South London and Maudsley NHS Foundation 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 rating for this trust	Good
Are services safe?	**Requires improvement**
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

The trust serves a population of 1.3 million people across the London boroughs of Lambeth, Lewisham, Southwark and Croydon and employs more than 5,000 staff, including over 1,200 nurses. Staff provide services to around 64,000 patients in the community and 3,700 patients in hospital every year. The trust has a turnover of £381 million and made a surplus of £10.5 million in 2017/2018. The trust provides some national specialist mental health services.

The service provides the following core services:

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

• 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

• Wards for people with learning disabilities or autism

• Mental health crisis services and health-based place 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

• Specialist neuropsychiatric services

• Substance misuse services

• Other national specialist services

The trust operates from eight registered locations including four hospitals, Maudsley Hospital, Ladywell Unit, Lambeth Hospital and the Bethlem Royal Hospital. The trust provides 786 inpatient beds in 49 wards. It provides community mental health and out-patient services from a number of team bases in the London boroughs of Lambeth, Lewisham, Southwark and Croydon.

The trust has been inspected seven times since 2014. We conducted a comprehensive inspection of the trust in September 2015. At that inspection we rated the trust at good overall. We rated it as requires improvement for one key question (safe) and good for four key questions (effective, caring, responsive and well-led). In 2017, we inspected three core services acute wards for adults of working age and psychiatric intensive care units; wards for older people with mental health problems and community based mental health services for adults of working age. Following the inspections in 2017, the overall rating for wards for older people with mental health problems went up from requires improvement to good; the overall rating for acute wards for adults of working age and psychiatric intensive care units stayed the same, requires improvement; and for community-based mental health services for adults of working age the overall rating went down from good to requires improvement.

Summary of findings

In 2018, we inspected six services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units
- Forensic inpatient/secure wards
- Mental health crisis services and health-based place of safety
- Community-based mental health services for older people
- Specialist eating disorder services
- Specialist neuropsychiatric services

At that inspection, our rating of the trust stayed the same. We rated the trust as good overall. We rated one service we inspected as inadequate and five services as good. When these ratings were combined with the other existing ratings from previous inspections, one of the trust services was rated inadequate, one was rated requires improvement, 11 were rated good, one was inspected but not rated and one had not been inspected.

Overall summary

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

What this trust does

South London and Maudsley NHS Foundation Trust provides mental health services from four main hospitals in south London. This includes a range of local and national inpatient and community mental health services for adults, older people, children and young people, and people with learning disabilities and autism.

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 four services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Long stay/rehabilitation mental health wards for working age adults

Summary of findings

• Perinatal services

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:

- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to continue making the necessary changes to provide high quality care to their local communities. Since the last inspection, the chair had retired unexpectedly and the deputy chair was acting during the interim while a new permanent chair was appointed. The non-executive directors felt that they were working closely and effectively with the executive directors and were well supported by the interim chair. The chief executive was retiring and a replacement appointed with a well-planned handover due to take place. The new chief executive was coming from a neighbouring trust and so was already familiar with the trust and local partnerships. A director of people and organisational development had been appointed working across two neighbouring trusts.
- Since the last inspection, the directorate structures and borough-based working for local services had become more embedded. The directorate structures ensured clinical leaders had manageable spans of control. The numbers of matrons across the organisation had been increased to support teams to provide high quality care. This was leading to improved partnership working to address challenges in boroughs with partners to meet the needs of local people.
- The board had improved oversight of operational issues. The governance processes had been strengthened with each directorate having a monthly quality and performance review. Links with wards and teams were also being strengthened. This was supported by a business information system which made information available in an accessible format at all levels of the organisation. This was enabling achievements and concerns to be escalated appropriately. The trust was identifying problem areas and work was, for the most part, underway to resolve matters.
- The trust's active participation in the South London Partnership was continuing to deliver new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home. The success of this work was leading to discussions with clinical commissioning groups about the transfer of budgets for local services.
- Since the last inspection the trust had launched its strategy 'Changing lives'. This recognised the needs of the population in the four London boroughs. The strategy also aligned to national priorities and the Five Year Forward View for Mental Health. The strategy stated how the trust will meet the aims of providing high quality services; working in partnership; being a great place to work; promoting innovation and providing value. The strategy had been presented using a range of formats including an excellent film following the lives of five patients and their clinicians talking about how the work of the trust had helped them to improve their lives.
- The trust was making progress with their quality improvement programme and had set ambitious targets for the next three years. At this inspection, most of the wards and teams we visited spoke with enthusiasm about the quality improvement projects that were taking place. On inpatient wards we saw positive examples of reductions in violence and aggression linked to the 'four steps to safety' programme. Over 1000 staff had been trained in QI. Patients and carers were active participants in many of the projects. However, further work was needed to ensure that projects were available on the QI intranet so they could be shared between teams.

Summary of findings

- Staff engagement remained a high priority for the trust. An ambitious programme of leadership walkabouts was continuing to promote good communication. This meant that the leadership team had a good understanding of the challenges being faced by staff working in front-line services and were working to address them. This was particularly apparent in the service transformation work being carried out in adult community mental health services. The trust promoted staff to speak up through the Freedom to Speak Up Guardian and at this inspection there was an improved awareness of this role.
- The trust, since the last inspection had continued to develop and deliver an equalities strategy. There had been a focus on BME staff experience led by the BME staff network. The trust had plans in place to improve the workforce race equality standards through offering leadership development for BME staff; having BME staff on recruitment panels for all band 7 posts and above; introducing a checklist to enable managers to reflect on whether alternative approaches could take place prior to a disciplinary process. Other networks were less well developed but were being supported to grow. This included an LGBTQ network and one for staff with lived experience.

However:

- The inspection took place at a time when change was happening for the board and executive leadership team. Whilst it was positive to see the progress that had taken place, further work was needed to ensure effective leadership across wards and teams and for the improvements across the trust to be further embedded.
- Although the trust had continued with their workforce strategy, staffing remained an issue. There were still a high number of nursing vacancies and staff turnover. Some staff and patients on acute wards told us that patient leave was often cancelled or postponed. Some wards did not have a permanent consultant psychiatrist, although locum arrangements were in place.
- The trust had improved the experience of working age adults from the local communities who were on the acute care pathway, either as inpatients or under the care of the adult community mental health teams. However, there was more to do to deliver sustainable change. Patients were affected by the ongoing extreme pressures on the acute care pathway. Bed occupancy was above 100% on most wards, which meant staff may not have been able to manage the care of patients safely. There was not always a bed available for someone who needed one. The trust had 300 patients in out-of-area beds between February 2018 and December 2018. We found six incidents where patients in psychiatric intensive care units were ready for discharge to acute wards but were unable to transfer due to the lack of acute beds. This meant patients experienced care at a higher level of security than what was needed.
- There were a few safety issues particularly on the acute inpatient wards that needed to be addressed to ensure the environments were safe and clean; that patients had their physical health monitored after the administration of rapid tranquilisation; that patient risk assessments were kept updated.
- Whilst learning from incidents had improved within services and boroughs, there was still scope to further develop the shared learnin

Are services safe?

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

- We rated safe as requires improvement in two of the four core services that we inspected on this occasion and good in the other two. When these ratings were combined with the other existing ratings from previous inspections, three of the trust services were rated requires improvement and 11 were rated good.

Summary of findings

- At the time of the last inspection of community based mental health services for adults of working age in July 2017, staff did not assess patients identified as needing a Mental Health Act assessment promptly. During this inspection, this remained an issue with delays in patients having Mental Health Act assessments in a timely manner. However, the trust was monitoring this closely and working with the local authorities and police to make improvements, with a clear message that assessments should never be cancelled due to difficulties in accessing a bed.
- At the last inspection in July 2018, there were a high number of nursing vacancies and a high staff turnover on some acute and PICU wards. Patients' leave was postponed or cancelled due to short staffing. At this inspection, although the trust had continued with their recruitment drive, staffing remained an issue. There were still a high number of nursing vacancies and staff turnover on some wards. Some staff and patients told us that patient leave was often cancelled or postponed. Some wards did not have a permanent consultant psychiatrist, although locum arrangements were in place. In perinatal community teams staffing vacancies and retention were having an impact on the consistency of support for patients, waiting times for non-urgent appointments and increased stress on the remaining staff.
- Although improvements had been made to the environmental risk assessments as required at the last inspection in July 2018, not all environmental risk assessments on the acute and PICU wards had timescales for identified work that needed to take place or a clear person responsible. The use of plastic bin bags in communal areas across the acute wards was not consistent, or always recorded on environmental risk assessments.
- Although most wards carried out physical health checks on patients after they received rapid tranquilisation as required at the last inspection in July 2018 in line with national guidelines and trust policy, we found three examples where records did not demonstrate staff completed physical health checks on patients following the administration of rapid tranquilisation. Staff did not always record on restraint records if patients received a debrief following a physical restraint.
- Although the service generally controlled infection control risk well and equipment was clean. Some of the acute and PICU wards were not clean or well-maintained, especially in bathrooms and toilets. Where staff had identified maintenance and repair issues, the trust did not always address these in a timely manner.
- Although staff in the community teams kept detailed records of patients' care and treatment, as required at the previous inspection in July 2017, they had not always ensured that key risk assessment and risk management documents were up to date. These documents were not always accurate in relation to the patient's current circumstances or risks.
- On two PICU wards we found examples where, while patients had been kept immediately safe, it was not clear that the trust safeguarding policies had been followed, as decisions had been made not to raise safeguarding concerns when they should have been. The trust was working with the wards to ensure safeguarding issues were appropriately alerted in response to our concerns.
- Incidents and learning from when things go wrong were not always effectively communicated across boroughs, particularly on the PICU wards.
- Following our findings at the previous inspection of rehabilitation wards in September 2015, there had been a review of blanket restrictions on the wards, but staff on one ward were not clear about how these implementing this in practice. We also found that patients on rehabilitation wards who had been reluctant to leave the ward during fire drills, did not have a personal emergency evacuation plan in place to ensure that staff knew how to support them in the event of a fire.

Summary of findings

- The Trust medicine management audits for community mental health services had not picked up concerns we found relating to management of prescription stationery, antipsychotic medicines prescribed for patients on a community treatment order, and monitoring of medicines in stock at each service. On one rehabilitation ward we found that there was insufficient storage space in the clinic room for patients' medicines.

However:

- Staff assessed and managed risks to patients and themselves. Risks to patients were discussed in multidisciplinary meetings, individual reviews, and handovers meetings. Staff responded promptly to sudden deterioration in a patient's health. In community teams, when necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in the level of risk. Staff followed good personal safety protocols. At our last inspection in July 2018, on one acute ward staff failed to record observations of a patient who required intermittent monitoring. At this inspection, this was no longer an issue. Staff recorded observations of patients as prescribed by the multidisciplinary team.
- The trust had worked hard to implement plans to reduce the number of patients being restrained. Since our last inspection in July 2018, the proportion of restraints that involved patients being restrained in the prone position had decreased from 54% to 39%. Staff were aware of the provider's restrictive interventions reduction programme and some wards had participated in Safe wards (a quality improvement initiative). The quality of the recording of patient restraint had improved across the wards.
- Most clinical premises where patients received care were safe, well equipped, furnished and maintained, and fit for purpose. Staff 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. At our last inspection of acute and PICU wards in July 2018, we found that patients on one ward did not have direct access to drinking water, and the service had not anticipated the expiry date of some items of emergency equipment. At this inspection, these issues had been addressed. Emergency equipment was well-maintained and were within its expiry date.
- At the last inspection of rehabilitation wards in September 2015, we identified risks with ligature points and fire safety arrangements. Improvements had been made to ensure the physical environment was safely managed. Staff ensured that improvements were made in how mixed-sex wards were controlled.
- At the 2015 inspection we also found that staff on the rehabilitation wards had not felt supported by management when staffing vacancies were high. At the current inspection we found that the service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. In the community mental health teams, the number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- At the last inspection of acute and PICU wards in July 2018, staff did not always identify and report patient safety incidents. At this inspection, there had been an improvement. Staff were pro-active in reporting incidents of restraint and rapid tranquilisation. 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, the learning from incidents was still being embedded on the rehabilitation wards and some PICU wards, and some staff found it hard to articulate the changes that had taken place in response to this learning.

