

# 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 trust was in the process of changing the structure of the organisation from one based on diagnostic categories to a borough based system at the time of our inspection.

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 six 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

# Summary of findings

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.

Following our inspection in September 2015 and three further inspections in 2017, we found areas for improvement in seven core services we inspected:

- 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
- Forensic inpatient/secure wards
- 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

We told the trust they must make improvements to:

- the quality and consistency of care plans and risk assessments
- physical environments in the health-based places of safety, which were not safe and the mitigation of environmental risks
- community staff transportation of medicines for use in people's homes
- the implementation of fire safety precautions
- the effectiveness of governance systems
- staff vacancies
- relevant suitability checks for non-executive directors
- staff understanding of safeguarding procedures
- plans to reduce patient restraints in the prone position
- staff supervision
- completion of physical health monitoring in the eating disorders ward.

These breaches related to six regulations under the Health and Social Care Act (Regulated Activities) Regulations: Regulation 9 Person-centred care; Regulation 12 Safe care and treatment; Regulation 15 Premises and equipment; Regulation 17 Good governance; Regulation 18 Staffing; and Regulation 19 Fit and proper persons employed

## Overall summary

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

# Summary of findings

## What this trust does

South 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 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

We did not re-inspect community-based mental health services for working age adults, which we had last inspected in July 2017. At that inspection, we identified significant concerns in the core service and asked the trust to act to address these concerns. The action plan provided by the trust following this inspection outlined improvements that would not be fully completed before October 2018. For that reason, we decided not to include community-based mental health services for working age adults in the inspections carried out in July 2018.

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:

# Summary of findings

- At this inspection 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.
- We rated well-led for the trust overall as good.
- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to make the necessary changes to provide high quality care to their local communities.
- The trust was participating very effectively in local care systems to drive progress to achieve integrated care. This was most developed in Lambeth but was also in progress in the other boroughs. The trust's active participation in the South London Partnership was delivering new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home.
- The trust's strong academic and research links meant that many patients had access to innovative treatment. The trust had been at the forefront of developing new evidence based practice, including for people with eating disorders, in peri-natal care and in work with people with dementia, leading to improvements in treatment adopted both nationally and internationally.
- The trust was making progress with their quality improvement programme and had set ambitious targets for the next three years. The early adopters of this work were understandably from higher performing teams. However, this needed to be embedded in more challenged teams as a way of facilitating improvements.
- Staff engagement was (as shown in the staff survey) better than many other similar trusts. An ambitious programme of leadership walkabouts was promoting good communication. The trust promoted staff to speak up through the Freedom to Speak Up Guardian, although some teams were not yet aware of how to access this support and Freedom to Speak Up advocates did not receive specific training for their role. The trust was aware that there were groups, teams and individuals where deep-seated concerns still needed to be resolved.
- The trust was working with the BME staff network to implement a range of measures to improve career progression and address discrimination for BME staff. It was recognised that this would take more time to fully implement and begin to have a positive effect on performance against the workforce race equality standard.
- The trust had many excellent examples of working with people who use services and carers. This was supported by an active involvement register and a wide range of opportunities for volunteers. The trust was also looking to extend the number of peer workers. Staff were proactive in addressing the needs of people with protected characteristics. Staff enabled access to services for patients with physical disabilities, took account of individual's cultural and religious needs and provided information in accessible formats. The trust worked in partnership with local BME communities to improve the design and delivery of services. Many staff were sensitive to the needs of LGBT+ people and the trust had developed a new policy to address needs of young people who were transgender.
- The governors were performing their role well and holding non-executive directors to account. This had significantly improved since the last inspection and reflected the desire of the board to be open and transparent.
- The trust had systems in place to identify risk and the board assurance framework had recognised the pressures on the acute care pathway. In addition, a system was in place to identify the performance of wards and teams using a range of indicators. However, there was a disconnect between these systems and the front-line services. This meant that where services needed to improve across the acute care pathway, targeted support had not been delivered.
- The quality of the investigation reports following a serious incident were of a high standard and provided the necessary insight into where improvements were needed but further work was needed to ensure this learning was embedded across the trust.

# Summary of findings

- The trust was actively engaged in pioneering and developing digital innovations. This included the piloting of electronic observations and a personal health record to digitally engage patients in their care.
- The trust had made significant improvements to care environments since the comprehensive inspection in September 2015. This was particularly noticeable in the introduction of a single, centralised, purpose-built health-based place of safety at the Maudsley Hospital. The facility had a dedicated space for children and young people and provision for their parents to stay overnight. A psychiatric intensive care unit had won an award for the design of a new sensory room for patients and commissioned art work for the ward, which created a more therapeutic environment.

