility needs, including the use of hoists. Staff compliance with all mandatory training was high on both wards.
- All wards were safe, clean, well equipped, and well maintained, with sufficient trained and skilled staff to support patients safely. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating and de-escalating challenging behaviour.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. The wards had a good track record on safety. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

# Wards for older people with mental health problems

- Staff ensured that physical health monitoring of patients' vital signs was undertaken and recorded to a high standard, including after every use of rapid tranquilisation, in line with trust policy.
- There was excellent medical provision on the wards, with good access to doctors at all times.

However:

- Not all relevant staff were trained in or knew how to check and maintain correct pressure of pressure relieving mattresses being used by individual patients, to ensure that they worked effectively.
- Staff did not always have clear instructions on the medicines administration recording system on how to safely administer each medicine authorised to be administered covertly.

## Is the service effective?

Good   

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

- Staff assessed the physical and mental health of all patients on admission. There was a strong multi-disciplinary team on each ward to review patients' needs and progress.
- Staff provided a high standard of physical health care and treatment to patients. Records of physical health assessments and treatment were detailed. Staff proactively obtained and followed up physical health investigations and results to support the delivery of effective care. Doctors worked very well with specialists from other health care organisations to provide the best possible care to patients.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They held weekly physical health clinics, made timely referrals to specialist healthcare teams, and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff had regular individual supervision sessions and annual appraisals and described good opportunities for professional development within the trust.
- Doctors were well integrated in the teams, and consultants actively led the teams in partnership with the ward managers. Doctors were available to patients and carers and always ready to discuss care and treatment concerns.

However:

- Care plans, particularly on Jasmines Ward, did not always include the detailed plans of care recorded in the progress notes. In a small number of cases patient records did not always include the management of incontinence and how this would be addressed.
- Staff did not have easy access to Mental Health Act documentation confirming the legal authority to administer medicines to detained patients at the point of administration. The trust had plans to change the electronic prescribing system to address this.

## Is the service caring?

Good   

# Wards for older people with mental health problems

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Since the inspection in March 2016, we found an improvement in staff interactions with patients on Crocus Ward, so that these were less task focussed.
- Staff provided weekly 'Know your rights,' and 'Know your medicines,' sessions for individual patients.
- Staff provided excellent support to families and carers, considered their needs and were proactive in involving them in their relative's care. The social worker held a social care surgery every week, supporting carers in the consideration of future placements. Staff of Crocus Ward developed care plans to address the needs of relatives and carers.

However:

- Although staff supported patients to understand their care, care plans were not in a format that was easy for patients to read and understand, particularly those with cognitive impairment.

## Is the service responsive?

Good   

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

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Staff worked creatively to prevent delayed discharges and avoided evening admissions.
- Since the inspection in March 2016, the décor, furnishings and layout on Crocus Ward had been upgraded to provide a homelier and dementia friendly environment, and we observed that patients were able to move freely around the ward.
- Since the inspection in March 2016 patients reported an improvement in laundry procedures on the ward, so items rarely went astray.
- Since the inspection in March 2016 there was an increase in occupational therapy support on the wards, ensuring that patients had access to a range of activities to meet their needs.
- Patients had a choice of meals and could make hot drinks and have snacks at any time. Staff were responsive to patients' feedback about food provision making changes accordingly.
- The wards met the needs of all people who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

# Wards for older people with mental health problems

## Is the service well-led?

Good   

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

- The leadership, governance and culture of the service were used to drive and improve the delivery of high-quality person-centred care.
- Leaders had the skills, knowledge and experience to perform their roles, had an excellent understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff provided care in accordance with those values.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.
- Ward teams had good access to the information they needed to provide safe and effective care and used that information to good effect.
- Leaders at all levels were compassionate, inclusive and effective. They demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. They had a clear understanding of the issues, challenges, and priorities in their service and beyond.
- Leaders strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act.
- Since the inspection in March 2016, staff morale on Crocus Ward had improved significantly. Staff on both wards were very positive about their role, and the senior management support in place. Staff were proud to work for the organisation and the service and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and policies and procedures positively support this process.
- There was strong collaboration, team-working and support across all disciplines and a common focus on improving the quality and sustainability of care and patients' and carers' experiences.
- The service had invested in innovation and Crocus Ward had an animatronic seal to support patients with dementia and help manage distress. Staff were committed to improving the service and actively engaged in quality improvement initiatives. Staff were involved in a quality improvement initiative to reduce falls on the wards.
- Strong multidisciplinary leadership supported the delivery of excellent standards of physical health care and ensured families and carers' needs were a high priority.