Are services effective?

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

- At this inspection we rated effective as good in two of the four core services and requires improvement in two core services. When these ratings were combined with the other existing ratings from previous inspections, 10 of the trust services were rated good, two were rated outstanding and two were rated requires improvement.

Summary of findings

- At the last inspection of community services in July 2017, we found that patients did not always have person-centred care plans. At the current inspection we found that staff in all services assessed the physical and mental health of all patients promptly. Most care plans were personalised, holistic and recovery-orientated. We saw good examples of community and inpatient care plans that were holistic and addressed the patient's mental health, physical health, and relationships including their sexual orientation, and accessing the community. Staff involved patient's family members or carers when possible. There were separate care plans in place for babies in the mother and baby unit.
- Staff supported patients to live healthier lives including smoking cessation. Most patients on the wards could access a gym and could access a healthy living group.
- Staff from different disciplines worked together as a team to benefit patients. Staff held regular and effective multidisciplinary team meetings, where patients' care and treatment were comprehensively discussed. Staff supported each other to make sure patients had no gaps in their care. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. The teams had effective working relationships with other relevant teams within and outside of the trust.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- 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 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- On the rehabilitation wards, patients' care plans did not reflect work to provide rehabilitation with a view to discharge, until near to the time when patients were being discharged. This meant that most patients did not have achievable goals designed to support their recovery. Although staff provided some interventions to support patients on these wards to develop everyday living skills, this was limited. Only one rehabilitation ward was supporting some patients to take their medicines independently, and support with self-catering was not sufficiently developed to promote patients to be fully independent in this area.
- In several community mental health teams, we found examples where community team staff had not updated the care plan document since the patient had been transferred to the team from an inpatient ward, so their current relevant needs had not been assessed.
- Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and Code of Practice these were not always discharged well. There were delays in requesting a second opinion appointed doctor and staff had not ensured that some patients had legally consented to medicines prescribed to them, on some acute and PICU, and rehabilitation wards. On the rehabilitation wards staff did not always know when they should explain a patients' rights to them or record this. In the community teams, record keeping in relation to patients who were subject to a Mental Health Act community treatment order required improvement.
- At the last inspection of acute and PICU wards in July 2018, some wards did not always carry out physical observations of patients with specific health needs. At this inspection, progress had been made, but there was still room for improvement in completing records of blood glucose monitoring and fluid charts for patients and supporting patients who had a high body mass index.

Summary of findings

- At the last two inspections in January 2017 and July 2018, on the acute and PICU wards we found that staff supervision rates were low. At this inspection, although supervision had improved on most wards, it was still particularly low on some wards. It had also been low on the mother and baby unit in recent months. Staff reported that this was due to staffing shortages.
- At the last inspection of acute and PICU wards in July 2018, we found that although staff had access to training in caring for patients with learning disabilities, this training did not specifically include autism. There were a number of patients with autism admitted to the wards, and staff said they did not have access to autism training. At this inspection, most staff had not received autism training, but since our inspection, the trust had established an autism training programme for all acute and PICU wards. We also found that the rehabilitation wards could offer a service to patients with autism, but staff had not received training to meet their specific needs.
- Psychology support varied across the team. One rehabilitation ward did not have a psychologist in place to support patients for eight months. On most acute wards psychology input was low with one psychologist working across several wards. Although there had been an increase in psychology input to some community teams since our last inspection, some patients in early intervention teams could still wait over a year for individual therapy. In perinatal teams waits for psychological therapies did not always meet the recommended timeframes. Group work was being offered to support patients in the interim period.

Are services caring?

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

- At this inspection we rated caring as good in all four core services. When these ratings were combined with the other existing ratings from previous inspections, 12 of the trust services were rated good, and two were rated outstanding.
- Staff treated patients, families and carers with compassion and kindness. They demonstrated a good understanding of patients' and carers' needs and interacted with them in a respectful and receptive way. Staff communicated well with patients so that they understood their care and treatment.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients' views were incorporated, even when they differed from the clinical teams. They ensured that patients had easy access to independent advocates, and wards held regular community meetings at which patients were encouraged to give feedback. The perinatal community teams had recently set up a service user forum across all four boroughs. Patients across the services provided feedback and input on services, training and policies and helped with recruitment.
- Staff informed and involved families and carers appropriately. Staff invited families and carers to attend patient multidisciplinary team meetings and gained their feedback on the service they received via surveys. Acute wards at the Bethlem hospital held regular carer's forums. Staff at Westways (one of the rehabilitation units) were establishing a family/carer user group to better understand their views. The trust facilitated service user and carer advisory groups as a way of involving patients and carers in the development of the services.
- At the last inspection in July 2018, patients on two wards said that some staff did not seem to care about them, were disrespectful towards them or too busy to help them promptly. At this inspection, this was no longer an issue and were very complimentary about the way they were treated by staff.
- At the last inspection in July 2018, we found that confidential information was visible to people standing outside the nurses' office on two wards. At this inspection, this was no longer an issue.

However:

- The trust did not have a standardised method for staff to record that the patient had been given a copy of their care plan unless they were under the Care Programme Approach review.

Summary of findings

Are services responsive?

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

- At this inspection we rated responsive as requires improvement in two of the four core services and good in the other two services. When these ratings were combined with the other existing ratings from previous inspections, two of the trust services were rated requires improvement and 12 were rated good.
- At the last inspection in July 2018, 20% of patient discharges from the acute wards were delayed, and staff had not always been proactive in addressing barriers to patients being discharged. At the current inspection, there had been an improvement. Three percent of patient discharges were delayed, and staff were demonstrably proactive in addressing barriers to patients being discharged.
- The community services were easy to access, with referral criteria that did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- Staff took account of patients' individual needs including those with a protected characteristic. Services provided interpreters for patients whenever this was needed, to support patients at ward rounds and in other aspects of their care. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The design, layout, and furnishings of the units supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. The community services, and most wards were accessible to patients with physical disabilities and mobility issues.
- Staff ensured patients had a choice of food to meet the dietary requirements of different religious, cultural and personal needs. Patients on most wards were satisfied with the quality and choice of food provided.
- The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them at admission and when patients were ready for discharge. Some patients were accessing community-based activities that promoted their rehabilitation.
- The services treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff, although on Rosa Parks Ward complainants were not always kept up to date about the status of their complaint.

However:

- Although there had been improvement since our last inspection in July 2017, the Croydon assessment and liaison team was unable to meet their target for assessing non-urgent referrals within 28 days and the team had a long waiting list of over 550 triaged non-urgent at the time of inspection
- The service needed to further improve its bed management of the acute wards and PICUs. Bed occupancy was above 100% on most wards, which meant staff may not have been able to manage the care of patients safely. There was not always a bed available for someone who needed one. The trust had 300 patients in out-of-area beds between February 2018 and December 2018. We found six incidents where patients in psychiatric intensive care units were ready for discharge to acute wards but were unable to transfer due to lack of acute beds. This meant patients experienced care at a higher level of security than what was needed.
- At the last inspection in July 2018, there was not always a bed available for patients returning from leave. At this inspection, although the number of incidents had decreased significantly, and senior managers had good oversight, there were still four occasions where a bed was not available when patients returned from leave.

Summary of findings

- The length of stay on the rehabilitation wards was very variable. Whilst the aim was for the length of stay to be under a year, several patients had been on the wards for a number of years. However, there were plans being developed with the South London Partnership to reconfigure the rehabilitation model and address this.
- There were shortfalls in the environment on some wards and in some community teams. The facilities on LEO Unit (acute ward) did not always promote patients' privacy and dignity. Some bedroom doors did not give patients the option to close vision into their bedrooms, therefore staff and patients passing by could see into their bedrooms. On the mother and baby unit there was a lack of ensuite facilities, an insufficiently sized nursery, lack of safe garden space, and not enough space for patients to meet with visitors. The trust had a long-term estate strategy, but these shortfalls could not be addressed quickly. In the Southwark, Lambeth and Lewisham perinatal community teams there were insufficient rooms available to meet with patients. Whilst appointments had not been cancelled, staff had to plan carefully to ensure everyone was seen.
- Some patients on the rehabilitation wards were not satisfied with the quality of food or the choices available to them, although work was underway to improve food provision.

Are services well-led?

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

- At this inspection we rated well-led as requires improvement in one of the four core services and good in the other three services. When these ratings were combined with the other existing ratings from previous inspections, one of the trust services was rated requires improvement, 11 were rated good, and three were rated outstanding.
- At the last inspection we found that, patients from the local communities of working age adults being supported on the acute care pathway, either as an inpatient or by adult community mental health teams could not be assured of receiving consistently high standards of care. There had been breaches of fundamental standards of care and on the acute wards with some patients sleeping on couches. At this inspection we found that the trust board and senior leaders had implemented changes that were improving care. Considerable work had already taken place but there was more to do to deliver sustainable change.
- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to continue making the necessary changes to provide high quality care to their local communities. Since the last inspection the chair had unexpectedly retired and the deputy chair was acting during the interim while a new permanent chair was appointed. The non-executive directors felt that they were working closely and effectively with the executive directors and were well supported by the interim chair. The chief executive was retiring and a replacement appointed with a well-planned handover due to take place. The new chief executive was coming from a neighbouring trust and so was already familiar with the trust and local partnerships. A director of people and organisational development had been appointed working across two neighbouring trusts.
- Since the last inspection the directorate structures and borough-based working for local services had become more embedded. The directorate structures ensured clinical leaders had manageable spans of control. The numbers of matrons across the organisation had been increased to support teams to provide high quality care. This was leading to improved partnership working to address challenges in boroughs with partners to meet the needs of local people.
- The board had improved oversight of operational issues. The governance processes had been strengthened with each directorate having a monthly quality and performance review. Links with wards and teams were also being strengthened. This was supported by a business information system which made information available in an accessible format at all levels of the organisation. This was enabling achievements and concerns to be escalated appropriately. The trust was identifying problem areas and work was, for the most part, underway to resolve matters.

Summary of findings

- The trust's active participation in the South London Partnership was continuing to deliver new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home. The success of this work was leading to discussions with clinical commissioning groups about the transfer of budgets for local services.
- Since the last inspection the trust had launched its strategy 'Changing lives'. This recognised the needs of the population in the four London boroughs. The strategy also aligned to national priorities and the Five Year Forward View for Mental Health. The strategy stated how the trust will meet the aims of providing quality services; working in partnership; being a great place to work; promoting innovation and providing value. The strategy had been presented using a range of formats including an excellent film following the lives of five patients and their clinicians talking about how the work of the trust had helped them to improve their lives.
- The trust was making progress with their quality improvement programme and had set ambitious targets for the next three years. At this inspection most of the wards and teams we visited spoke with enthusiasm about the quality improvement projects that were taking place. On inpatient wards we saw positive examples of reductions in violence and aggression linked to the 'four steps to safety' programme. Over 1000 staff had been trained in QI. Patients and carers were active participants in many of the projects. However, further work was needed to ensure that projects were available on the QI intranet so they could be shared between teams.
- Staff engagement remained a high priority for the trust. An ambitious programme of leadership walkabouts was continuing to promote good communication. This meant that the leadership team had a good understanding of the challenges being faced by staff working in front-line services and were working to address them. This was particularly apparent in the service transformation work being carried out in adult community mental health services. The trust promoted staff to speak up through the Freedom to Speak Up Guardian and at this inspection there was an improved awareness of this role.
- The trust, since the last inspection had continued to develop and deliver an equalities strategy. There had been a particular focus on BME staff experience led by the BME staff network. The trust had plans in place to improve the workforce race equality standards through offering leadership development for BME staff; having BME staff on recruitment panels for all band 7 posts and above; introducing a checklist to enable managers to reflect on whether alternative approaches could take place prior to a disciplinary process. Other networks were less well developed but were bring supported to grow. This included an LGBTQ network and one for staff with lived experience.