However:

- At the time of the inspection, adult patients from the local communities 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. These unwarranted variations in standards of care had a negative impact on the largest group of patients receiving care and treatment from the trust. We have taken enforcement action to ensure services improve.
- The quality of leadership at a ward and team level varied and was a key factor in whether the service was operating well. The trust was aware of these variations and that some leaders needed more support to enable them to deliver a high-quality service. The trust had not ensured that the necessary support had been put into place. The trust anticipated that the recently introduced restructure of the operational directorates, resulting in smaller spans of control and increased levels of professional input, would deliver the support needed to make required improvements.
- There had been breaches of fundamental standards of care on the acute inpatient wards, which had not been appropriately escalated to senior leaders in the trust. The flow of patients into and out of the acute care pathway was poor. Bed occupancy was above 100% on most of the acute wards. There was not always a bed available for someone who needed one. Some patients were sleeping on couches or in seclusion rooms rather than in a bed. This was unsafe and compromised the dignity of the patients. In the previous year there were over 30 incidents of this happening. Governance systems had not identified this unacceptable practice, or a few other serious shortfalls such as staff not always carrying out physical health checks on patients after they were administered intra-muscular rapid tranquilisation. This put patients at risk of avoidable harm.
- The communication with wards and teams did not always happen effectively. Whilst the governance system included the expectation that each ward or team would have a quality governance meeting, these were not always happening regularly or including all staff. Information was not always shared consistently, which meant there were teams who did not have access to adequate learning from incidents, complaints or other methods of assurance such as clinical audits.
- Staff did not always identify and report patient safety incidents, which prevented them from being investigated in promptly and prevented staff from learning from them. Environmental risk assessments were not always thorough and significant potential risks to patients had not been identified and therefore mitigated.

## Are services safe?

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

- At this inspection we rated safe as requires improvement in one of the six core services and good in the other five services. When these ratings were combined with the other existing ratings from previous inspections, four of the trust services were rated requires improvement and nine were rated good.

# Summary of findings

- Staff did not always provide safe care and treatment to patients. Staff on the acute wards and psychiatric intensive care units did not always carry out and record physical health checks on patients following the administration of rapid tranquilisation. This was contrary to national guidelines and trust policy and put patients at risk of avoidable harm.
- Although staff completed environmental and ligature risk assessments for all wards these sometimes failed to identify important risks. For example, some acute wards had failed to include the use of plastic bin bags in bathrooms, blind spots, and ligature points in their environmental risk assessments, which meant they were not adequately mitigated.
- Following the use of restraint staff did not record in sufficient detail what had taken place, such as, the staff involved, the holds used or duration of the restraint. Of 32 records of patient restraint we reviewed on AL3, Ruskin/AL2 and John Dickson Wards, all acute wards, none of these recorded details of the holds used by staff or the staff involved.
- Following our last inspection of acute wards and psychiatric intensive care units in February 2017, we told the trust to develop clear plans to reduce the number of restraints in the prone position. Although we found the trust did have an overarching plan in place, and in forensic wards significant progress had been made to reduce the number of restraints, on some acute wards, staff were unaware of key initiatives to reduce the level of restraint and prone restraint.
- Staff did not always identify and report patient safety incidents. We found incidents on three acute wards that had not been reported but should have been. As a result, managers either failed to investigate them, or there were delays in investigation. Staff in the neuropsychiatric service recorded incidents but did not always categorise incidents appropriately to ensure that appropriate learning was shared with staff within the trust. Some acute wards teams had not met together for several months. Staff on those wards had not discussed and were not aware of incidents that had occurred in the service or trust as a whole or the learning identified from them.
- Patients on one ward did not have direct access to drinking water and cups putting them at increased risk of dehydration.
- Although the trust undertook regular recruitment campaigns to attract nurses with a range of skills there remained staff shortages in some wards and teams. In the acute wards and psychiatric intensive care units the overall vacancy rate had improved to 19% but there were seven vacancies on Tyson West 1, seven vacancies for nurses on Nelson Ward and five vacancies on Gresham 1. Staff turnover rates were above 25% on Rosa Parks Ward, ES1 and Nelson Ward. Staff and patients on these wards, told us that sometimes patients' leave was postponed or cancelled when staff were not available but this was not recorded. There were a high number of vacancies on Norbury and Waddon wards in the forensic service. Sometimes shifts could not be filled and this had led to patient leave being cancelled on 22 occasions in a six-month period.
- While most services prescribed, gave, recorded and stored medicines safely and there had been improvements in the way community staff transported medicines, staff did not always leave medicines in patients' home in the correct packaging and labelling or assess and record the suitability of patients' own medicines, before administration, in accordance with trust policy.
- Equipment was not always replaced before it expired. While the trust provided suitable equipment for staff to use, in Lambeth Hospital, staff had not anticipated the expiry date of some items of emergency equipment. This led to a delay in receiving replacements for items that had passed their expiry date. In the clinic room on the neuropsychiatric ward we found wound dressings and blood testing equipment that were past their expiry dates.

