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

Quality Report

South West London and St George's Mental Health
NHS Trust
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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

South West London and St George's Mental Health NHS Trust provides integrated mental health and social care services to the communities of Kingston, Merton, Richmond, Sutton and Wandsworth.The trust also offers a number of specialist regional and national services. These include the National Deaf Services, which support Deaf people with mental health needs, an Eating Disorders Service, and the Behavioural Cognitive Psychotherapy Unit, which provides treatment and support for people with obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD) services.

The trust operates from over 90 sites (most of which offer services covered under the Trust Headquarters registration) with three main inpatient sites. The trust currently employs about 2,300 staff, serving a population of just over 1 million people, having 460,000 patient contacts a year. The trust has an annual budget of £156 million and is nearing its final stages towards achieving Foundation Trust status.

The trust has three acute inpatient services at Springfield Hospital in Tooting, Tolworth Hospital in Surbiton and Queen Mary's Hospital in Roehampton. The trust also has other inpatient services at Hayden House in Battersea, Westmoor House in Roehampton and Thrale Road in Wandsworth.

CQC has inspected all of the trust's locations in the last two years. Inspections of the acute services at Tolworth Hospital resulted in compliance actions. The trust had prepared action plans in both these areas and we checked their progress as part of this inspection.

During our visit we held focus groups with a range of staff (qualified and in training nurses and doctors, allied health professionals, Associate Hospital Managers and the trade unions). We talked with carers and/or family members, observed how people were being cared for, and reviewed patients' care and treatment records. We visited the three hospital locations and community bases.

We carried out unannounced visits on 21 March to Ward 3 at Springfield Hospital and 1 May 2014 to Seacole Ward at Springfield Hospital.

During this inspection we visited the following services:

Springfield University Hospital

Core service provided: Five acute admission wards; two specialist deaf services; one Health Based Place of Safety; two eating disorder wards; one ward for older people; five long stay/forensic/secure service; and one child and adolescent mental health service.

The wards are a mix of same sex and mixed accommodation.

Capacity: 250 beds

Queen Mary's Hospital

Core service provided: Three acute admission wards.

The wards are a mix of same sex and mixed accommodation.

Capacity: 67 beds

Tolworth Hospital

Core service provided: Two wards for older people; one acute admission ward.

The wards are all mixed sex accommodation.

Capacity: 48 beds

As part of the inspection we met with key members of staff and executives. In these meetings it was clear that the trust board were aware of the progress required to become a Foundation Trust. Members of the board gave us a clear account of the challenges they faced and the journey they had been on to put quality at the front of the agenda which, in their view, it had not been in place when they took up office. During the inspection it was clear that there was still some required work, for example some of the front line staff we met with did not understand some of the initiatives which have been put in place to improve quality. Board members, in general, recognised this to be the case.

CQC were assured that the members of the board had a good recognition of the current position of the quality within the trust.

We found that the non-executive directors were a strong and effective group who had a good knowledge of their role and who exercised their duties effectively.

Summary of findings

People using the service told us, and we observed, that the trust's staff were caring and had a good approach to patient care, and interacted positively and compassionately with people. Much of the care delivered followed best practice and we also saw examples, where no guidance existed, of the trust's staff working with the National Institute for Health and Care Excellence to produce this.

We found that the trust's staff had completed mandatory training; however we also noted that in several clinical areas training for the specific needs of the people using the services was not available. Many of the staff working in older people's services had not undertaken training in dementia care and this was having an impact on the quality of care received by people using this service.

The working relationship between inpatient and community services was well established across trust's service areas. We also saw good examples of people using services being engaged and involved in the planning and review of their care.

We found that application of the Mental Health Act across the services was good. People were lawfully detained and had their rights read to them at the appropriate times. We noted that some of the actions identified in the monitoring of the Mental Health Act had not been completed by the trust.

There had been concerns about compliance with the rapid tranquilisation policy. However, the trust had identified this in an audit and was making improvements. We confirmed this when we looked at records on four separate wards.

We looked at records for people prescribed medicines 'as required'. We saw patients who were administered as required lorazepam and promethazine with no record in their progress notes as to why it was being given. This meant it could not be checked if these medicines were being used appropriately.

The planning and delivery of care in some clinical areas did not meet the service users individual needs or ensure their welfare and safety as we found comprehensive management plans were not consistently being put in place for people using the service where a risk to themselves or others had been identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

There were examples of learning from incidents at individual sites and across the trust.

However, we identified a range of errors and weaknesses in the reporting of risks and quality and the action taken following an incident at Springfield University Hospital, which could affect the trust's overall assurance. The trust needs to disseminate the learning from these incidents better to protect people using the service and to use the information to drive improvement across all areas.

The trust's Quality Assurance framework was used to monitor the trust's risks.

The staff we spoke to during our inspection across all the trust's sites clearly understood their roles and responsibilities around safeguarding the people they were caring for.

Staff also had a good awareness of the trust's whistleblowing procedure and were able to describe several methods for raising concerns.

Generally, services at South West London and St Georges Mental Health Trust were safe. Incidents were reported and reviewed.

Are services effective?

In the majority of services we inspected, most teams were using National Institute for Health and Care Excellence (NICE) guidance as part of their treatment plans. In the deaf child and adolescent mental health services (CAMHS) area, where there were no current guidelines, the team were working with NICE to develop these.

Care and treatment in most services was effective. Information about people's needs was effectively handed over between the community teams and inpatient areas. In the CAMHS this was particularly effective.