However:

- The inspection took place at a time when change was happening for the board and executive leadership team. Whilst it was positive to see the progress that had taken place, further work was needed to ensure effective leadership across wards and teams and for the improvements across the trust to be further embedded. The trust recognised that continuing to improve the care of patients receiving acute care and treatment remained an ongoing priority.
- Services did not use a recognised model of rehabilitation care on each rehabilitation unit and did not have a clear overarching rehabilitation strategy. Most staff did not understand the model of care provided. Some interventions to support the development of independent living skills and support their rehabilitation and recovery were quite limited.
- At the last inspection in July 2018, eight of the acute and PICU wards did not have a permanent ward manager, which led to a lack of stability. At this inspection, there had been an improvement, and the trust had worked hard to recruit into these posts. However, there were five wards that did not have a permanent ward manager. The interim ward managers told us they were being supported by senior managers. Whilst progress had been made the five ward managers and three consultant psychiatrist posts needed to be filled to strengthen the leadership across the acute wards.

Summary of findings

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 two services we inspected:

- Long stay/rehabilitation mental health wards for adults of working age
- Perinatal services

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

Areas for improvement

We found areas for improvement including breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 9 Person-centred care; Regulation 12 Safe care and treatment; Regulation 17 Good governance and Regulation 18 Staffing. There were nine things the trust must put right in relation to breaches of these four regulations. In addition, we found 44 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.

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

Action we have taken

We issued requirement notices in respect of the four regulations that had been breached within three core services.

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

Long stay/rehabilitation mental health wards for adults of working age

- Staff at Heather Close involved patients in their Care Programme Approach (CPA) meetings. Patients were encouraged to chair their own CPA meeting. Staff and patients had co-produced the questions they would ask to facilitate the meeting. Seventy percent of patients said they would like to chair their CPA meeting again having experienced it.
- Heather Close had devised health passports for patients as well as communication passports for patients with learning disabilities. Health passports and communication passports could be used by patients to share information about themselves with medical professionals external to the organisation, for example their GP or medical staff at a general hospital. Passports included vital information, was in an easy to read format and supported by pictures.

Summary of findings

- Staff at Tony Hillis Unit helped facilitate a group in conjunction with the forensic personality disorder community team to support patients with substance misuse problems alongside their mental health problems. This group used a behavioural treatment for substance misuse model, an evidence-based harm-reduction approach, which involved payments for patients who attended groups. Group evaluation measures showed a decrease in the number of patients going absent from the ward and a reduction in illicit drug use by participants.

Perinatal services

- The team leader of the Croydon community perinatal team founded and chaired the pan-London perinatal nurse's network where staff across all community perinatal services in London meet four times a year to share learning and best practice.
- Psychiatrists from the perinatal service had cowritten a paper published in the British Journal of Psychiatry titled 'Mother and Baby Units matter: improved outcomes for both.'

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 eight actions relate to three core services. There is also one breach outstanding from the previous inspection of wards for older people with mental health problems in March 2017.

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

- The trust must continue to address the high number of nursing vacancies on some wards through active recruitment and retention strategies to ensure patients receive care appropriate to their needs. **Regulation 18(1) Staffing**
- The trust must improve patient flow to and between acute and PICUs and continue to work on access to appropriate beds which meet the needs of patients who are on the wards, so that patients are not detained on wards with higher levels of security than they need. **Regulation 9(1) Person centred care**

Community mental health services for adults of working age

- The trust must continue to ensure that all patients have up-do-date risk assessments and staff update these after any changes to patients' circumstances and risk events. **Regulation 12(1)(2)(a)(b) Safe care and treatment**
- The trust must continue to ensure that patients who require a Mental Health Act assessment are assessed without undue delay to ensure their safety and that of others. **Regulation 12(1)(2)(a)(b)**
- The trust must continue to ensure that the Croydon assessment and liaison team meets their target for assessing non-urgent referrals within 28 days and continues to reduce its waiting list. **Regulation 9(1)(a)(b) Person centred care**
- The trust must ensure that medicine management audits are sufficiently rigorous to pick up errors in the management of prescription stationery, monitor medicines of patients on a community treatment order and monitor medicines in stock in individual services. **Regulation 12(2)(g) Safe care and treatment**

Long stay or rehabilitation mental health wards for working age adults

Summary of findings

- The trust must ensure that there is a clear rehabilitation strategy and model of rehabilitative recovery-oriented care provided, which staff on all rehabilitation wards can understand and articulate. **Regulation 17(2)(a) Good governance**
- The trust must ensure that patient care plans contain details of work to support recovery including goals for how each patient can successfully achieve their discharge. **Regulation 9(1)(2)(3) Person centred care**

Wards for older people with mental health problems (from inspection in March 2017)

- The provider must ensure that all relevant staff complete training in mandatory areas including intermediate life support, basic life support, and fire safety.

Action the trust SHOULD take to improve

We told the trust that it should take action to comply with minor breaches that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These 45 new actions related to the whole trust and four core services.

Trust wide

- The trust should continue to work to ensure effective leadership across wards and teams and to ensure that improvements across the trust are fully embedded, particularly for patients receiving acute care and treatment.

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

- The trust should ensure that staff continue to consistently carry out physical health checks on patients after they receive rapid tranquilisation in line with trust policy.
- The trust should ensure that wards have medical input from a permanent consultant psychiatrist to promote medical leadership and consistency of care and treatment to patients.
- The trust should continue the autism training for staff on all acute and PICU wards.
- The trust should continue to ensure they recruit permanent ward managers for the wards.
- The trust should ensure that all environmental risks are recorded on environmental risk assessments, that environmental risk assessments have timescales for actions identified, and the trust policy is clear on the use of plastic bin liners in communal areas.
- The trust should ensure that all ward areas, including bathroom and toilets, are kept clean.
- The trust should ensure maintenance and repair issues are addressed in a timely manner.
- The trust should ensure there are sufficient alarms available for staff and patients especially on Virginia Woolf ward.
- The trust should ensure patient restraint records demonstrate patients have been offered a debrief following a restraint.
- The trust should ensure all patients have care plans to meet their physical and mental health needs.
- The trust should continue to ensure that staff carry out physical observations of patients with specific physical health needs, including blood glucose monitoring for patients with diabetes and food and fluid intake monitoring.
- The trust should keep the number of clinical psychologists under review to ensure there are sufficient numbers to meet the needs of patients in line with NICE guidance.
- The trust should ensure that all staff receive regular managerial and clinical supervision in line with trust policy.

Summary of findings

- The trust should ensure that staff request a second opinion appointed doctor when necessary in a timely manner, and that all pharmacological treatments are included on patients' certificate of consent to treatment.
- The trust should ensure that staff have a clear understanding of safeguarding policies and are consistently making appropriate referrals to local authorities as necessary.
- The trust should ensure that managers handle complaints in line with the trust policy.
- The trust should ensure that on Leo Unit, patients have the option to close vision panels on their bedroom doors, to ensure privacy and dignity is promoted.
- The trust should continue to work on embedding communication across boroughs where there are similar wards so that learning from incidents can be better shared.
- The trust should ensure that there are clear governance processes so that issues raised on the wards are reflected on local risk registers as necessary.

Community mental health services for adults of working age

- The trust should continue to work on recruiting permanent staff to reduce vacancy levels.
- The trust should continue to ensure all patients have an up-to-date care plan that reflects their current needs.
- The trust should continue to ensure that patients have access to psychological therapies without undue delay in line with best practice guidance.
- The trust should ensure that staff explain patients' rights in respect of community treatment orders consistently in accordance with the Mental Health Act (MHA) Code of Practice and keep accurate records of consent to treatment in line with the MHA and when patients' rights have been explained.
- The trust should ensure that all patients are offered a copy of their care plan.

Long stay or rehabilitation mental health wards for working age adults

- The trust should ensure that staff at Tony Hillis Unit are all clear about the use of blanket restrictions and how these should meet the needs of individual patients.
- The trust should ensure there is enough space to store medicines safely at Heather Close.
- The trust should ensure that all the necessary details are included when recording incidents of restraint.
- The trust should ensure that the clinical psychology post at Heather Close is filled.
- The trust should ensure that staff at Heather Close have adequate pharmacy support to enable patients to be able to take part in a self-medication programme.
- The trust should ensure appropriate measures are in place on the Tony Hillis Unit so that patients NEWS scores are accurately recorded.
- The trust should ensure that where patients may be reluctant to vacate the ward in the event of a fire that individual evacuation plans are in place and understood by staff.
- The trust should provide staff with training on how to meet the needs of patients with autism.
- The trust should ensure that staff at understand when patients' rights need to be explained to them in accordance with Mental Health Act and trust policy. The mental health medicines prescribed at Heather Close must align with those that have been legally approved policy. The trust should ensure that there is enough information available to patients with protected characteristics to ensure they feel included and welcomed.

Summary of findings

- The trust should continue to work with the catering company to ensure that food provided for patients is of adequate quality and that a suitable variety of meals is offered to all patients including meeting the cultural needs of patients.
- The trust should continue to promote the rights of patients with protected characteristics.
- The trust should ensure that the ward-based governance meetings cover all the topics thoroughly and are clearly recorded.
- The trust should ensure that where clinical audits identify areas for improvement that the actions to address this are recorded.

Perinatal services

- The trust should continue to address staffing vacancies and retention in the MBU and community perinatal teams to ensure consistency of staffing for patients.
- The trust should ensure that waiting times for non-urgent appointments do not routinely exceed four weeks.
- The trust should continue to recruit psychologists in order to address long waits for psychological therapies in the community perinatal teams, to ensure that they are provided within National Institute for Health and Care Excellence recommended timeframes.
- The trust should provide perinatal specific competencies for staff working in the MBU or community perinatal teams.
- The trust should ensure that staff working in the MBU and community teams consistently receive monthly management and clinical supervision, in line with trust policy.
- The trust should consider providing equipment for community perinatal teams to use for measuring patients' physical health, if they are unable to access their GP.
- The trust should address the identified shortfalls in the MBU environment, and the premises in which the community teams are based to ensure they meet the needs of the patients.

Forensic inpatient/secure wards (from inspection in July 2018)

- The trust should ensure that staff maintain detailed restraint records that include the specific type of hold, duration and staff members involved.
- The trust should ensure there is adequate staffing cover across all the wards and that there are sufficient staff to provide escorted leave.
- The trust should ensure that staff on Effra Ward are able to access meetings where lessons learned from incidents in the service and across the trust are discussed.
- The trust should ensure that where clinical audits identify areas for improvement that action plans are in place.

Mental health crisis services and health based place of safety (from inspection in July 2018)

- The trust should ensure that when staff supply medicines to patients at home that it is packaged and labelled in accordance with the Human Medicines Regulations 2012.
- The trust should ensure staff follow the trust policy for assessing and recording the suitability of patients' own medicines before administering them.
- The trust should ensure that the patient s.132 rights poster displayed in the health-based place of safety assessment rooms clearly explains patients' rights in line with the Mental Health Act.

Summary of findings

- The trust should continue to monitor and work towards making sure patients do not stay in the health-based place of safety for longer than 24 hours.
- The trust should ensure that staff in the health-based place of safety clearly document how they arrive at their decision when completing mental capacity assessments for consent to treatment.
- The trust should ensure staff are aware of the role of the Freedom to Speak up Guardian and how to contact them.

Community-based mental health services for older people (from inspection in July 2018)

- The trust should enable more effective mobile working in all teams through the provision of appropriate technology.
- The trust should ensure that systems for capturing the completion of staff supervision are effective and accurately record the supervision taking place.
- The trust should ensure that learning from incidents and complaints is discussed at team business meetings to support improvements.