## Outstanding practice

- Staff provided excellent support to families and carers, considered their needs and were proactive in involving them in their relative's care. The social worker held a social care surgery every week, supporting carers in the consideration of future placements. Staff developed specific care plans for carers to ensure their own needs were met.

# Wards for older people with mental health problems

- Staff provided a very high standard of physical health care and treatment to patients. Records of physical health assessments and treatment were detailed. Staff proactively obtained and followed up physical health investigations and results to support the delivery of effective care. Doctors worked very well with specialists from other health care organisations to provide the best possible care to patients. Staff ensured that physical health monitoring of patients' vital signs was undertaken and recorded to a high standard, including after every use of rapid tranquilisation.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The trust should ensure that staff are trained in how to check and maintain correct pressure for individual patients using a pressure relieving mattresses, to ensure that this is effective.
- The trust should ensure all Mental Health Act consent to treatment documents are easily accessible to nursing staff at the point of medicines administration.
- The trust should ensure that staff have clear instructions on the medicines administration recording system on safe administration of each medicine authorised to be administered covertly, to ensure that this is carried out appropriately.
- The trust should ensure that staff record patients' needs in respect of incontinence and how this will be addressed.
- The trust should review the use of care plans, particularly on Jasmines Ward, to ensure that they provide essential information, and ensure that care plans are accessible to patients, particularly those with cognitive impairment.



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

Good   

## Key facts and figures

The service is comprised of:

- Ward 1 (PICU) at Springfield University Hospital: a 13 bed single gender ward for male patients of working age.
- Ward 2 (Acute admission ward) at Springfield University Hospital: an 18 bed mixed gender ward for male and female patients of working age.
- Ward 3 at Springfield University Hospital: a 20 bed mixed gender ward for male and female patients of working age.
- Jupiter Ward at Springfield University Hospital: a 21 bed mixed gender ward for male and female patients of working age.
- Ellis Ward at Springfield University Hospital: a 12 bed single gender ward for male patients of working age.
- Lilacs Ward at Tolworth Hospital: an 18 bed mixed gender ward for male and female patients of working age.

The last comprehensive inspection of this service took place in February 2018. We rated the service as good overall. We rated Safe as requires improvement and Effective, Caring, Responsive and Well-led as good. We issued a requirement notice for one regulation:

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

The current inspection was an unannounced focussed inspection, to follow-up the regulatory breaches from the last inspection, in line with CQC guidance. We reviewed two of the key questions as part of this inspection, Safe and Effective. The ratings for Caring, Responsive and Well-led were not reviewed and remained rated as good. As part of the inspection we visited six of the nine wards; Ward 1 (PICU), Ward 2, Ward 3, Jupiter Ward, Ellis Ward and Lilacs Ward.

During the inspection visit, the inspection team:

- spoke with four ward managers, two deputy ward managers, and two service matrons
- spoke with 33 members of staff including doctors, registered and non-registered nurses, student nurses, pharmacists, occupational therapists and activities coordinators.
- spoke with 26 patients
- observed a community meeting, two staff handovers, and a multi-disciplinary meeting
- reviewed 23 patient care records
- completed tours of the ward areas
- reviewed clinic rooms on each of the wards
- reviewed 35 medication charts
- reviewed 12 staff supervision and appraisal files
- reviewed 23 physical health records

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

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Since the inspection in February 2018, the trust had taken steps to improve the recording of physical health observations of patients following rapid tranquilisation. Staff across all wards had recorded necessary checks in-line with trust policy in all but one of records we reviewed. Similarly, improvements had been made in the recording of patients' physical health. Staff escalated deterioration in patients' health in accordance with trust guidance.
- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to a range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The trust was rated as good for caring, responsive and well-led at the last inspection in 2018. We did not reinspect these key questions at the current inspection. The ratings remained the same.