In the 2012 NHS Staff Survey, 95% of staff indicated they had received an appraisal in the past 12 months. Partial information for 2013/14, presented to the board in December 2013, showed that Personal Appraisal Development Reviews (PADR) were currently at 84%.

The trust monitored their use of the Mental Health Act. This monitoring had identified there were areas for improvement, but the use of the Act was mostly in line with the Code of Practice.

Many staff told us that there was no money or time given for training beyond mandatory training.

Are services caring?

The majority of patients and carers we spoke to described staff as caring and compassionate. While we were on the wards we saw staff treating people with dignity and respect.

The electronic patient notes (EPN) did not show that people were involved in decisions about their care or had contributed to their care plan. In areas where the EPN was not being used, we saw examples of people being involved in decisions about their care, contributing to their care plans and having their own copies of these plans.

Interventions, including restraint and seclusion, needed to be reviewed to ensure they were being properly recorded and monitored and were happening safely across all parts of the trust by properly trained staff.

Summary of findings

Are services responsive to people's needs?

Some people could access services, including inpatient and community teams, at the right time and without delay. However, bed occupancy was a concern. On several of the wards we visited we found patients sleeping out on other wards due to bed shortages.

In the children and adolescent mental health service, children and young people were waiting a long time to receive the right service after initial referral. The individual needs of people in the older people's services were not always met due to a lack of specific training for staff. There was no psychiatric intensive care service at the trust for female patients and we heard that patients had to be transferred to services out of the area.

Many clinical areas had mixed sex wards. This meant, in the acute admission wards, CAMHS wards and older people's service, people did not always receive the care they required and their privacy and dignity was not always maintained.

The trust had recently changed the process for replying to and investigating complaints. This had shortened the length of time complaints were taking to be reviewed, and meant no complaints were backlogged.

Are services well-led?

All members of the trust's board, with the exception of the director of finance, were relatively new in post, and since their appointment the trust has made some significant changes to the leadership of the organisation. The board members were able to describe to us the vision and direction of the trust. The non-executive members explained how they were able to challenge where appropriate. We found that these directors were a strong group who understood their roles and duties effectively. Before our inspection we engaged with stakeholders, who described the trust as 'being on a journey'. Without exception, the people we spoke with, were confident that the new chief executive and the trust's board were able to provide the leadership and governance required.

At the time of our inspection, a transformation programme was underway within the directorates. Feedback from staff we met during the inspection indicated that there was a mixed level of engagement with this process. Many staff spoke highly of their line managers, but felt disconnected with more senior managers.

While there was some concern about the future of the community CAMHS service, the staff in these teams were resilient to this and were delivering a very good level of care to the people using the service.

Systems were in place to enable people using services, staff and others to give feedback. These included Listening into Action (LiA), a programme to place staff at the centre of decision making in the trust, which empowered staff to make changes to the way they work to improve the quality of the care provided. The chief executive had also hosted five 'staff conversation' sessions. Over 300 staff attended these. The themes emerging from these events have also been addressed by the LiA team.

While staff engagement was improving, this was an area for more work as this was integral to making the changes a success.

There was also a Service User Reference Group that met monthly. Members of this group told us that it felt like it has lost its way and become tokenistic.

Summary of findings

What people who use the provider's services say

We spoke with a range of patients and relatives during the inspection and with patient representative groups during the inspection.

The trust's inpatient surveys showed year-on-year improvement that the majority of patients were satisfied with their care. The community service had identified concerns regarding crisis and care planning.

Listening Events

We held a number of listening events before our inspection.

We held a public listening event at Earlsfield Library on 10 February. The listening event was held jointly with the acute listening event at St Georges Healthcare NHS Trust. The event was very well attended but this made engagement very difficult.

There were positive comments about activities in the community and the caring attitude of staff that worked in the community. There were also positive comments about the inpatient wards and the staff working on these wards.

Some negative comments about staff were shared and these described people being too busy to help or provide care. There were also concerns that staff did not fully consider cultural issues and the impact on care and treatment, and concerns that there were not sufficient numbers of people from black, Asian and minority ethnic communities in senior positions in the trust.

Some people raised concerns that wards were mixed sex.

Some people told us that, for out patients, it was often difficult to access key members of staff, including care co-ordinators and social workers.

Comment Cards

We left comment cards at three hospital sites and community locations before and during the inspection. Unfortunately we did not receive any completed comment cards during the inspection.

Areas for improvement

Action the provider MUST take to improve

- Ensure that planning and delivery of care meets people's individual needs, safety and welfare.
- Ensure that suitable storage, recording and monitoring systems are in place to ensure medications are handled safely and appropriately.
- Continue to monitor the mixed gender wards across the service to ensure they comply fully with the national guidance

Action the provider SHOULD take to improve

- Develop effective arrangements to identify, assess and manage risks consistently across services.
- Ensure that people using services are protected against the risks of potentially unsafe or unsuitable premises.
- Develop an effective system in place for making statutory notifications in a timely manner.
- Ensure that specialist training is provided to all staff working in specialist areas of the trust.
- Develop the electronic patient notes system to ensure that it supports and evidences true patient involvement in the planning of their care.
- Develop and implement the falls recording and learning system to ensure that falls are recorded and learning is put into practice.
- Ensure that all people referred to services are provided with the contact details for a named staff member they can talk to regarding their care and support.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- We saw how staff empowered patients and carers to be at the heart of planning their care and treatment. We saw evidence of comprehensive care and risk plans that were developed with reference to relevant National Institute for Health and Care Excellence (NICE) guidance.
- The staff team had detailed knowledge and awareness of local safeguarding reporting procedures.