Specialist eating disorder services (from inspection in July 2018)

- The trust should put in place a formal eating disorders competency framework for staff to ensure that have all the specialist skills they need to care for a patient with an eating disorder.
- The trust should ensure staff record incidents of restraint accurately including the type of restraint, position of restraint, members of staff involved, length of time the restraint took place and whether the patient received a physical health check for any injuries post restraint.
- The trust should ensure that the service continues to review the dietitian and social worker input to the ward, as well as to the Step Up to Recovery team.
- The trust should ensure that all staff receive regular monthly supervision.
- The trust should ensure that patients are given a copy of their care plan and an induction to the ward on admission.
- The trust should ensure that learning and improvements result from audits.

Specialist neuropsychiatric services (from inspection in July 2018)

- The trust should ensure that all staff receive regular clinical supervision, to support them in carrying out their duties effectively.
- The trust should ensure that all areas of the ward identified as a risk are consistently monitored to mitigate the risks to patients, especially when staffing levels are low.
- The trust should ensure that staff check the expiry date of all items in the clinic room to ensure that these are removed and replaced before expiry.
- The trust should ensure that staff complete their mandatory training, especially in life support.
- The trust should review the blanket restriction with regard to no patients having keys to their bedrooms, which means that they have to rely on staff to lock and unlock their rooms.
- The trust should ensure that incidents relating to the service, especially medicines incidents, are categorised correctly to ensure that appropriate learning is shared with staff.
- The trust should ensure that patients have access to appropriate leisure activities and not spend too much time watching television during the day.

Summary of findings

- The trust should ensure that patients have opportunities to give feedback on the service they received, for example by holding regular community meetings.
- The trust should ensure that family members of patients on the ward are encouraged to give feedback about the service.
- The trust should ensure that that patient details recorded on the office whiteboard are not visible to people outside the room.

Wards for older people with mental health problems (from inspection in March 2017)

- The provider should ensure that accurate records are maintained of post dose vital sign monitoring after patients receive rapid tranquilisation.
- The provider should ensure that records are maintained of blind spots on each ward, to ensure that new staff are aware of these risk areas.
- The provider should ensure that all staff receive regular supervision sessions in line with the trust policy and that this is monitored effectively.
- The provider should ensure that staff provide patients with the option of having clinical observations carried out in a private area such as the ward clinic room or their bedroom.
- The provider should review the policy regarding ensuring that informal patients are given clear information about their right to leave each ward.
- The provider should ensure that staff and patients are aware of how to ensure their privacy in the identified bathroom on Aubrey Lewis 1 ward, by closing the frosted windows.
- The provider should consider the addition of an accessible bathroom within the female patients' area on Aubrey Lewis 1 ward.
- The provider should ensure that patients have access to the laundry rooms on the wards, following a risk assessment, to ensure and they are supported to maintain their independent living skills.
- The provider should ensure that accessible menus are available to patients with dementia and improve consistency in ensuring that patients have a choice of meals.
- The provider should ensure that ward managers are made aware of the issues recorded on the clinical academic group risk register and further develop links between senior management and ward level.
- The provider should ensure that informal patients on Hayworth Ward are given clear information about their right to leave the ward in the posters on display.

Child and adolescent mental health wards (from inspection in September 2015)

- The trust should continue to recruit new staff to fill vacancies and that it ensures safe staffing numbers are met at all times.
- The trust should ensure that it continues to monitor risk assessments and care plans on Acorn Lodge to ensure that all are up-to-date.
- The trust should ensure that it develops a clear timetable for planning, approving and commencing redesign work to separate the wards on the Woodlands unit.
- The trust should ensure that it looks into developing a child friendly menu for Acorn Lodge.
- The trust should ensure that all staff receive regular one-to-one formal supervision.

Summary of findings

- The trust should ensure that sufficient staff are trained in using the gym equipment, so young people can access this resource at more times.

Specialist community mental health services for children and adolescents (from inspection in September 2015)

- The trust should ensure that the environment at Lambeth is safe for those people who use or work in the service.
- The trust should ensure that infection control audits are carried out across all CAMHS.
- The trust should continue to monitor and review the services to ensure that all children and young people can access the service in a timely manner.
- The trust should ensure that all staff have IT equipment and patient record systems that enable them to access the information they need in a timely manner.
- The trust should ensure that there is a consistent approach to the documentation of patient care and treatment, including risk assessments, care plans and consent.

Other specialist services (National Psychosis Unit) (from inspection in September 2015)

- The trust should ensure that where patients are being observed that this is recorded correctly.
- The trust should ensure the ligature risk assessment covers all areas of the ward used by patients.
- The trust should ensure that the door to the women's bedroom area of the ward is kept secured when needed.
- The trust should ensure that all temporary staff working on the ward receive a timely local induction.
- The trust should ensure that the ongoing refurbishment work includes the redecoration of the communal lounge.
- The trust should ensure that risk assessments are kept updated as new potential risks are identified.
- The trust should ensure that where a safeguarding alert is made, that the patient records are kept up to date to ensure any actions identified as part of that process are followed through.

All musts and shoulds outstanding from inspections in 2015, 2017 and 2018 will be followed up at the next inspection of the relevant core services.

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.

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

Summary of findings

- At the last inspection we found that, patients from the local communities of working age adults being supported on the acute care pathway, either as an inpatient or by adult community mental health teams could not be assured of receiving consistently high standards of care. There had been breaches of fundamental standards of care and on the acute wards with some patients sleeping on couches. At this inspection we found that the trust board and senior leaders had implemented changes that were improving care. Considerable work had already taken place but there was more to do to deliver sustainable change.
- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to continue making the necessary changes to provide high quality care to their local communities. Since the last inspection the chair had unexpectedly retired and the deputy chair was acting during the interim while a new permanent chair was appointed. The non-executive directors felt that they were working closely and effectively with the executive directors and were well supported by the interim chair. The chief executive was retiring and a replacement appointed with a well-planned handover due to take place. The new chief executive was coming from a neighbouring trust and so was already familiar with the trust and local partnerships. A director of people and organisational development had been appointed working across two neighbouring trusts.
- Since the last inspection the directorate structures and borough-based working for local services had become more embedded. The directorate structures ensured clinical leaders had manageable spans of control. The numbers of matrons across the organisation had been increased to support teams to provide high quality care. This was leading to improved partnership working to address challenges in boroughs with partners to meet the needs of local people.
- The board had improved oversight of operational issues. The governance processes had been strengthened with each directorate having a monthly quality and performance review. Links with wards and teams were also being strengthened. This was supported by a business information system which made information available in an accessible format at all levels of the organisation. This was enabling achievements and concerns to be escalated appropriately. The trust was identifying problem areas and work was, for the most part, underway to resolve matters.
- The trust's active participation in the South London Partnership was continuing to deliver new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home. The success of this work was leading to discussions with clinical commissioning groups about the transfer of budgets for local services.
- Since the last inspection the trust had launched its strategy 'Changing lives'. This recognised the needs of the population in the four London boroughs. The strategy also aligned to national priorities and the Five Year Forward View for Mental Health. The strategy stated how the trust will meet the aims of providing quality services; working in partnership; being a great place to work; promoting innovation and providing value. The strategy had been presented using a range of formats including an excellent film following the lives of five patients and their clinicians talking about how the work of the trust had helped them to improve their lives.
- The trust was making progress with their quality improvement programme and had set ambitious targets for the next three years. At this inspection most of the wards and teams we visited spoke with enthusiasm about the quality improvement projects that were taking place. On inpatient wards we saw positive examples of reductions in violence and aggression linked to the 'four steps to safety' programme. Over 1000 staff had been trained in QI. Patients and carers were active participants in many of the projects. However, further work was needed to ensure that projects were available on the QI intranet so they could be shared between teams.
- Staff engagement remained a high priority for the trust. An ambitious programme of leadership walkabouts was continuing to promote good communication. This meant that the leadership team had a good understanding of the

challenges being faced by staff working in front-line services and were working to address them. This was particularly apparent in the service transformation work being carried out in adult community mental health services. The trust promoted staff to speak up through the Freedom to Speak Up Guardian and at this inspection there was an improved awareness of this role.

- The trust, since the last inspection had continued to develop and deliver an equalities strategy. There had been a particular focus on BME staff experience led by the BME staff network. The trust had plans in place to improve the workforce race equality standards through offering leadership development for BME staff; having BME staff on recruitment panels for all band 7 posts and above; introducing a checklist to enable managers to reflect on whether alternative approaches could take place prior to a disciplinary process. Other networks were less well developed but were bring supported to grow. This included an LGBTQ network and one for staff with lived experience.

However:

- The inspection took place at a time when change was happening for the board and executive leadership team. Whilst it was positive to see the progress that had taken place, further work was needed to ensure effective leadership across wards and teams and for the improvements across the trust to be further embedded. The trust recognised that continuing to improve the care of patients receiving acute care and treatment remained an ongoing priority.

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
Requires improvement →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 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	Requires improvement → ← Jul 2019	Requires improvement → ← Jul 2019	Good → ← Jul 2019	Requires improvement ↑ Jul 2019	Good ↑↑ Jul 2019	Requires improvement ↑ Jul 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Jul 2019	Requires improvement ↓ Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Requires improvement ↓ Jul 2019	Requires improvement ↓ Jul 2019
Forensic inpatient or secure wards	Good ↑ Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good ↑ Oct 2018	Good → ← Oct 2018	Good ↑ Oct 2018
Child and adolescent mental health wards	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016
Wards for older people with mental health problems	Requires improvement → ← Jun 2017	Good → ← Jun 2017	Good → ← Jun 2017	Good → ← Jun 2017	Good → ← Jun 2017	Good → ← Jun 2017
Wards for people with a learning disability or autism	Good → ← Jan 2016	Outstanding → ← Jan 2016	Outstanding → ← Jan 2016	Good → ← Jan 2016	Outstanding → ← Jan 2016	Outstanding → ← Jan 2016
Community-based mental health services for adults of working age	Requires improvement → ← Jul 2019	Good ↑ Jul 2019	Good → ← Jul 2019	Requires improvement → ← Jul 2019	Good → ← Jul 2019	Requires improvement → ← Jul 2019
Mental health crisis services and health-based places of safety	Good ↑ Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018
Specialist community mental health services for children and young people	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016	Good → ← Jan 2016
Community-based mental health services for older people	Good ↑ Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Outstanding ↑ Oct 2018	Good → ← Oct 2018
Community mental health services for people with a learning disability or autism	Good → ← Jan 2016	Outstanding → ← Jan 2016	Outstanding → ← Jan 2016	Good → ← Jan 2016	Outstanding → ← Jan 2016	Outstanding → ← Jan 2016
Perinatal services	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Services for people with acquired brain injury	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Specialist eating disorders service	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Requires improvement → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 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.

Perinatal services

Good

Key facts and figures

South London and Maudsley Foundation Trust provides an inpatient Mother and Baby Unit (MBU) and community based perinatal mental health teams for the London boroughs of Croydon, Lambeth, Lewisham and Southwark. Perinatal services come under the trust's Psychological Medicine and Older Adults directorate.

The MBU offers multidisciplinary mental health assessments, treatment and support for women from all over the country and is based at the Bethlem Royal Hospital. It provides support to women during pregnancy and in the 12 months following the birth of their baby, with beds for up to 13 patients and their babies. The team are also able to provide one be for a parenting assessment on the unit.

The community perinatal mental health teams offer multidisciplinary specialist assessment, care and treatment for women who are pregnant or have a baby up to 12 months old and are experiencing mental health problems that are moderate or severe in nature. They also provide preconception advice for women with mental health issues.

The teams mainly receive referrals from a wide range of sources including GPs, community mental health services, maternity, general or mental health inpatient wards.

The current inspection was announced 30 minutes before the inspection. This was in line with CQC guidance.