However:

- Although the trust had guidance in place, ward staff we spoke with were not clear about what to do if a patient refused to leave in the event of a fire.
- Mental Health Act forms confirming the legal authority to administer certain medicines were not easily accessible to staff at the point of medicines administration.
- There was no contingency plan in place to enable the provision of psychological therapies to patients on the acute wards when the clinical psychologist was absent for an extended period.
- Although the trust was actively working to reduce this through implementing the safety in motion programme, a high proportion of patient restraints took place in the prone position

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- Since the inspection in February 2018 the trust had taken steps to improve the recording of physical health observations of patients following rapid tranquilisation. Staff across all wards had recorded necessary checks in-line with trust policy in the majority of records we reviewed.

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

- Since the inspection in February 2018 the trust had taken steps to improve regular checks of patients' physical health using a recognised assessment and escalation tool, National Early Warning Score 2. Staff across all wards had documented checks. Staff escalated deterioration in patients' health appropriately, and in accordance with guidance.
- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received suitable training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves. The trust had introduced the 'safety in motion' programme on the acute wards and PICU. The programme involved the introduction of eight evidence-based interventions aimed at reducing violence and aggression on the wards. Staff followed trust guidance and best practice in anticipating, de-escalating and managing behaviour which challenged. As a result, staff used restraint only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training in how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had access to appropriate clinical information and it was easy for them to maintain high quality clinical records.
- Staff followed best practice when administering medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Although the trust had guidance in place, ward staff we spoke with were not clear about what to do if a patient refused to leave in the event of a fire.
- Although the trust was actively working to reduce this through implementing the safety in motion programme, a high proportion of patient restraints took place in the prone position.

## Is the service effective?

Good ● → ←

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

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

- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff explained patients' rights to them.
- Staff supported patients to make decisions about their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The wards at Springfield University Hospital had been without the support of a clinical psychologist for an extended period of time due to their temporary absence. The trust did not have a contingency plan in place to cover nor continue to provide the same level of psychology input to patients on the wards.
- Staff did not have easy access to Mental Health Act documentation confirming the legal authority to administer medicines to detained patients at the point of administration. The trust had plans to change the electronic prescribing system to address this.

## Is the service caring?

Good ● → ←

As this was a focussed inspection we did not rate this key question

## Is the service responsive?

Good ● → ←

As this was a focussed inspection we did not rate this key question

## Is the service well-led?

Good ● → ←

As this was a focussed inspection we did not rate this key question

## Outstanding practice

- The trust had introduced the 'safety in motion' programme on the acute wards and PICU. The programme involved the introduction of eight evidence-based interventions aimed at reducing violence and aggression on the wards. The

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

interventions had been gradually introduced on the acute wards since May 2019 following a successful pilot. As part of the implementation of 'safety in motion,' ward staff had co-produced with patients a set of clear mutual expectations these were individual to each ward. Mutual expectations helped clarify expected behaviours on wards and address lack of consistency between staff.

## Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure staff have clear guidance on what to do if a patient refuses to leave the building in the event of a fire.
- The trust should continue to work on reducing the number of incidents of prone restraint.
- The trust should ensure there is sufficient capacity to provide support and cover for the clinical psychologist, should they be on extended leave, and maintain the provision of psychology input to the acute wards at all times.
- The trust should ensure that the relevant legal documentation of consent to treatment is available to staff when administering medicines to patients detained under the Mental Health Act.

# Mental health crisis services and health-based places of safety

Good   

## Key facts and figures

South West London and St Georges Mental Health NHS Trust provides crisis home treatment teams, a clinical assessment unit called the Lotus Suite and a health-based place of safety to patients from the London Boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.

The home treatment teams are based in each of the five boroughs and provide short-term treatment in the community as an alternative to hospital admission. This service is available 24 hours a day, 365 days a year. These teams also support patients who are being discharged from hospital and returning to home or community settings. During this inspection we visited four of the five home treatment teams. We did not inspect Merton home treatment team.