Queen Mary's Hosptial

- We saw people using the service and staff interacting well together.
- We saw people being involved well in the planning and review of their care, and collaborative multi-disciplinary team working.

Tolworth Hospital

- There were good systems in place for receiving detention papers when patients were first admitted under the Mental Health Act. Individuals had their rights explained to them, and were reminded of these throughout the period of their detention.
- Staff empowered patients and carers to be at the heart of planning their care and treatment. We saw evidence of comprehensive care and risk plans that were developed with reference to relevant NICE guidance.
- Good knowledge and awareness of local safeguarding reporting procedures.
- Good knowledge and awareness of local whistleblowing procedures.

Trust Headquarters Services

- The Behaviour and Communication Support Service in Wandsworth and the Challenging Behaviour service in Sutton and Merton were providing specialised outreach services to older people in residential and nursing homes. These interventions were already proving effective in reducing the use of anti-psychotic medication.
- The Intensive Home Treatment Team and Sutton and Merton provided a specialist service to older people into the evenings and through the weekends, thus helping to avoid hospital admissions.
- Positive work was noted in ensuring that people could access services through the use of CAPA (Choice and Partnership Approach) with a single point of referral scheme and single point of access scheme.

Springfield University Hospital

- There were good systems in place for receiving detention papers when patients were first admitted under the Mental Health Act and ensuring that individuals had their rights explained and were reminded of these throughout the period of their detention.
- We saw people using the service and staff interacting well together.
- We saw good involvement of each person in the planning and review of their care, and collaborative multi-disciplinary team working.

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

Detailed Findings

Registered locations we looked at:
Trust Headquarters; Springfield University Hospital; Queen Mary's Hospital; Tolworth Hospital

Our inspection team

Our inspection team was led by:

Chair: Steven Michael Chief Executive South West Yorkshire Partnership NHS Foundation Trust

Team Leader: Nicholas Smith Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultant psychiatrists, junior doctors, nurses, social workers, Mental Health Act Commissioners, psychologists, patient "experts by experience" and senior managers

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

The trust operates from over 100 sites (most of which offer services covered under the Trust Headquarters. The trust has a total of eight active registered locations serving people with mental health and learning disability needs, including three hospitals sites: Springfield University Hospital, Tolworth Hospital and Queen Mary's hospital.

The trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in the Kingston, Merton, Richmond, Sutton and Wandsworth boroughs of London.

The trust also offers a number of specialist regional and national services. These include the National Deaf Services, which support Deaf people with mental health needs, an Eating Disorders Service, and the Behavioural Cognitive Psychotherapy Unit, which provides treatment and support for people with obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD).

South West London and St George's Mental Health NHS Trust has been inspected 15 times by CQC. The 15 inspections covered seven locations, two of which are no longer registered with CQC (Barnes Hospital and Old Church). The most recent inspection took place on 5 November 2013 at Tolworth Hospital. This location was

found to be compliant with all outcomes inspected except Outcome 2 (R18) Consent to care and treatment, which was found to be non-compliant with moderate impact. This report can be found here http://www.cqc.org.uk/search/all/Tolworth Hospital

The locations that have been inspected by CQC are listed below together with their level of compliance.

Barnes Hospital (RQY05)
This location (deregistered with CQC in March 2013) was inspected once. The inspection was carried out in July 2011.

Moderate concerns were found in respect of; Outcome 1 (R17) Respecting and involving people who use services, Outcome 4 (R9) Care and welfare of people who use services, Outcome 9 (R13) Management of medicines and Outcome 14 (R23) Supporting staff.

Minor concerns were also found in respect of Outcome 5 (R14) Meeting nutritional needs, Outcome 10 (R15) Safety and suitability of premises and Outcome 17 (R19) Complaints.

Haydon House (RQY04)
This location has been inspected once. The inspection was carried out in September 2013 and found the location compliant against all outcomes inspected.

Old Church (RQY12)
This location (deregistered with CQC in October 2012) was inspected once. The inspection was carried out in February 2012.

Moderate concerns were found in respect of Outcome 4 (R9) Care and welfare of people who use services.

Minor concerns were found in respect of Outcome 1 (R17) Respecting and involving people who use services, Outcome 5 (R14) Meeting nutritional needs, Outcome 9 (R13) Management of medicines and Outcome 14 (R23) Supporting staff.

Queen Mary's Hospital (RQY07)
This location has been inspected three times. The most recent inspection was carried out in February 2013 and found the location compliant against the only outcome inspected, which was Outcome 13 (R22) Staffing. This inspection was to follow up non-compliance identified during the previous inspection completed in September 2012.

Springfield University Hospital (RQY01)
This location has been inspected four times. The most recent inspection was carried out in July 2013 and found the location to be compliant against all outcomes inspected.

Tolworth Hospital (RQY08)
This location has been inspected four times. The most recent inspection was carried out in November 2013.

Moderate concerns were found in respect of Outcome 2 (R18) Consent to care and treatment.

Westmoor House (RQY14)
This location has been inspected once. The inspection was carried out in September 2013 and found the location compliant against all outcomesinspected.

Why we carried out this inspection

We inspected this provider in the first wave of our new in-depth mental health inspection programme. We chose this provider because they are an aspirant Foundation Trust.