We inspected these services:

- The Channi Kumar mother and baby unit (MBU)
- Croydon Perinatal mental health community team
- Southwark Perinatal mental health community team
- Lambeth Perinatal mental health community team
- Lewisham Perinatal mental health community team

This was the first CQC inspection of this core service.

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

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

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

- visited the MBU and four community perinatal mental health teams
- spoke with the manager or most senior person available for each of the teams

Perinatal services

- checked the quality and safety of the premises
- observed how staff worked with patients
- spoke with three patients at the MBU
- observed one patient pre-birth planning consultation
- spoke with 32 staff, including psychiatrists, junior doctors, clinical support leads, registered nurses, nursery nurses, occupational therapists, psychologists, social workers, support workers, and administrators
- spoke with the general manager and deputy director from the directorate covering these services
- spoke with a community midwife, and a maternity ward midwife who had links with two perinatal community teams
- read 11 staff supervision records
- attended and observed four multi-disciplinary meetings including handovers, referrals and zoning meetings
- checked 17 patient risk assessments and care and treatment records
- checked four baby care plans in the MBU
- checked 11 medicines administration records in the MBU
- read a range of policies, procedures and other documents relating to the operation of the services.

Following the inspection, we spoke with 14 patients from the four community perinatal mental health teams by telephone.

Summary of this service

We rated this service as **good** because:

- The service provided safe care. Staff assessed and managed risk well and followed good practice with respect to safeguarding and management of medicines. Managers investigated incidents appropriately, shared lessons learned with the wider service, and gave patients honest information and suitable support.
- Staff developed holistic, recovery-oriented care and treatment informed by a comprehensive assessment. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of patients. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation. Staff directed patients to other services when appropriate and, if required, supported them to access services, such as local children's centres.
- 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 respected their privacy and dignity. They understood the complex individual needs of patients preparing for motherhood, and as new mothers, and supported them to manage their mental health, and develop parenting skills. They actively involved patients and families and carers in care decisions.

Perinatal services

- The service was easy to access. Staff assessed and treated patients who required urgent care promptly. The criteria for referral to the service did not exclude patients who would have benefitted from care. Staff followed up patients who missed appointments.
- The service was well-led, and governance processes ensured that procedures relating to the work of the service ran smoothly. Staff were encouraged to be involved in research and innovative practices.

However:

- Staffing vacancies and poor staff retention were having an impact on the consistency of support for patients and led to increased stress on the remaining staff. However, recruitment was taking place specifically for the service and they were also using regular temporary staff where possible. One community perinatal team had waiting times for non-urgent appointments to see a doctor of over four weeks although urgent appointments were available.
- Although it did not compromise safety because staff mitigated the risks, the physical environment of the mother and baby unit was not ideally suited to support high quality care. There was a lack of ensuite facilities, the nursery was too small, the garden space was not safe for use by all patients, and there was not enough space for patients to meet with visitors. The trust had a long-term estate plan but these shortfalls could not be addressed quickly. In the Southwark, Lambeth and Lewisham perinatal community teams, there were insufficient rooms available to meet with patients. Whilst appointments had not been cancelled, staff had to plan carefully to ensure everyone was seen.
- There were long waits for psychological therapies in the community perinatal teams, which did not always meet the recommended timeframes of assessing patients within two weeks and providing treatment within four weeks. In two boroughs patients were waiting up to 16 weeks. More clinical psychologists were being recruited and assistant psychologists were offering more group work in the interim period.
- Whilst average numbers of staff receiving regular supervision across the services was over 80% there were a few areas where this had gone lower. For example, in March 2019 this had fallen to 67% in the MBU. However, all staff felt well supported by their managers and had regular access to reflective practice. The MBU manager was aware of levels of supervision and was working to ensure they were consistently within the trust target.

Is the service safe?

Good

This was our first time inspecting this service. We rated it as good because:

- Staff assessed and managed risks to patients and their families, and to themselves. They responded promptly to deterioration in a patient's health and worked with patients and their families to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in their level of risk. Staff followed personal safety protocols.
- Risks to patients were discussed in multidisciplinary meetings, individual reviews, and handovers meetings. Staff used a red, amber, green rating system in place to identify patients at the highest risk levels.
- Staff understood how to protect patients and their family members from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it.
- Staff used systems and processes to safely prescribe, administer, record and store medicines in the MBU. Staff across the service regularly reviewed the effects of medicines on each patient's physical health.

Perinatal services

- 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.

However:

- Staffing vacancies and retention were having an impact on the consistency of support for patients and led to increased stress on the remaining staff. However, recruitment was taking place specifically for the service and they were also using regular temporary staff where possible. One community perinatal team had waiting times for non-urgent appointments to see a doctor of over four weeks although urgent appointments were available.

Is the service effective?

Good

This was our first time inspecting this service. We rated it as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and their families/carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. There were separate care plans in place for babies in the MBU.
- Staff provided a range of treatment and care for the patients based on national guidance and 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 teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, 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 teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation such as midwife and health visitor services.
- 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 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- There were long waits for psychological therapies in the community perinatal teams, which did not always meet the recommended timeframes of assessing patients within two weeks and providing treatment within four weeks. In two boroughs patients were waiting up to 16 weeks for individual treatment. The trust was recruiting more clinical psychologists and, while this was taking place, assistant psychologists were offering more group work.

Perinatal services

- Whilst average numbers of staff receiving regular supervision across the services was over 80% there were a few areas where this had gone lower. For example, in March 2019 this had fallen to 67% in the MBU. However, all staff felt well supported by their managers and had regular access to reflective practice. The MBU manager was aware of levels of supervision and was working to ensure they were consistently within the trust target.
- There were no perinatal specific competencies for staff working in the MBU or community perinatal teams.

Is the service caring?

Good

This was our first time inspecting this service. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the complex individual mental health needs of patients preparing for motherhood and as new mothers, and supported patients to understand and manage their care, treatment or condition and develop parenting skills. Patient feedback was very positive about the quality of care they received across all perinatal services.
- Staff directed patients to other services when appropriate and, if required, supported them to access services, such as local children's centres and baby groups.
- 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 access to advocates when needed.
- Staff enabled patients to give feedback on the service they received. The MBU held weekly community meetings, and community teams had recently set up a service user forum across all four boroughs that met every six to eight weeks. Patients provided feedback and input on services, training and policies and helped with recruitment.
- Staff informed and involved families and carers appropriately. Staff had undertaken a recent survey of the views of fathers/partners of patients in the MBU, to find out their preferences for support. Teams provided family and couple therapy with patients.

Is the service responsive?

Good

This was our first time inspecting this service. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Staff followed up patients who missed appointments.
- The service met the needs of all patients 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 all staff.

However:

- Although it did not compromise safety because staff mitigated the risks, the physical environment of the mother and baby unit was not ideally suited to support high quality care. There was a lack of ensuite facilities, the nursery was too

small, the garden space was not safe for use by all patients, and there was not enough space for patients to meet with visitors. The trust had a long-term estate plan but these shortfalls could not be addressed quickly. In the Southwark, Lambeth and Lewisham perinatal community teams, there were insufficient rooms available to meet with patients. Whilst appointments had not been cancelled, staff had to plan carefully to ensure everyone was seen.

- The community perinatal teams did not have equipment for staff to use for measuring patients' physical health if they were unable to access their GP.

Is the service well-led?

Good

This was our first time inspecting this service. 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 trust provided 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 team level and that performance and risk were managed well.
- Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. On the MBU recent quality improvement projects improved the focus of the nursing handover meeting, and rearranged ward rounds, so that fewer staff attended, as this could be intimidating for some patients.

Outstanding practice

- The team leader of the Croydon community perinatal team founded and chaired the pan-London perinatal nurse's network where staff across all community perinatal services in London meet four times a year to share learning and best practice.
- Psychiatrists from the perinatal service had cowritten a paper published in the British Journal of Psychiatry titled 'Mother and Baby Units matter: improved outcomes for both.'

Areas for improvement

Action the provider SHOULD take to improve:

- The trust should continue to address staffing vacancies and retention in the MBU and community perinatal teams to ensure consistency of staffing for patients.
- The trust should continue to address waiting times for the community perinatal teams, in particular the Lewisham team, to ensure that waiting times for non-urgent appointments do not routinely exceed four weeks.
- The trust should continue to recruit psychologists in order to address long waits for psychological therapies in the community perinatal teams, to ensure that they are provided within National Institute for Health and Care Excellence recommended timeframes.

Perinatal services

- The trust should provide perinatal specific competencies for staff working in the MBU or community perinatal teams.
- The trust should ensure that staff working in the MBU and community teams consistently receive monthly management and clinical supervision, in line with trust policy.
- The trust should consider providing equipment for community perinatal teams to use for measuring patients' physical health, if they are unable to access their GP.
- The trust should address the identified shortfalls in the MBU environment, and the premises in which the community teams are based to ensure they meet the needs of the patients.

Community-based mental health services of adults of working age

Requires improvement 

Key facts and figures

South London and Maudsley Foundation Trust provides a range of community based mental health teams for adults of working age living in the London boroughs of Croydon, Lambeth, Lewisham and Southwark. The teams offer specialist assessment, care and treatment for adult patients whose mental health needs cannot be met by their GP. Each team has staff from arrange of disciplines and links with a group of GP practices and statutory and voluntary agencies in their local area.

The teams mainly receive referrals from in-patient mental health wards, accident and emergency departments and GPs. The teams aim to work in partnership with patients and other services to promote recovery and social inclusion. Teams deliver and coordinate a range of mental health care and treatment. Staff refer patients to the care of their GP when their mental health has improved.

This was a comprehensive inspection which was announced two working days in advance to ensure that everyone we needed to talk to was available.

We inspected these services:

- Croydon assessment and liaison team
- Croydon early intervention team
- Croydon promoting recovery team - Thornton Heath, Woodside and Shirley
- Croydon promoting recovery team - Mayday Network
- Lambeth assessment and liaison team
- Lambeth early intervention team
- Lambeth promoting recovery team - north
- Lambeth promoting recovery team - south east
- Lewisham assessment and liaison team
- Lewisham early intervention team
- Lewisham promoting recovery neighbourhood 1 team
- Lewisham promoting recovery neighbourhood 2 team
- Southwark assessment and liaison team - south
- Southwark early intervention team
- Southwark promoting recovery team – northwest

The CQC previously inspected these services in July 2017.

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

Community-based mental health services of adults of working age

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information. We also sought feedback from patients and their informal carers through telephone calls made by an expert by experience. An expert by experience is someone who has personal knowledge of community-based services for people with mental health needs. During this inspection we:

- visited 15 community mental health teams
- spoke with the manager for each of the teams
- checked the quality and safety of the premises used by the team
- observed how staff worked with patients
- spoke with 22 patients who were using the service and 6 carers of patients
- spoke with 82 staff, including psychiatrists, doctors, nurses, occupational therapists, pharmacists, psychologists and support workers
- spoke with the lead approved mental health professional (AMHP) for each borough
- read 45 staff supervision and appraisal records
- attended and observed 12 multidisciplinary meetings
- checked 90 patient records including medicines records, risk assessments and care plans and information on community treatment orders
- read a range of policies, procedures and other documents relating to the operation of the community mental health teams.

Summary of this service

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

- Although staff kept detailed records of patients' care and treatment, they had not always ensured that key risk assessment and risk management documents were up to date. These documents were not always accurate in relation to the patient's current circumstances or risks.
- At the last inspection in July 2017, patients identified as in need of a Mental Health Act assessment were not assessed promptly. During this inspection, this remained an issue. There were still delays with patients getting Mental Health Act assessments done in a timely manner. However, the trust was monitoring this closely and working with the local authorities and police to make ongoing improvements. They had also given a clear message that assessments should never be cancelled due to difficulties in accessing a bed.

Community-based mental health services of adults of working age

- Although there had been improvement since our last inspection, the Croydon assessment and liaison team was unable to meet their target for assessing non-urgent referrals within 28 days and the team had a long waiting list of over 550 non-urgent cases.However, the teams did have systems in place to monitor patients on the waiting list.
- The trust did not have effective medicine management audits, monitoring of prescribing and prescription stationery management.