The health-based place of safety is based at Springfield University Hospital. Section 136 of the Mental Health Act allows for someone thought by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place. The service operates 24 hours a day.

The Lotus Assessment Suite provides a safe and stable, calming environment away from A&E which allows mental health staff to undertake more detailed and informed assessments of people experiencing a mental health crisis and to agree what the best follow up support for them will be. The suite does not contain beds but consists of five reclining chairs that patients can stay in for a maximum of 72-hours, although staff made efforts to ensure patients stayed no longer than 48-hours. All patients using the Lotus Assessment Suite are informal patients (not detained). Staff work together across the Lotus Assessment Suite and the health-based place of safety and managers increase staffing to each area as needed where needed. Staff are usually allocated to one unit for their shift, unless there are no patients in that unit.

We inspected this service as part of our comprehensive programme of inspections. The inspection was short-notice announced.

During this inspection we:

- conducted a tour of the environment at each home treatment team base, the lotus suite and health-based place of safety
- carried out checks of each clinic room and the arrangements for medicines management
- observed two home visits
- observed three appointments with patients and two patient assessments
- interviewed the clinical service manager
- interviewed the team leaders at each of the home treatment teams we visited and the team manager of the Lotus Assessment Suite and health-based place of safety
- interviewed 23 staff including a matron, psychiatrists, recovery support workers, nurses, social workers and administrators
- interviewed 10 patients
- attended handover meetings at each home treatment team we visited and a multidisciplinary handover in the Lotus Suite

# Mental health crisis services and health-based places of safety

- reviewed 28 patient care and treatment records
- looked at a range of documentation relating to the running of these services

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean and the physical environment of the health-based place of safety met the requirements of the Mental Health Act Code of Practice. The number of patients on the caseload of the mental health crisis teams was not too high to prevent staff from giving each patient the time they needed. Staff ensured patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff working for the mental health crisis teams developed recovery-oriented care plans informed by a comprehensive assessment. They provided treatments that were informed by best-practice guidance and suitable to the needs of the patients. Local audits of the quality of patient care and treatment records were completed and the trust had plans to strengthen these in the future.
- The trust was working to expand the range of specialists working within the crisis teams to meet the needs of the patients. Managers ensured that staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. Progress was being made to involve patients, families and carers in care decisions.
- The mental health crisis service and the health-based place of safety were easy to access. Staff assessed patients promptly. Those who required urgent care were seen immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude patients who would have benefitted from care.
- The service was well-led and the governance processes ensured that service procedures ran smoothly.

However:

- Staff did not always clearly record, which team or practitioner had oversight and managed patients' long term physical health conditions, where relevant.
- Staff at Wandsworth home treatment team did not always keep patients updated about changes to their appointments.
- The trust acknowledged that it needed to continue with its work to consider the multi-disciplinary make-up of the home treatment teams and to develop a consistent auditing process for patient care and treatment records.
- The trust had only recently started to reliably record how many times patients waited longer than 24 hours in the health-based place of safety and whether an extension to their length of stay had been authorised. The trust was working to improve the overall quality of data going forward and was monitoring this closely.

# Mental health crisis services and health-based places of safety

## Is the service safe?

Good  → ←

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

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- The services had enough staff, who received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff continually monitored patients to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Since our last comprehensive inspection in March 2016 staff actively considered whether some patients might benefit from seeing the same staff members at each appointment. Where this need was identified staff made efforts to ensure this continuity of care happened.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

Good  → ←

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

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised and recovery-oriented.
- Although staff working for the mental health crisis teams provided predominantly medical treatment interventions, good examples of other interventions including social support were identified at the Wandsworth home treatment team.



# Mental health crisis services and health-based places of safety

- The trust was working to extend its range of care and treatment interventions for patients using the home treatment teams. At Wandsworth and Merton home treatment teams, staff actively addressed patient's social needs. Occupational therapists were also being introduced to the teams.
- Staff participated in quality improvement projects, such as introducing improvements to the way they supported patients to lead a healthy lifestyle. Staff also completed local audits to help detect areas for improvement.
- Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- The trust had a 'commitment to care' project under development. This project aimed to improve the quality of care plans and to strengthen the auditing of patient care and treatment records.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005.