We selected the trust to review as they represented the variation in mental health care according to our new intelligent monitoring model. This looks at a wide range of data, including user and staff surveys, provider performance information and the views of the public and local partner organisations.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team always inspects the following core services at each inspection:

- Mental Health Act Monitoring

Detailed Findings

- Acute admission wards
- Psychiatric intensive care units and health-based places of safety
- Long stay/forensic/secure services
- Child and adolescent mental health services
- Services for older people
- Services for people with learning disabilities or autism
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services
- Specialist deaf services

Before visiting, we reviewed a range of information we held about the provider and asked other organisations to share what they knew about the provider. We carried out an announced visit from 18 to 20 March 2014. During the visit we held focus groups with a range of staff in the location, such as nurses, doctors, therapists. We talked with people who used services and staff from all areas of each location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who used services. We met with people who used services and carers, who shared their views and experiences receiving services from the provider. We carried out a unannounced visit on 1 April 2014.

Are services safe?

Summary of findings

We judged that services were safe. There were systems to identify, investigate and learn from incidents. Staff at all levels of the organisation said that there was an open culture that supported them to report and learn from incidents. The trust's board had a focus on quality and this was reflected across the organisation.

However we identified weaknesses in risk and quality reporting and action taken following the identification of risks at Springfield Hospital, which could affect assurance across the trust locations.

Staff across all services were aware of both children and adult safeguarding procedures and training was in place for staff.

The systems to share learning tended to be ward based and the examples of learning was not shared across the trust locations effectively.

Our findings

The staff sickness absence rates for South West London and St George's had been consistently lower than the national average for mental health and learning disability trusts over the time period September 2011 to September 2013

Learn from incidents and improve standards of safety for people who use services

Overall we found that care had been safe in the past. Between December 2012 and November 2013, 630 patient safety incidents had been reported, 68 were classed as serious incidents. These incidents were evenly distributed between 'ward areas' (32%), 'patient's home' (31%) and 'public place/street' (30%).

The most common type of serious incident was unexpected death of community patient, which accounted for 22% of incidents (15 in total). There were an additional six incidents relating to unexpected deaths; four unexpected deaths of an inpatient, one unexpected death of outpatient and one unexpected death of a community patient.

A total of 16 incidents related to suicide. There were 10 suicides (six outpatients, three inpatients one not classed). There were five attempted suicides (four outpatients in receipt and one inpatient) and one suspected suicide.

There were two incidents relating to 'homicide by outpatients. One concerned a patient charged with murder following the death of his mother after he attacked her. The other related to a patient alleged to have stabbed the boyfriend of his ex-girlfriend.

CQC received 630 notifications via the national reporting and learning system (NRLS) between November 2012 and November 2013. The largest proportion (41%) of the 102 'moderate' incidents were categorised as 'self-harming behaviour' (mostly 'self-harm' or attempted suicide) followed by 'patient accident' (mostly 'slips, trips, falls') which accounted for 30%.

The trust monitored performance as part of the national safety thermometer programme. The trust rate had been at 0% for the period December 2012 to December 2013. This rate for falls with harm for all patients was below the England average.

The trust reported one absconding incident for the period December 2012 to November 2013 this was classified and reported as a serious incident.

Every six months, the Ministry of Justice publishes a summary of Schedule 5 recommendations which have been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.There were no concerns regarding the trust in the Schedule 5 Reports.

Safeguarding

Staff were familiar with safeguarding procedures, and the majority of staff had received safeguarding training at the level correct for their roles.

Almost all of the staff spoken to were able to describe the local safeguarding policy and procedure was and we observed good safeguarding practices during the course of the inspection in one of the teams visited.

The trust closely monitors its safeguarding incidents and trends are monitored by the Safeguarding lead.

Safe Environment

Much of the trust estate was old and presented a challenge for staff to meet the needs of the patients. We were able to

observe ligature points and saw that in some ward areas staff did not having clear lines of sight. Many of the clinical areas did not provide same sex accommodation. The trust did have systems in place to manage some of these risks including a ligature risk assessment however in some cases these were not always consistent or working that effectively for example on one ward a member of staff was positioned all day in an area where male and female patients had to pass each others bedroom area.

We observed a patient in seclusion who was able to climb on to the window sill with the aid of the mullion and from this jump/throw himself from this onto the mattress.This trust took immediate action to remove this risk once is was identified.

Understand and manage risk to the person using services and others with whom they may live with

The trust used a system of risk registers to manage risk. The Board Assurance Framework (BAF) is at the top of this and is the board risk register. Below this each directorate has their own risk register. These are managed by the Executive Management Committee (EMC) and the Directorate Governance Committees respectively.

Risks were graded and dependent of the grading they could be managed locally, within the directorate, the EMC or the trust board.

All of the ward or department managers and deputies with risk management responsibility had received risk training to allow them to validate the accuracy of risk assessments.

All the patient records we examined showed that an individual risk assessment had been completed indicating a consistent approach across trust sites regarding the use of risk assessments to keep people safe.

However these risk assessment were included in the electronic patient notes and it was not clear that where identified more specific risk assessments were taking place. For example where a patient was identified to be a risk of suicide. Nor was it clear whether the person had been involved in assessing their risks.

In the forensic services the Historical Clinical Risk Management-20 (HCR-20), which is an assessment and management of violence risk risk tool, was also being used to provide a more specific assessment of risk.

Staffing levels and quality of staffing enables safe practice

The trust completed a review in to the level of staffing in the ward areas and was reported to the trust board in the September 2013 board minutes. The trust is in the process of increasing the staff to bed rate from one member of staff for every 6.8 beds to a maximum of four patients to each member of staff on acute wards and three patients on forensic and CAMHS wards.

This uplift in staffing numbers had lead to an increase in the numbers of agency and bank staff that the trust were relying on to cover the shortfall.

We also identified that some community crisis services we visited and staff we spoke with told us of high vacancies and use of agency and bank staff to cover the shortfall.