However:

- The service provided safe care. The premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided. The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- 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.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and most patients who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude patients who would have benefitted from care. Governance processes ensured that that procedures relating to the work of the service ran smoothly.

Is the service safe?

Requires improvement  

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

- Although staff kept detailed records of patients' care and treatment, they had not always ensured that key risk assessment and risk management documents were up to date. These documents were not always accurate in relation to the patient's current circumstances or risks.
- At the last inspection in July 2017, patients identified as in need of a Mental Health Act assessment were not assessed promptly. During this inspection, this remained an issue. There were still delays with patients getting Mental Health Act assessments done in a timely manner. The trust was monitoring this closely and working with the local authorities and police to make ongoing improvements. They had also given a clear message that assessments should never be cancelled due to difficulties in accessing a bed.
- The Trust's medicine management audits for community mental health services had not picked up concerns we found relating to management of prescription stationery, antipsychotic medicines prescribed for patients on a CTO and monitoring of medicines in stock at each service.

However:

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Community-based mental health services of adults of working age

- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, 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 worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- 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 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 Although
- 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 improved. We rated it as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and 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 teams included or had access to the full range of specialists required to meet the needs of patients under their care. 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 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 team(s) 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.
- 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:

Community-based mental health services of adults of working age

- We found examples in several teams where community team staff had not updated the care plan document since the patient had been transferred to the team from an inpatient ward.
- Record keeping in relation to patients who were subject to a Mental Health Act community treatment order did not always show that patients' rights were explained regularly, or record patients' consent to treatment.
- Although there had been an increase in clinical psychology input to some teams since our last inspection, some patients in early intervention teams could still wait over a year for individual therapy. However, during that time patients had access to groups facilitated by clinical psychologists.

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 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 advocates when needed.
- Staff informed and involved families and carers appropriately.

However:

- The trust did not have a standardised method for staff to record that the patient had been given a copy of their care plan unless they were under the Care Programme Approach review. Some patients told us they were not offered a copy of their care plan.

Is the service responsive?

Requires improvement 

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

- Although there had been improvement since our last inspection, the Croydon assessment and liaison team was unable to meet their target for assessing non-urgent referrals within 28 days and the team had a long waiting list of over 550 triaged non-urgent at the time of inspection. However, the team did had systems in place to monitor patients on the waiting list.

However:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Staff followed up patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support, and treated concerns and complaints seriously, learning lessons from the results.

Community-based mental health services of adults of working age

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, 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 team level and that performance and risk were managed well.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- The trust had repeatedly raised the issue of long waiting lists for non-urgent assessments with the Croydon assessment and liaison team, with the local clinical commissioning group.

However:

- Although teams had access to most of the information they needed to provide safe and effective care, dashboards did not assist managers and staff in assuring that risk assessment and care plan documents reflected the patient's current situation.

Outstanding practice

Areas for improvement

Action the provider MUST take to improve

- The trust must continue to ensure that all patients have up-do-date risk assessments and staff update these after any changes to patients' circumstances and risk events.
- The trust must continue to ensure that patients who require a Mental Health Act assessment are assessed without undue delay to ensure their safety and that of others.
- The trust must continue to ensure the Croydon assessment and liaison team meets their target for assessing non-urgent referrals within 28 days and continues to reduce its waiting list.
- The trust must ensure that medicine management audits are sufficiently rigorous to pick up errors in the management of prescription stationery, monitor medicines of patients on a community treatment order and monitor medicines in stock in individual services.

Action the provider SHOULD take to improve

- The trust should continue to work on recruiting permanent staff to reduce vacancy levels.

Community-based mental health services of adults of working age

- The trust should continue to ensure all patients have an up-to-date care plan that reflects their current needs.
- The trust should continue to ensure that patients have access to psychological therapies without undue delay in line with best practice guidance.
- The trust should ensure that staff explain patients' rights in respect of community treatment orders consistently in accordance with the Mental Health Act (MHA) Code of Practice and keep accurate records of consent to treatment in line with the MHA and when patients' rights have been explained.
- The trust should ensure that all patients are offered a copy of their care plan.

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

Requires improvement 

Key facts and figures

The South London and Maudsley NHS Foundation Trust provides acute mental health services in four London boroughs: Southwark, Lambeth, Lewisham and Croydon. The trust serves a local population of 1.3 million people. The acute care pathway consists of 17 inpatient acute wards and four psychiatric care units (PICUs) based at four hospitals. Staff in the acute referral centre review and manage all referrals for admission to an acute ward or PICU in the trust.

As part of the inspection we visited the following wards:

Lambeth Hospital:

Eden – 10 bed male psychiatric intensive care unit

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

Rosa Parks – 18 bed mixed acute admissions ward

Luther King – 18 bed male acute admissions ward

Nelson – 18 bed female acute admissions ward

The Bethlem Royal Hospital:

Croydon PICU – 10 bed male psychiatric intensive care unit

Gresham 1 – 20 bed female acute admission ward

Gresham 2 – 20 bed male acute admission ward

Fitzmary 1 – 14 bed female admission ward

Tyson West - 17 bed male acute admission ward

Maudsley Hospital:

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

Eileen Skellern 2 (ES2) – 19 bed male acute admission ward

John Dickson – 20 bed male acute admission ward

Aubrey Lewis 3 (AL3) – 18 bed male acute admission ward

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

Ladywell Unit:

Johnson PICU – 10 bed male psychiatric intensive care unit

Clare – 17 bed male acute admissions ward

Powell – 18 bed male acute admissions ward

Wharton – 18 bed female acute admissions ward

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

Jim Birley Unit – 16 bed female acute admissions ward

Virginia Woolf – 16 bed female acute admissions ward

The last comprehensive inspection of the service took place in July 2018. At that inspection, we took enforcement action and issued a warning notice in respect of regulation 17 Good governance for acute wards for adults of working age and psychiatric intensive care units. We issued requirement notices in respect of the other three regulations that had been breached:

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

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

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Following the July 2018 inspection, we rated the acute wards and PICUs as inadequate overall. We rated responsive and well-led as inadequate, and safe and effective as requires improvement, and caring as good.

The current inspection was announced 30 minutes before the inspection. This was in line with CQC guidance.

During the inspection, we carried out the following activities:

- Looked at the quality of the ward environment and observed how staff were caring for patients
- Interviewed the ward managers and senior managers for each hospital, including modern matrons, clinical service leads, the Lambeth deputy borough inpatient lead, the Lewisham head of nursing, and the Croydon operational manager
- Spoke with 118 staff including nurses, healthcare assistants, occupational therapists, consultant psychiatrists, pharmacists and junior doctors
- Attended 18 meetings including multidisciplinary team meetings, shifts handovers, bed management meetings
- Spoke with 75 patients
- Spoke with 7 carers
- Reviewed all, or specific parts, of 74 care records
- Reviewed medicine administration records
- Reviewed other documents and policies relating to the running of the service

Summary of this service

Our rating of this service **improved**. We rated it as requires improvement because:

- Although the trust had made improvements since our last inspection in July 2018, there were still areas that required improvement.
- The trust had continued with their recruitment drive. However, staffing remained an issue. Some wards had high number of nursing vacancies and some wards had consultant psychiatrist and ward manager vacancies. Some wards had high staff turnover rates. This impacted on the stability of teams and the consistency of patient care and experience.

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

- The service needed to improve bed management on the acute wards and PICUs. Bed occupancy was above 100% on most wards. In the last 12 months, the trust had 300 patients in out-of-area beds. There were six incidents where patients in PICUs were ready for discharge to acute wards but were unable to transfer due to lack of acute beds. This meant patients experienced care at a higher level of security than what was needed.
- At the last inspection in July 2018, there was not always a bed available for patients returning from leave. At this inspection, although the number of incidents had decreased significantly, and senior managers had good oversight, there were still four occasions where a bed was not available when patients returned from leave.
- Although improvements had been made to the environmental risk assessments, the trust had not ensured all environmental risk assessments had timescales for identified work that needed to take place. The trust did not have clear information about who was going to take responsibility for these actions. The use of plastic bin bags, which can present a safety risk for some patients, in communal areas across the acute wards was not consistent. Plastic bags in communal areas were not always identified on the wards' environmental risk assessment.
- Although most wards carried out physical health checks on patients after they received rapid tranquilisation, in line with national guidelines and trust policy, we found three examples where this was not always the case.
- Some of the wards were not clean or well-maintained, especially in bathrooms and toilets.
- The service did not always provide support to staff to ensure they had the necessary skills to support patients. Not all staff had access to autism training despite caring for some patients with autism on the wards. The trust had recently established an autism training programme for acute/PICU wards, but staff from some wards had not yet been provided with the training. Supervision had improved since our last inspection, however, it remained low on some wards.
- Managers did not always ensure that lessons learned from the investigation of incidents and adverse events that happened on the PICUs was communicated across boroughs.
- Some wards did not always follow the trust safeguarding policy. We found examples on ES1 and Eden Ward, where safeguarding alerts had not been escalated.
- On some wards, staff did not always request an opinion from a second opinion appointed doctor in a timely manner. Not all patients' physical health treatment was included on their certificate of consent to treatment, therefore it was not clear from the records what legal authority was relied upon to permit this treatment.
- Although improvements had been made in supporting patients with specific physical health needs, we still found examples where recording of blood glucose monitoring and fluid charts were incomplete.

However:

- The trust had made improvements in many areas identified at the previous inspection. These areas included ensuring all patient restraints were recorded in sufficient detail, improved recording of patient observations and incident reporting, appropriate checking of emergency equipment, ensuring that patient information was not visible to other patients on Nelson Ward, and ensuring that staff on Croydon PICU and Aubrey Lewis 2 demonstrated kindness and compassion in their interactions towards patients.
- Most staff told us that the trust's move to a borough-based structure had improved their way of working. Staff said senior managers were much more visible and approachable on the wards. Senior managers said they had better oversight of the wards, and communication had improved from ward to board. Staff told us that the culture had also improved since the last inspection, in particular the trust promoted a more positive and open culture.

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

- At the last inspection in July 2018, whilst governance systems and processes could identify the wards at risk of not delivering high quality care and treatment, appropriate support had not been put in place. At this inspection, improvements had been made. We found the trust had implemented support plans for wards that needed to improve. Managers had a greater oversight of the wards, which led to less variation in the quality and safety of care and treatment being delivered between wards.
- The trust had worked hard to implement plans to reduce the number of patients being restrained. Since our last inspection in July 2018, the proportion of restraints that involved patients being restrained in the prone position had decreased. Staff were aware of the provider's restrictive interventions reduction programme.
- At our previous inspection in August 2018, staff restricted patients on Johnson Ward's access to drinking water. At this inspection, we found that this was not the case on any of the wards we visited.
- The trust had made improvements to delayed patient discharges since our last inspection in July 2018. There had been a 17% decrease in the number of delayed discharges and staff were proactive in addressing barriers to patients being discharged.
- Most care plans were personalised, holistic and recovery orientated. We saw good examples of care plans that included needs such as mental health, physical health, LGBT+ and accessing the community.
- Staff treated patients, families and carers with compassion and kindness. Staff demonstrated a good understanding of patients' and carers' needs and interacted with them in a respectful and responsive way.

Is the service safe?