However:

- Although staff made sure patients had support for their physical health needs from their GP or community services and discussed these needs in daily multidisciplinary meetings, staff did not always clearly record, which team or practitioner had oversight and managed patients' long terms physical health conditions, where relevant.
- The trust was working to improve the multi-disciplinary make-up of the home treatment teams. Patients were not able to access psychological support during their short time with the service and social workers were only in place at Wandsworth and Merton. The trust was making progress with recruiting occupational therapists to each home treatment team.

## Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the mental health crisis teams involved patients in care planning and risk assessment. They ensured that patients had easy access to advocates when needed.
- Systems to enable patients and carers to provide feedback about the service had been introduced since our last comprehensive inspection in March 2016.
- Although we received mixed feedback about how well staff involved relatives and carers, staff had made particular efforts to meet with and support carers individually at Wandsworth home treatment team. Staff at the health-based place of safety and Lotus Suite signposted carers to a local carers network for support.

# Mental health crisis services and health-based places of safety

## Is the service responsive?

Good  → ←

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

- The mental health crisis service was available 24-hours a day and was easy to access. Each team had a specific telephone number that patients could call out-of-hours. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- The health-based place of safety was available when needed and there was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- Length of stay breaches at the health-based place of safety and Lotus Suite had reduced over the last year.
- Some staff at the Richmond home treatment team worked agilely. This meant that staff did not report they felt cramped working from the team base, as they had when we last inspected the service in March 2016.
- The services met the needs of all patients who use the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- Curtains that could be pulled around reclining chairs in the Lotus Suite did not fully protect patients' privacy and dignity. The trust took immediate action to address this.
- The trust had only recently started to reliably record how many times patients waited longer than 24 hours in the health-based place of safety and whether an extension to their length of stay had been authorised. The trust was working to improve the overall quality of data going forward and was monitoring this closely.
- Staff did not always update patients about changes to their appointments promptly at Wandsworth home treatment team.

## Is the service well-led?

Good  → ←

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. Since the previous inspection, progress had been made to positively transform the culture at Kingston and Wandsworth home treatment teams.

# Mental health crisis services and health-based places of safety

- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- The Lotus Suite was particularly innovative in approach and the staff team was continually looking to improve the service.
- Staff collected and analysed data about outcomes and performance and the trust had identified areas they wanted to gain better oversight of, including the quality of physical health documentation.
- There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based place of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

## Outstanding practice

- Lotus Suite and health-based place of safety staff took part in a rotational programme for nurses in partnership with local acute trust emergency department. Mental health nurses rotated with physical health nurses from the emergency department to share and build the skills and knowledge in respect of mental and physical health.
- In the Lotus Suite staff took part in well-being huddles, where they gathered for reflective practice and to encourage healthy living and appreciation for the work they did.

## Areas for improvement

Action the trust SHOULD take:

- The trust should ensure that staff clearly record how patients' ongoing physical health needs, including long-term physical health conditions, are being managed and by which team or primary care practitioner.
- The trust should ensure staff keep patients updated about changes to their appointments at Wandsworth home treatment team.
- The trust should continue with its work to consider the multi-disciplinary make-up of the home treatment teams
- The trust should ensure that curtains around reclining chairs fully protect patients' privacy and dignity.
- The trust should continue to collect reliable data on performance in the health-based place of safety and ensure that patients remain for no longer than 24 hours unless an extension is authorised and recorded.

# Forensic inpatient or secure wards

Good   

## Key facts and figures

The forensic service provided by South West London and St George's Mental Health NHS Trust are part of the trust's specialist directorate.

We inspected the following forensic wards:

**Turner Ward** - 18 beds, men's medium secure ward

**Halswell Ward** - 16 beds, men's medium secure ward

**Ruby Ward** - 10 beds, women's medium secure ward

**Hume Ward** - 16 beds, men's low secure ward

**Burntwood Villas** - a 15 bed step-down rehabilitation unit within a specialist forensic pathway. The service comprises three units. Burntwood Villa is a eight bed mixed sex unit, which is staffed 24 hours a day. In addition, there are two semi-independent houses, one three bed and one four bed. These two houses are not staffed on a 24 hour basis. One house is for females and the other males only.