The staff sickness absence rates for South West London and St George's had been lower than the national average for mental health and learning disability trusts over the time period September 2011 to September 2013.

Are Services Effective?

(for example, treatment is effective)

Summary of findings

In the majority of services we inspected, most teams were using National Institute for Health and Care Excellence (NICE) guidance as part of their treatment plans. In the deaf CAMHS area where there is no current guidelines the team are working with NICE to develop this.

Care and treatment in most services was effective. Information about people's needs was effectively handed over between the community teams and inpatient areas. In the CAMHS this was particularly effective.

In the 2012 NHS Staff Survey 95% of staff indicated they had received an appraisal in the past 12 months. 2013/14 year to date information presented to the board in December 2013 showed that Personal Appraisal Development Reviews (PADR) were currently at 84%.

The trust monitored their use of the Mental Health Act, this monitoring had identified there were areas for improvement, the use of the Act was mostly in line with the Code of Practice.

Many staff told us that there was no money or time given for training outside of the mandatory training.

Our findings

In most of the South West London and St Georges NHS Trust services we found that the care and treatment provided was effective. This was because people's needs were discussed at the time of referral and decisions were made among professionals following a review. We saw that individuals and their carers were involved in the planning and the review of their care packages.

We found that staff access to training was inconsistent. In some services the staff had received training to effectively support their responsibilities and roles operationally. However some staff reported they did not get regular access to specific training to support them in the area they were working. Staff were also concerned that time for training was difficult to secure.

The bed occupancy rate was high in the acute area of the trust. This was being monitored on a daily basis and patients were graded on a red, amber, green basis to identify who could be discharged early or accommodated in other clinical areas to ensure the most acutely unwell patients received care in the service best able to meet their needs.

We saw that there was good collaborative working between the in-patient and community teams.

We found that where the Mental Health Act 1983 was used people were lawfully detained and treated appropriately and the staff were working within the Code of Practice.

Evidence-based clinical guidance, standards and best practice

In the services we inspected, most teams were using evidence based models of treatment and references to NICE guidelines. Where NICE guidance was not available the trust were working actively with NICE to develop this.

Focus groups were held with all grades of staff. Clinical staff told us they were able to discuss and raise issues about clinical quality and felt confident that their immediate line managers would listen to and take action as required. Some of the community teams raised concerns that their caseloads had exceeded manageable limits.

The bed occupancy rate was high in the acute area of the trust. This was being monitored on a daily basis and patients were graded on a red, amber, green basis to identify who could be discharged early or accommodated in other clinical areas to ensure the most acutely unwell patients received care in the service best able to meet their needs.

Demonstrate collaborative multi-disciplinary working across all services

We saw examples of good multidisciplinary and collaborative team working. We found examples of in-patient services working alongside the community crisis resolution/home treatment teams to provide person centered care and treatment to people. People using the service told how there were involved in the planning and review of their care.

We saw a positive example of working with the local acute hospital where there were concerns over a person's physical health needs.

We saw that there were multidisciplinary team meetings held on a weekly basis in the in-patient areas these meetings included the person using the service..

Are Services Effective?

(for example, treatment is effective)

We saw that the trust worked collaboratively and in partnership with a number of other providers within their specialist in-patient services .

Suitably qualified and competent staff

We saw that trust staff were able to access regular supervision and appraisal. The take up of mandatory training was also good; the move to on line training had enabled staff to undertake this training at times convenient to them and the service where they were employed. Specific training for their role, for example dementia training, was inconsistent. We found that in some services the staff had received training to effectively support their responsibilities and roles operationally. However some staff reported that they did not get regular access to training nor was there time available for training.

The trust had recently undertaken a benchmark looking at staffing number to beds. Following this the Board agreed to increase the staffing in all clinical areas, the numbers had been increased and a recruitment process was underway, but this had caused a temporary increase in the use of bank and agency staff in some areas. In several of the focus groups staff from these clinical areas identified that this inconstancy was having a negative impact on the care and treatment in these areas.

Are services caring?

Summary of findings

The majority of patients and carers we spoke to described staff as caring and compassionate. Whilst we were on the wards we saw staff treating people with dignity and respect.

The electronic patient notes (EPN) did not show that people were involved in decisions about their care or had contributed to their care plan, we found in areas where the EPN was not being used we saw examples of people being involved in decisions about their care, contributing to their care plans and having their own copies of these plans.

Many clinical areas had mixed sex wards. This meant, in the acute admission wards, CAMHS wards and older people's service, people did not always receive the care they required and their privacy and dignity was not always maintained.

Interventions, including restraint and seclusion, needed to be reviewed to ensure they were being properly recorded and monitored and were happening safely across all parts of the trust by properly trained staff.

Our findings

The majority of people we spoke with before and during the inspection told us they felt involved in their care and treatment. They told us that staff treated them as individuals and encouraged them to recover. Carers also explained that they felt involved with the care of their relatives.

Some people did tell us they had experienced difficulty in accessing services while under the care of the community teams. We were also told that your recovery was dependent on the ward you were admitted to.

Some CAMHS staff expressed concerns that the outcome of the current review of services would have a detrimental effect on patient care, particularly in relation to accessing talking therapies.

Several of the Wards visited were not same sex services and this meant that people were not always receiving the care they required and their privacy and dignity was not always maintained.

We saw a seclusion room that had a window ledge protruding into the room and a patient in seclusion was observed to climb on this and throw himself from this on to a mattress in the room This seclusion room did not ensure the safety and wellbeing of the patient who was secluded. The trust took action in relation to this concern and provided evidence of the remedial action taken to make this area safer for people.