Requires improvement ↑

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

- At the last inspection in July 2018, there were many nursing vacancies and high staff turnover on some wards. Patients' leave was postponed or cancelled due to short staffing. At this inspection, although the trust had continued with their recruitment drive, staffing remained an issue. There were still a high number of nursing vacancies and staff turnover on some wards. Some staff and patients told us that patient leave was often cancelled or postponed. Some wards did not have a permanent consultant psychiatrist, although locum arrangements were in place.
- Although improvements had been made to the environmental risk assessments, not all environmental risk assessments had timescales for identified work that needed to take place. The trust did not have a clear plan for who was going to take responsibility for these actions. The use of plastic bin bags in communal areas across the acute wards was not consistent, some wards did not permit plastic bags, whilst other wards allowed them. On two wards, staff had not identified the use of plastic bin bags in communal areas on the environmental risk assessment.
- Although most wards carried out physical health checks on patients after they received rapid tranquilisation, in line with national guidelines and trust policy, we found three examples where records did not demonstrate staff completed physical health checks on patients following the administration of rapid tranquilisation.
- Although the service generally controlled infection control risk well and equipment was clean. Some of the wards were not clean or well-maintained, especially in bathrooms and toilets. Where staff had identified maintenance and repair issues, the trust did not always address these in a timely manner.
- Staff did not always record on restraint records if patients received a debrief following a restraint.

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

- On ES1 and Eden Ward, we found examples where, while patients had been kept immediately safe, it was not clear that the trust safeguarding policies had been followed, as decisions had been made not to raise safeguarding concerns when they should have been. The trust was working with the wards to ensure safeguarding issues were appropriately alerted in response to our concerns.
- Managers did not always ensure that lessons learned from the investigation of incidents and adverse events that happened on the PICUs was communicated across boroughs.
- The trust had worked hard to implement plans to reduce the number of patients being restrained. Since our last inspection in July 2018, the proportion of restraints that involved patients being restrained in the prone position had decreased from 54% to 39%. Staff were aware of the provider's restrictive interventions reduction programme and some wards had participated in Safewards. The quality of the recording of patient restraint had improved across the wards.
- At our last inspection in July 2018, the service had not anticipated the expiry date of some items of emergency equipment. This meant there was a delay in receiving replacements for items that had passed their expiry date. At this inspection, this was no longer an issue. Emergency equipment was well-maintained and were within their expiry date.
- At our last inspection in July 2018, on Clare Ward, staff failed to record observations of a patient, who required intermittent monitoring, for a two-hour period. At this inspection, this was no longer an issue. Staff recorded observations of patients as prescribed by the multidisciplinary team.
- At the last inspection in July 2018, staff did not always identify and report patient safety incidents. At this inspection, there had been an improvement. Staff were pro-active in reporting incidents of restraint and rapid tranquilisation.

Is the service effective?

Requires improvement  

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

- Staff assessed the physical and mental health of all patients promptly on admission. Most care plans were personalised, holistic and recovery-orientated. We saw good examples of care plans that were holistic and addressed the patients' mental health, physical health, relationships including their sexual orientation and accessing the community.
- Staff supported patients to live healthier lives. Staff supported patients with smoking cessation. Most patients could access a gym, and staff facilitated healthy living groups facilities on the wards.
- Staff from different disciplines worked together as a team to benefit patients. Staff held regular and effective multidisciplinary team meetings, where patients' care and treatment were comprehensively discussed. Staff 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 of the organisation.

However:

- The service needed to improve its practice in respect of the Mental Health Act. Staff did not always request an opinion from a second opinion appointed doctor (SOAD) in a timely manner. Not all patients' physical heath treatment was included on their certificate of consent to treatment, therefore it was not clear from the records what legal authority was relied upon to permit this treatment.

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

- At the last two inspections in January 2017 and July 2018, we found that staff supervision rates were low. At this inspection, although supervision had improved on most wards, it was still particularly low on some wards. Staff reported that this was due to staffing shortages.
- At the last inspection in July 2018, some wards did not always carry out physical observations of patients with specific health needs. At this inspection, progress had been made, but there was still room for improvement. For example, we found gaps in the recording of blood glucose monitoring for three patients with diabetes, fluid charts were not always completed, and staff did not always take a pro-active approach in supporting patients who had a high body mass index.
- At the last inspection in July 2018, although staff had access to training in caring for patients with learning disabilities, this training did not specifically include autism. There were a number of patients with autism admitted to the wards, and staff said they did not have access to autism training. At this inspection, most staff had not received autism training. Since our inspection, the trust had established an autism training programme for all acute and PICU wards.
- Whilst patients had access to clinical psychology input, on most acute wards this input was low with one psychologist working across several wards.

Is the service caring?

Good

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

- Staff treated patients, families and carers with compassion and kindness. Staff demonstrated a good understanding of patients' and carers' needs and interacted with them in a respectful and responsive way.
- 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. Staff invited families and carers to attend patient multidisciplinary team meetings and gained their feedback on the service they received via surveys.
- At the last inspection in July 2018, on Croydon PICU and Aubrey Lewis 2 Ward, patients said that some staff did not seem to care about them, were disrespectful towards them or too busy to help them promptly. At this inspection, this was no longer an issue. On Croydon PICU and Aubrey Lewis 2, patients were very complimentary about the way they were treated by staff.
- At the last inspection in July 2018, we found that confidential information was visible to people standing outside the nurses' office. At this inspection, this was no longer an issue.

Is the service responsive?

Requires improvement 

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

- The service needed to improve its bed management of the acute wards and PICUs. Bed occupancy was above 100% on most wards, which meant staff may not have been able to manage the care of patients safely. There was not always a bed available for someone who needed one. The trust had 300 patients in out-of-area beds between

February 2018 and December 2018. There were sometimes delays transferring patients between acute wards and PICUs. We found six incidents where patients in psychiatric intensive care units were ready for discharge to acute wards but were unable to transfer due to lack of acute beds. This meant that patients experienced care at a higher level of security than what was needed.

- At the last inspection in July 2018, there was not always a bed available for patients returning from leave. At this inspection, although the number of incidents had decreased significantly, and senior managers had good oversight, there were still four occasions where a bed was not available when patients returned from leave.
- The facilities on LEO Unit did not always promote patients' privacy and dignity. Some bedroom doors did not give patients the option to close vision into their bedrooms, therefore staff and patients passing by could see into their bedrooms. There were 15 dining chairs, which did not accommodate the 18 patients on the ward.
- On Rosa Parks Ward, staff did not always send holding letters or final complaint responses to patients and carers to keep them updated on the status of their complaint.

However:

- At the last inspection in July 2018, 20% of patient discharges from hospital were delayed. Staff were not always proactive in addressing barriers to patients being discharged. At this inspection, there had been an improvement. Three percent of patient discharges were delayed and staff were proactive in addressing barriers to patients being discharged.
- Staff took account of patients' individual needs. Wards provided interpreters for patients whenever this was needed, to support patients at ward rounds and in other aspects of their care. Staff ensured patients had access to spiritual support, which patients found to be therapeutic. The wards were accessible to patients with physical disabilities and mobility issues.
- The food was mostly of a good quality and patients could make hot drinks and snacks at any time. Staff ensured patients had a choice of food to meet the dietary requirements of different religious, cultural and personal needs.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good because:

- Most staff told us that the trust's move to a borough-based structure had improved their way of working. Staff said senior managers were much more visible and approachable on the wards, and senior managers said they had better oversight of the wards, and communication had improved between ward to board. Staff told us that the culture had also improved since the last inspection, in particular the trust promoted a more positive and open culture.
- At the last inspection in July 2018, whilst governance systems and processes could identify the wards at risk of not delivering high quality care and treatment, appropriate support had not been put in place. At this inspection, improvements had been made. We found the trust had implemented support plans for wards that needed to improve. Managers had a greater oversight of the wards, which led to less variation in the quality and safety of care and treatment being delivered between wards.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Managers consulted with staff on changes to shift patterns and ward refurbishments.

- Some wards engaged in quality improvement activities. For example, on Jim Birley Unit, staff were involved in a quality improvement project looking at improving the efficiency of handover meetings.

However:

- At the last inspection in July 2018, eight wards did not have a permanent ward manager, which led to a lack of stability. At this inspection, there had been an improvement, and the trust had worked hard to recruit into these posts. There were five wards that did not have a permanent ward manager however some posts had been recruited to with two vacancies remaining. The interim ward managers were people who knew the wards and they told us they were being supported by senior managers. The interim ward managers told us they were being supported by senior managers. Whilst progress had been made, the five vacant ward manager posts and three consultant psychiatrist posts meant that there were gaps in the leadership across the acute wards.
- On Eden Ward, we identified a risk following an incident in January 2019, which had been added to the borough risk register in March 2019. This meant that there was a potential delay in some aspects of concern being escalated to the formal risk register and for senior manager oversight.

Areas for improvement

Action the provider MUST take to improve

- The trust must continue to address the high number of nursing vacancies on some wards through active recruitment and retention strategies to ensure patients receive care appropriate to their needs.
- The trust must improve patient flow to and between acute and PICUs and continue to work on access to appropriate beds which meet the needs of patients who are on the wards, so that patients are not detained on wards with higher levels of security than they need.
- The trust must ensure that staff on all acute and PICU wards undertake autism training.

Action the provider SHOULD take to improve

- The trust should ensure that staff continue to consistently carry out physical health checks on patients after they receive rapid tranquilisation in line with trust policy.
- The trust should ensure that wards have medical input from a permanent consultant psychiatrist to promote medical leadership and consistency of care and treatment to patients.
- The trust should continue to ensure they recruit permanent ward managers for the wards.
- The trust should ensure that all environmental risks are recorded on environmental risk assessments, that environmental risk assessments have timescales for actions identified, and the trust policy is clear on the use of plastic bin liners in communal areas.
- The trust should ensure that all ward areas, including bathroom and toilets, are kept clean.
- The trust should ensure maintenance and repair issues are addressed in a timely manner.
- The trust should ensure there are sufficient alarms available for staff and patients especially on Virginia Woolf Ward.
- The trust should ensure patient restraint records demonstrate patients have been offered a debrief following a restraint.
- The trust should ensure all patients have care plans to meet their physical and mental health needs.

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

- The trust should continue to ensure that staff carry out physical observations of patients with specific physical health needs, including blood glucose monitoring for patients with diabetes and food and fluid intake monitoring.
- The trust should keep the number of clinical psychologists under review to ensure there are sufficient numbers to meet the needs of patients in line with NICE guidance.
- The trust should ensure that all staff receive regular managerial and clinical supervision in line with trust policy.
- The trust should ensure that staff request a second opinion appointed doctor when necessary in a timely manner, and that all pharmacological treatments are included on patients' certificate of consent to treatment.
- The trust should ensure that staff have a clear understanding of safeguarding policies and are consistently making appropriate referrals to local authorities as necessary.
- The trust should ensure that managers handle complaints in line with the trust policy.
- The trust should ensure that on Leo Unit, patients have the option to close vision panels on their bedroom doors, to ensure privacy and dignity is promoted.
- The trust should continue to work on embedding communication across boroughs where there are similar wards so that learning from incidents can be better shared.
- The trust should ensure that there are clear governance processes so that issues raised on the wards are reflected on local risk registers as necessary.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement 

Key facts and figures

South London and Maudsley NHS Foundation Trust (SLAM) provides long stay and rehabilitation services for people aged between 18 and 65 with severe mental health symptoms (multiple) co-morbidities. Some patients are detained under the mental health act with significant risk issues. Referrals are received in from acute inpatient wards as well as forensic units. Patients move on from these inpatient wards to community rehabilitation services or on to supported or independent living, depending on individual circumstances and progress made.

SLAM has the following rehabilitation units for people with mental health problems, each of which are aligned to a different directorate within their locality.

- Tony Hillis Unit, based at Lambeth Hospital is a 15 bed, male only, high dependency unit. All patients are detained under the Mental Health Act. The service accepts referrals from the National Psychosis Unit as well as patients from acute and forensic wards within the South London Partnership (SLP).
- Heather Close, based in Lewisham is a 24 bed, high dependency unit. The unit consists of three buildings (one building has recently been decommissioned to make a separate space to provide therapy for patients). There are two wards, one is male only, the other is mixed gender. The service accepts referrals from within Lewisham as well as five beds on a cost per case basis from clinical commissioning groups within the SLP.
- Westways, based at the Bethlem Royal Hospital is an 18 bed, mixed gender rehabilitation ward that accepts patients suitable for high dependency care. The service accepts patients from acute and forensic units who live within the catchment area of Croydon.