The last comprehensive inspection of this service took place in March 2016. We rated the service as good overall. We rated safe as requires improvement and effective, caring, responsive and well-led as good. We issued a requirement notice for one regulation:

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

The current inspection was a short notice announced focussed inspection in line with CQC guidance.

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

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff interacted with patients
- spoke with 24 patients who were using the service
- spoke with the managers for each of the wards
- spoke with 27 other staff members; including doctors, registered nurses, non-registered nurses, occupational therapists, exercise therapists, pharmacist technicians, clinical psychologists and social workers
- attended and observed three community meetings and one 'moving on' group
- looked at 21 treatment records of patients
- looked at 34 prescription charts
- attended and observed two handover meetings
- looked at a range of policies, procedures and other documents

# Forensic inpatient or secure wards

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors to provide safe care to patients. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed trust safeguarding policies and procedures.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who had a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- At Burntwood Villas staff did not always dispose of expired medicines in a timely way and did not always label patients' medicines clearly.
- Blood glucose monitoring equipment on two wards was not calibrated in line with the manufacturer's instructions.
- Although the trust had guidance in place, ward staff we spoke with were not clear about what to do if a patient refused to leave in the event of a fire
- On Ruby and Halswell wards it was not always clear that issues brought up by patients in the community meetings were quickly addressed by staff.

## Is the service safe?

**Good** ● ↑

Our rating of this service improved. We rated it as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.

# Forensic inpatient or secure wards

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

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had access to clinical information which helped them to maintain high quality clinical records.
- Most wards used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support

However:

- At Burntwood Villas staff did not always dispose of expired medicines in a timely way and did not always label medicines clearly when placing patients' medicines on individual trays in the medicine cupboard or after opening. The trust took immediate action to address the concerns.
- Although the trust had guidance in place, ward staff we spoke with were not clear about what to do if a patient refused to leave in the event of a fire.
- Although most risk patient assessment records had been completed comprehensively. Three of 21 records were either incomplete or had missing information in the summary document.
- Although most equipment was well maintained and regularly calibrated, blood glucose monitoring equipment on two wards was not calibrated in line with the manufacturer's instructions.

## Is the service effective?

Good ● → ←

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

# Forensic inpatient or secure wards

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

## Is the service caring?

Good   

Our rating of this service stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However:

- On Ruby and Halswell wards it was not always clear that issues brought up by patients in the community meetings were addressed promptly by staff.

## Is the service responsive?

Good   

Our rating of this service stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The feedback about the food was mixed, the trust was aware of this and were having tasting sessions with new food providers at the time of the inspection. Patients could make hot drinks and snacks at any time.

# Forensic inpatient or secure wards

- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

## Is the service well-led?

Good ● → ←

Our rating of this service stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

## Outstanding practice

- The trust's 'safety in motion programme' was part of the provider's reducing restrictive interventions programme. Staff and patients were positive about the impact 'safety in motion' had had on the wards. Staff were committed to using the least restrictive practice and this was evident in the low usage of restraint, seclusion and rapid tranquilisation across the service.

## Areas for improvement

We found the trust SHOULD take:

- The trust should ensure all expired medicines are disposed of in accordance with trust policy and all individual patient medicines are labelled so that they can be identified accurately at Burntwood Villas.
- The trust should ensure that all blood glucose monitoring equipment is calibrated and tested in accordance with the manufacturer's instructions.
- The trust should ensure that local procedures, as well as trust policy, are clear on what action staff should take if a person refuses to leave the ward and/or unit in the event of a fire.
- The trust should ensure that issues raised by patients in community meetings are followed up promptly.



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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

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

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

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

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

# Our inspection team

Helen Rawlings, Head of Inspection, led this inspection.

An executive reviewer, Tom Cahill, Chief Executive at Hertfordshire Partnership University NHS Foundation Trust, supported our inspection of well-led for the trust overall. The well-led inspection was also supported by a representative from NHSE/I.

The team included 18 CQC inspection staff, 11 specialist advisers, and three experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.