Is there choice and are people enabled to participate

The majority of people we spoke with before and during the inspection told us they felt involved in their care and treatment. They told us that staff treated them as individuals and encouraged them to recover. Carers also explained that they felt involved with the care of their relatives.

The care plan documents across the trust were found in the electronic patient notes (EPN) system and from reviewing this is was difficult to see how the involvement of the individual was recorded. One area was not using the EPN and all of the people using this service were able to demonstrate their involvement in the planning and review of their care. People using the service and carers told us that care was planned and reviewed with them however in most cases this was not evidenced in the EPN care plans.

We identified some concerns about access to advocacy for people using the national services. In the deaf service referrals were taken from across England and the local independent advocacy service was not funded to provide the service for people from out of the area. this may have an impact on their ability to participate effectively.

People participate in a review of needs

The majority of people we spoke with before and during the inspection told us they felt involved in reviewing their needs. They told us that staff listened to them and encouraged them to recover.

In the older peoples service it was evident that patients were actively involved in decisions about their care and treatment where they had capacity to do so. Where people lacked capacity we spoke to family carers who told us that they were fully involved in these discussions.

Staff communicate effectively

We saw several examples of effective working and communicating between teams. These included internally between in-patient and community services and between

Are services caring?

the in-patient service and local acute services. Some of the community services attending regularly to work with the ward teams. There were also liaison psychiatry teams in three local acute hospitals.

On the wards, we saw staff interacted with people and engaged positively with the people using the service. The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about the ward.

There was also a service user reference group which has been established for the past three and a half years. Members of the group told us that more recently trust executives had not been in attendance at these meetings.

We saw that there was good handover of patient information from in-patient teams to community/crisis teams. Most staff that we spoke with were knowledgeable about the needs of the people.

People receive the support they need

The Community Mental Health Patient Experience Survey 2013 was conducted to find out about the experiences of people who received care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition, aged 18 and above and had been seen by the trust between 1 July 2012 and 30 September 2012.

Analysis of data showed that the trust was performing 'about the same' as other trusts in all nine areas. There was one area where the trusts performance had decreased and the result was worse than the previous year. The risk related to patients understanding of their care plans and whatwas contained within. This risk could be highlighting potential communication issues between staff and patients. We asked people about this, most people using services said they had been involved in a review of their care.

The trust also used an electronic interface in each ward area website where patients, carers and staff could provide feedback on the service. We saw the trust had responded to concerns raised in this way.

During our inspection we were told of concerns in the community teams. Staff from these teams told us that they had what they considered caseloads that they were not able to effectively manage and this increased the potential risk level to both staff and people living in the community.

We were told that the trust had identified the need for an increased staffing level across all areas of the service and that recruitment was underway but not completed this meant there were areas where there was a high use of bank and agency staff.

We held engagement events before the inspection including with people who used the community services. These people told us of mixed experiences of care. Some people stating they had received the support that they needed whilst others had less positive experiences frequently mentioned was the difficulty for out patients in accessing key people when required.

Privacy and dignity respected

Many of the wards we visited cared for people of both sexes. During the inspection we saw that in several wards the male and female toilet and bathrooms were located next to one another or that patients had to pass through areas designated for the opposite sex to access bath and toilet facilities. On one ward a member of staff was positioned at all times on a corridor to support access to these areas

The trust had an Estates Strategy dated November 2013 this was established following the results of the 2012 Patient Environment Action Team (PEAT) performance assessments. The assessment focused on the environment in which care was provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity was supported.

The trusts scores for the 2012 assessment reflected a significant improvement over the previous years and did not identify any areas of risk.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Some people could access services, including inpatient and community teams, at the right time and without delay. However bed occupancy was a concern on several of the wards we visited we found patients sleeping out on other wards due to bed shortages.

In the children and adolescent mental health service, children and young people were waiting a long time to receive the right service after initial referral.The individual needs of people in the older people's services were not always met due to a lack of specific training for staff.There was no psychiatric intensive care service at the trust for female patients and we heard that patients had to be transferred to services out of the area.

The trust had recently changed the process for replying to and investigating complaints, this had shortened the length of time complaints were taking to be reviewed, there were no complaints backlogged.

Our findings

Some people could access services, including inpatient and community teams, at the right time and without delay.

The individual needs of people in the older people's services were not always met due to a lack of specific training for staff to meet those needs.

There was no psychiatric intensive care service at the trust for females and we heard that patients had to be transferred to services out of area.

We found that the trust had recently reviewed the complaints processes to ensure that they were dealt with effectively.

Teams worked hard to ensure individualised and person centred care tailored to best meet the needs of patients, families and carers. Some people could access services, including acute admission wards and community teams, at the right time and without delay.

Our analysis of data from our intelligence monitoring before the visit showed that the trust received 376 written complaints in 2012-13, a slight increase from the previous year. Just over half of complaints received in 2012-13 were upheld, compared to 36% of in 2011-12. The time taking to review complaints had been reviewed and the trust has changed to a complaints team function to process complaints rather than sending them to the clinical areas. This change had seen the backlog of complaints processed. There were no outstanding complaints at the time of inspection,

We found a number of issues in regard to high bed occupancy. On some wards bed occupancy was over 100%. We saw evidence that people had to sleep out on other wards to enable new people to be admitted. This is an agreed trust wide structure, the consultant and juinor doctor on the ward are responsible for care and treatment whilst he return to the designated ward is arranged as quickly as possible.

Individual needs met

We found that most people in acute care got a responsive service and benefitted from good links between the community teams and in-patient services.