The last comprehensive inspection of this service took place in September 2015. We rated the service as good overall. We rated safe as requires improvement and effective, caring, responsive and well-led as good. We issued requirement notices for two regulations:

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

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The current inspection was announced 30 minutes before the inspection. This was in line with CQC guidance.

During the inspection visit, the inspection team:

- spoke with three ward managers, two service managers and two matrons
- spoke with nineteen members of staff including doctors, nurses, unqualified nurses, psychologists, occupational therapists and activity co-ordinators
- spoke with nine patients
- observed two handovers, one ward round and two multidisciplinary meetings
- observed one planning meeting for patients and one community meeting
- reviewed 10 patient care records

Long stay or rehabilitation mental health wards for working age adults

- completed three tours of the ward areas
- reviewed two clinic rooms
- reviewed 50 medication charts
- reviewed nine staff files
- reviewed physical health records

Summary of this service

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

- Whilst improvements had been made and embedded on each of the units since the previous inspection, more work was required to address some of the concerns from last time and we identified some new concerns.
- The three inpatient mental health rehabilitation services had not clearly defined the model of rehabilitation they were using and how they would deliver a recovery orientated approach. Whilst they described themselves as being predominantly high dependency rehabilitation units there were varying lengths of stay within each service. However, work was taking place through the South London Partnership to define an integrated complex care pathway and identify models of care to optimise the inpatient rehabilitation service.
- Patients care plans lacked any meaningful planning for recovery, including achievable goals designed to support patients towards discharge.
- Governance meetings on each ward were still being embedded so they were used effectively to improve the safety and quality of the service for patients.
- Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice they did not always discharge these well. Staff did not always know when they should explain a patients' rights to them and the recording of this was sporadic. Staff at Heather Close had not ensured that some patients had legally consented to medication prescribed to them or that it had been appropriately authorised by a second opinion doctor.
- Whilst the wards were working to minimise the use of blanket restrictions, staff at the Tony Hillis Unit were confused about recent reductions in restrictions and how to apply these appropriately to meet the individual needs of each patient.
- Although work was underway to make improvements, patients were not satisfied with the quality of food or the choices available to them. Patients could be supported further to self-cater.
- Staff had limited understanding on how to support the needs of patients with protected characteristics and there was little information available to these patients to make them feel welcomed onto the wards.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Improvements had been made in terms of how ligature risks were managed. Maintenance repairs were reported and undertaken within reasonable timescales. Fire safety arrangements at Heather Close had also been addressed, in terms of signage and ensuring fire doors were not wedged open.

Long stay or rehabilitation mental health wards for working age adults

- Staff assessed and managed risks to patients and themselves. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed and this was very rare. The ward staff participated in the provider's restrictive interventions reduction programme. We found improvements had been made in the observation arrangements of patients as well as ensuring that adequate precautions were taken if a patient went absent without authorisation.
- 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 on how to recognise and report abuse and/or exploitation and they knew how to apply it. The environments were suitable for mixed gender and appropriate security arrangements had been put in place by the trust.
- Staff assessed the physical and mental health of all patients on admission. Care plans had improved and were reviewed regularly through multidisciplinary discussion and updated as needed.
- Staff actively engaged with commissioners, GPs, social care organisations and other secondary care services. This ensured that staff could plan, develop and deliver the service to meet the needs of the patients.
- 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 at Westways and Tony Hillis and patients' views were incorporated, even when they differed from the clinical teams. All units actively sought patient feedback on the quality of care provided. Staff supported patients to make a formal complaint if they needed to.
- Staff involved families and carers and invited them to attend patient review meetings. Staff at Westways were establishing a family/carer user group to better understand their views.
- Staff helped patients with communication advocacy and spiritual support.
- Staff engaged actively in quality improvement activities and national accreditation schemes.

Is the service safe?

Good  

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. At the last inspection, we identified risks with ligature points and fire safety arrangements. Improvements had been made to ensure the physical environment was safely managed. Staff ensured that improvements were made in how mixed-sex wards were controlled. At Heather Close, a swipe card system was installed so that bedroom areas remained segregated.
- Staff assessed and managed risks to patients and themselves. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. The ward staff participated in the provider's restrictive interventions reduction programme. As a result, they used restraint rarely and only after attempts at de-escalation had failed. However, the records of individual restraints were not always completed thoroughly.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. At the last inspection, staff had not felt supported by management when staffing vacancies were high. Westways still had a high vacancy rate but this was managed through use of regular bank staff and staff felt supported to ensure that there were enough numbers of staff on duty.

Long stay or rehabilitation mental health wards for working age adults

- 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 on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff followed best practice when dispensing medicines. Staff regularly reviewed the effects of medications on each patient's physical health. However, at Heather Close some medication was out of date and there was insufficient storage space for the medicines.
- The wards 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, the learning from incidents was still being embedded and some staff found it hard to articulate the changes that had taken place in response to this learning.

However:

- Whilst the wards were working to minimise the use of blanket restrictions, staff at the Tony Hillis Unit were confused about recent reductions in restrictions and how to apply these appropriately to meet the individual needs of each patient.
- Some patients who had been reluctant to leave the ward during fire drills did not have a personal emergency evacuation plan in place to ensure that staff knew how to support them in the event of a fire.

Is the service effective?

Requires improvement

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

- Staff assessed patients' physical and mental health on admission. However, individual care plans did not reflect work to provide rehabilitation with a view to discharge, until near to the time when patients were being discharged. This meant that most patients did not have achievable goals designed to support their recovery.
- Staff provided some interventions to support the patients to develop everyday living skills, but this was limited. Only one unit (Westways) was supporting some patients to take their medicines independently. Whilst there was some support with self-catering, this was not sufficiently developed to promote patients to be fully independent in this area.
- At Heather Close a part-time clinical psychology post had been vacant for eight months.
- Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and Code of Practice these were not always discharged well. Staff did not always know when they should explain a patients' rights to them and the recording of this was sporadic. Staff at Heather Close had not ensured that some patients had legally consented to medication prescribed to them or that it had been appropriately authorised by a second opinion doctor.
- The wards could offer a service to patients with autism, but staff had not received training to meet their specific needs.

However:

- Staff used recognised rating scales to assess and record severity and outcomes and ensured that patients had good access to physical healthcare. They supported patients to live healthier lives with regards to smoking cessation and being active.
- Managers at Westways and Tony Hillis Unit made sure they had staff with a range of skills needed to provide high quality care. This included access to occupational therapists. Staff from different disciplines worked together as a team to benefit patients, and had regular supervision, appraisals, reflective practice sessions, and opportunities to further develop their skills.
- 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 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 patient feedback on the quality of care provided. Patients' views were incorporated, even when they differed from the clinical teams. Staff ensured that patients had easy access to independent mental health advocates.
- Staff involved families and carers and invited them to attend patient review meetings. Staff at Westways were establishing a family/carer user group to better understand their views.

Is the service responsive?

Good 

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

- The design, layout, and furnishings of the units 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. Patients could make hot drinks and snacks at any time.
- The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them at admission and when the patient was ready for discharge.
- Staff helped patients with communication, advocacy and cultural and spiritual support. Advocates attended the units or could be contacted to attend on request. Patients at Westways and Tony Hillis Unit could access the on-site multi-faith room. Patients at all units were supported to attend places of religious worship if they wished to do so.
- Some patients were accessing community-based activities that promoted their rehabilitation.
- The service treated concerns and complaints seriously, investigated them and invited patients and/or their carers to discuss their concerns with management.

However:

- The length of stay was very variable on each ward. Whilst the aim was for the length of stay to be under a year, several patients had been on the wards for a number of years. However, there were plans being developed with the South London Partnership to reconfigure the rehabilitation model and address this.
- Patients were not satisfied with the quality of food or the choices available to them, although work was underway to improve food provision.
- Staff had limited understanding on how to support the needs of patients with protected characteristics and there was little information available to these patients to make them feel included and welcomed onto the wards.

Is the service well-led?

Requires improvement 

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

- Services did not use a recognised model of rehabilitation care on all the units and did not have a clear overarching rehabilitation strategy. Most staff did not understand the model of care provided. Some interventions to support the development of independent living skills and support their rehabilitation and recovery were quite limited.
- New governance systems, designed to support the delivery of high-quality care, were still being embedded. The records of governance meetings suggested that discussions of essential topics were very limited and did not provide enough detail for staff who could not attend.
- Where audits identified areas for improvement, action plans were not always available.

However:

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt able to raise concerns without fear of retribution.
- 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 quality improvement projects and in accreditation schemes.

Outstanding practice

We found examples of outstanding practice in this service:

Staff at Heather Close involved patients in their Care Programme Approach (CPA) meetings. Patients were encouraged to chair their own CPA meeting. Staff and patients had co-produced the questions they would ask to facilitate the meeting. Seventy percent of patients said they would like to chair their CPA meeting again having experienced it.

Heather Close had devised health passports for patients as well as communication passports for patients with learning disabilities. Health passports and communication passports could be used by patients to share information about themselves with medical professionals external to the organisation, for example their GP or medical staff at a general hospital. Passports included vital information, was in an easy to read format and supported by pictures.

Long stay or rehabilitation mental health wards for working age adults

Staff at Tony Hillis Unit helped facilitate a group in conjunction with the forensic personality disorder community team to support patients with substance misuse problems alongside their mental health problems. This group used a behavioural treatment for substance misuse model, an evidence-based harm-reduction approach, which involved payments for patients who attended groups. Group evaluation measures showed a decrease in the number of patients going absent from the ward and a reduction in illicit drug use by participants.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff at Tony Hillis Unit are all clear about the use of blanket restrictions and how these should meet the needs of individual patients.
- The trust should ensure there is enough space to store medicines safely at Heather Close.
- The trust should ensure that all the necessary details are included when recording incidents of restraint.
- The trust should ensure that the clinical psychology post at Heather Close is filled.
- The trust should ensure that staff at Heather Close have adequate pharmacy support to enable patients to be able to take part in a self-medication programme.
- The trust should ensure appropriate measures are in place on the Tony Hillis Unit so that patients NEWS scores are accurately recorded.
- The trust should ensure that where patients may be reluctant to vacate the ward in the event of a fire that individual evacuation plans are in place and understood by staff.
- The trust should provide staff with training on how to meet the needs of patients with autism.
- The trust should ensure that staff at understand when patients' rights need to be explained to them in accordance with Mental Health Act and trust policy. The mental health medicines prescribed at Heather Close must align with those that have been legally approved policy.
- The trust should ensure that there is enough information available to patients with protected characteristics to ensure they feel included and welcomed.
- The trust should continue to work with the catering company to ensure that food provided for patients is of adequate quality and that a suitable variety of meals is offered to all patients including meeting the cultural needs of patients.
- The trust should continue to promote the rights of patients with protected characteristics.
- The trust should ensure that the ward-based governance meetings cover all the topics thoroughly and are clearly recorded.
- The trust should ensure that where clinical audits identify areas for improvement that the actions to address this are recorded.

Action the provider MUST take to improve

- The trust must ensure that there is a clear rehabilitation strategy and model of rehabilitative recovery-oriented care provided, which staff on all rehabilitation wards can understand and articulate. **Regulation 17(2)(a) Good Governance**
- The trust must ensure that patient care plans contain details of work to support recovery including goals for how each patient can successfully achieve their discharge. **Regulation 9(1)(2)(3) Person Centred Care**

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)

This guidance (see 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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Jane Ray, Head of Hospitalsled this inspection. An executive reviewer, Kathryn Singh, Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation Trust supported our inspection of well-led for the trust overall.

The team included four inspection managers,12 inspectors, four pharmacist inspectors, two assistant inspectors, one executive reviewers,22 specialist advisers, five Mental Health Act reviewers andthree 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.