We were told that translation and interpretation service were available through an external service provider. The trust are also training staff working in the deaf service to ensure that there were sufficient staff who could communicate with British sign language on duty at all times.

We found that people with eating disorders got a good, responsive service and benefited from the link between in-patient and out-patient services. This supported good admission and discharge transition processes and also access to the acute hospital services when physical needs dictated.

We found a number of issues in regard to high bed occupancy. On some wards bed occupancy was over 100%. We saw evidence that people had to sleep out on other wards to enable new people to be admitted.

We found issues with single sex accommodation. Many of the wards we visited cared for people of both sexes. During the inspection we saw that in several wards the male and female toilet and bathrooms were located next to one another or that patients had to pass through areas designated for the opposite sex to access bath and toilet facilities.

Are services responsive to people's needs?

(for example, to feedback?)

We found that the individual needs of people in the older people's services were not always met due to a lack of specific training for staff to meet those needs.

There was no psychiatric intensive care service at the trust for females and we heard that patients have to be transferred to services out of area.

Provider act on and learn from concerns and complaints

Our analysis of data from our intelligence monitoring before the visit showed that the trust received 376 written complaints in 2012-13, a slight increase from the previous year. Just over half of complaints received in 2012-13 were upheld, compared to 36% of in 2011-12. The time taken to review complaints had been reviewed and the trust has changed to a complaints team function to process complaints rather than sending them to the clinical areas. This change has seen the backlog of complaints processed. There were no outstanding complaints at the time of inspection,

The majority of the complaint received by the trust were in relation to;

- Communication / information to patients (written and oral) - 130
- All aspects of clinical treatment – 80
- Failure to follow agreed procedures - 69
- Attitude of staff total - 50

We were told that following the introduction of the new processes complaints were manager swifter and that they were resolved at an earlier stage.

We were told by people using the service that they knew how to raise a complaints and concerns.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

All members of the trust board with the exception of the director of finance were relatively new in post and since appointment the trust had made some significant changes to the leadership of the organisation. The board members were able to describe to us the vision and direction of the trust. The non-executive members explained how they were able to challenge where appropriate. We found that these directors were a strong group who understood their roles and duties effectively. Prior to the inspection we engaged with stakeholders, who described the trust as being on a journey without exception the people we spoke with, were confident that the new chief executive and the trust board were able to provide the leadership and governance required.

At the time of our inspection, a transformation programme was underway within the directorates. Feedback from staff we met during the inspection indicated that there was a mixed level of engagement with this process. Many staff spoke highly of their line managers and explained that there was disconnected at a level higher than them.

While there was some concern about the future of the community CAMHS service the staff in these teams were resilient to this and delivering a very good level of care to the people using the service.

Systems were in place to enable people using services, staff and others to give feedback. These included Listening into Action (LiA) a programme to place staff at the centre of decision making in the trust, and empowering staff to make changes to the way they worked to improve the quality of the care provided. The chief executive had also hosted five 'staff conversation' sessions. Over 300 staff attended these. The themes emerging from these events had also been actioned by the LiA team.

While staff engagement was improving, this was an area for more work as this was integral to making the changes a success.

There was also a Service User Reference Group that met monthly. Members of this group told us that it felt like it had lost its way and become tokenistic.

Our findings

South West London and St George's Mental Health NHS Trust is currently in the process of applying to become a foundation trust. The Trust currently has 2,800 foundation trust members. A full-time membership and communications officer had been appointed and a detailed plan of engagement was being developed to support the membership strategy

We saw that the trust board members and service directors managers had good oversight of the challenges that the trust faced. There were systems and measures in place to manage risks. We did find however that ward level risks in some areas were not being reported or recorded consistently and there were also blockages in the cascading of learning from incidents across all organisational areas.

We found that the non-executive directors were a competent team who understood their role and exercised their duties effectively.

At the time of the inspection, a transformation programme was underway. We spoke with staff in clinical areas. Some staff felt engaged fully in this process others said they did not feel fully engaged. Almost all of the staff spoken with told us they experienced good support from their immediate line managers.

The trust had introduced systems to engage with patients, their carers, the public and staff. This included introducing Listening into action which was commenced in April 2013, with the aim of improving patient care by increasing staff engagement and satisfaction, looking at; quality and safety, patient experience and working together. The trust has also introduced Real Time Feedback (RTF) kiosks. These were available in all wards and some community services. The RTF kiosk allow people to provide immediate feedback, this was not limited to the kiosks and could be accessed from any computer.

The governance framework is coherent, complete, clear, well understood and functioning

As part of the process to achieve Foundation Trust status the trust board completed a self-assessment against the Monitor Quality Governance Framework. This was reported in December 2012. At this point the Trust score was 8.5 (A

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

trust is required to score below 3 to enable them to progress to the next stage of approval.). The trust at this point identified key areas for development which included the following:

- To implement SIREN (Service Intelligence Risk Evaluation Network)
- To introduce a revised quarterly Trust Board Integrated Quality and Performance Report
- To publish a Quality Manual for staff
- To introduce electronic incident reporting
- To implement service transformation
- To launch PDSA (Plan Do Study Act) Groups
- To embed improvements to the management of risk across the Trust
- To finalise and test the robustness of a clear organisational structure and governance flow

In January 2013 KPMG undertook an independent evaluation of the Trusts self-assessment against Monitors Quality Governance Framework. KPMG assessed the Trust as having a score of 3.5.

In August 2013, the Trust carried out its second self-assessment against the Monitor Quality Governance Framework At this point the Trust score was 2. A score of below 3 would enable them to progress to the next stage of approval.

In October 2013 KPMG undertook a second independent evaluation of the Trusts self-assessment against Monitors Quality Governance Framework. KPMG assessed the Trust as having a score of 2.5.

The trust used a Board Assurance framework to record and monitor risks. This records risks, control measures and identifies any gaps, from this an action plan is produced providing the board assurance. The trust also used an early warning system Service Intelligence Risk Evaluation Network (SIREN). This gives the trust board information that can be responded to more effectively.

The trust had an Integration Governance Group that reported to the board through the Quality, Safety Assurance Committee. We were informed that all the trusts other committees feed into the Integration Governance Group and the board received exception reports.

We found that staff's understanding of the trust's governance framework function was inconsistent in the services we inspected. Most staff reported positive leadership in their direct line managers but reported that they had little contact from people at director leave and above.

Staff concerns dealt with; risks identified ,managed and mitigated

Following the Monitor Quality Governance Framework self assessment which was reported in December 2012. This had lead the trust to introduce some significant changes to systems and processes.

In order to improve practice and ensure the Trust staffed the ward to a similar level as other services a review of staffing on the wards was undertaken and this had led to a change in shift patterns for the staff working in the ward areas. The staff were spoke with explained there concerns about how these changes were impacting on workloads.

The staff in the community teams were particularly concerned about the size of thier caseload. In some teams there was uncertainty about job security. Many of the staff we spoke with expressed negative experiences of how the changes to the shift patterns had come about. Staff told us that this was done in an uncaring way and staff felt that they were given a decision rather than being involved in or able to influence the process.The trust had completed a major consultation regarding the shift patterns with staff prior to the changes being made.

We were told that the trust wanted to ensure that staff felt well supported at work and enjoyed working for the trust. Senior managers we spoke with had an understanding of the issues and recognised that there was a disconnect that the senior team were trying to bridge.

The Department of Health conducts an annual survey of NHS organisations to help gauge the views of staff across the country. The 2012 NHS staff survey showed a 'risk' relating to staff believing the trust provided equal opportunities for career progression or promotion. The trust were in the top 20% of mental health trusts for the percentage of staff appraised in last 12 months.

There were a further seven 2012 staff survey indicators in which the trust score placed them within the bottom 20% of trusts nationally. This included questions around training and relations with senior management.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The trust had introduced that Real Time Feedback (RTF) kiosks.so allow people to become involved in feeding back to the senior team. Staff did tell us this had led to changes being introduced.

Most of the staff we spoke to reported that the leadership from their direct line managers was very positive.

As part of the inspection process we ran several focus groups across different staffing groups. At these groups staff told us they felt they had not been fully involved or engaged in the changes to the services that were taking place, people often stated that changes were done to them and not with them and that consultation only took place once decisions had been made.

Leadership within the organisation is effective, maintained and developed

The trust had developed robust communication strategies including Listening in to action and Real Time Feedback (RTF) kiosks to ensure that staff at all levels were able to provide feedback to the trust board. aware of the vision and values of the organisation and to keep people informed.

The trust board assurance framework identified a risk for the ability to attract, recruit and retain high quality staff to meet the needs of the services which may negatively impact on care.

Using our intelligence monitoring we identified that the staff sickness absence rates for South West London and St George's had been consistently lower than the national average for mental health and learning disability trusts between September 2011 to September 2013.

Staff in focus groups and in the clinical area we visited told us frequently that additional training to support their work in the specialist clinical areas was not available and if training was identified time to undertake this training was not always available.

Functioning Governance Framework for Mental Health Act duties

The trust undertook a review which was reported in July 2013 to examine the way in which the Mental Health Act Office discharges its responsibilities. The audit looked at the effectiveness of systems within the Mental Health Act Office to facilitate compliance with the Mental Health Act, to confirm the necessary processes being completed within the required deadlines; the efficiency of systems and processes, to identify opportunities for improving the efficiency of processes; and structures, responsibilities, governance arrangements and resources, including monitoring and reporting arrangements to ensure that significant issues are brought promptly to the attention of senior management. This review identified areas where assurance was not present and an action plan was developed and introduced.

Therewas a Mental Health Act office team to monitor the legality of the detention paperwork, as well as ensuring that first tier mental health tribunals and hospital manager review meetings took place.

The independent hospital manager hearing outcomes were audited to ensure the quality of these reviews. The lead hospital manager and the Mental Health Act manager were members of the Mental Health Law Governance Group, and reported to the group on assurance and monitoring around the powers of discharge.

The Mental Health Law Governance Group reported to the Quality, Safety and Assurance Committee which in turn reported to the trust Board.

We found that people who were detained under a section of the Mental Health Act 1983 were detained lawful. These people also lacked capacity or were not consenting were receiving treatment that was authorised appropriately.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows: Comprehensive management plans were not consistently being put in place for people using the service where a risk to themselves or others had been identified. This was a breach of Regulation 9(1)(b), 9(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of Medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to record medicines administered. The reasons why sedative drugs prescribed 'as required' were given were not recorded in people's records. This means that we could not be assured that people were being given their medicines appropriately and consistently. This was a breach of Regulation 13

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

Care and welfare of people who use services

How the regulation was not being met:

This regulation was not being met as patients were not always cared for in an environment that assured their safety and welfare.

Many clinical areas had mixed sex wards. This meant, in the acute admission wards, CAMHS wards and older people's service, people did not always receive the care they required and their privacy and dignity was not always maintained.

This means there was a risk that the environment was not effective in ensuring the privacy and dignity of people was maintained.

This was a breach of Regulation 9.