However:

# Summary of findings

- The trust had improved the environment for patients requiring a health-based place of safety since the inspection in 2015. The purpose-built, centralised service was visibly clean and well-maintained. The service was permanently staffed on a 24-hour, seven day a week basis and there was no need to obtain staff from other wards. Community teams operated from suitable premises that were safe.
- We found improvements in the quality of risk assessments and risk management plans in several services. Staff used a new template, which prompted them to complete these records in detail. Staff completed and updated risk assessments for each patient when necessary and used these to understand and manage risks individually. In the forensic wards staff completed clinical risk management assessments (HCR-20) for all patients within three months of admission and reviewed the HCR-20 every six months in accordance with national guidance. The home treatment teams stored risk assessments consistently, which made them easily accessible, an improvement since September 2015. In the home treatment teams, for adults and for older people, staff discussed, categorised and managed patient risk using a zoning system in daily meetings to keep patients and others safe. Patients had crisis plans so they knew who to contact if their health had deteriorated.
- Staff understood how to protect patients from abuse and the services worked well with other agencies to keep patients safe. Staff had training in how to recognise and report abuse. Staff knew what incidents to report and how to do so and escalated incidents in line with trust policy.
- The trust had clear lone working protocols, which helped protect staff working on their own in the community. Staff understood and followed the protocols and knew how to summon assistance in an emergency.
- Community teams (in older people's services and the home treatment teams) had enough staff with the right qualifications, skills, training and experience to provide safe care and treatment. A dedicated team staffed the health-based place of safety day and night. Community-based staff had manageable caseloads. New posts had been created at Croydon memory service to shorten waiting times for the service. Teams responded promptly to urgent referrals and provided timely assessments of patients. The community mental health teams for older people were able to allocate patients to a care coordinator immediately, when needed.
- The services planned for emergencies, reviewed procedures, and undertook regular fire drills. Staff understood their roles if an emergency should happen.

## Are services effective?

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

- At this inspection we rated effective as requires improvement in one of the six core services and good in the other five services. When these ratings were combined with the other existing ratings from the previous inspections, two services were rated as requires improvement for effective, nine as good and two as outstanding.
- The services provided care and treatment based on national guidance and evidence of its effectiveness. Staff used a range of evidence-based, validated tools to complete comprehensive assessments for patients in the memory clinics. Some tools were available in other languages and more culturally appropriate versions to enable effective assessments for all patients. Staff provided a range of evidence-based care and treatment interventions and were knowledgeable in respect of relevant national guidelines. Staff participated in clinical audit to provide assurance of the quality of care and treatment delivered to patients and drive improvement. Outcomes for patients were measured using appropriate tools to monitor the effectiveness of the interventions implemented.
- Staff worked together as a team to benefit patients. Nurses, doctors and other healthcare professionals supported each other in the provision of care and treatment. A full range of professional disciplines worked within the teams. When necessary staff made referrals to specialist health staff outside the team or trust. Most staff were experienced in their roles and many had undertaken specialist training.

# Summary of findings

- We found there had been improvement in the quality of patient care plans since our previous inspections in 2015 and 2017. Care plans in most services were personalised, holistic and recovery oriented. Patients' recovery goals were determined by their needs.
- Staff supported patients to live healthier lives. The trust provided very good support for patients who wanted to stop smoking and encouraged patients to exercise. Staff completed a comprehensive physical health assessment on each patient shortly after admission and used a recognised tool to monitor patients' physical health. The home treatment teams ran a weekly physical health clinic to support patients with their physical health needs.
- Staff used technology to support patients effectively. Staff in Lambeth, Lewisham and Southwark had good access to information held about patients by other health providers, which enabled prompt and effective care and treatment. Staff were able to use a secure portal to review patients' physical health investigation results directly. On ES2, an acute ward, staff had completed a quality improvement project where patients' physical observations were monitored electronically. This had positive outcomes in terms of improving patient care and the accuracy of monitoring.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They had received appropriate training and knew how to support patients, including those who lacked the capacity, to make decisions about their care.

However:

- In some wards and teams, managers did not hold regular supervision meetings with staff to monitor the effectiveness of their work and provide timely support. At the previous inspection of acute wards for working age adults and psychiatric intensive care units in January 2017, we found that staff supervision rates were low. At this inspection, we found that supervision rates continued to be low in the acute wards. Fifty-two per cent of staff had received the required supervision from March 2017 to February 2018. Although this improved between April to June 2018 to 75%, nearly one quarter of the acute wards had completed less than 65% of planned staff supervision in that period. Similarly, less than half of the registered and non-registered nursing staff in the Lishman Unit (specialist neuropsychiatric service) had received regular clinical supervision. In the eating disorders inpatient service completion of monthly staff supervision had fallen to 70% in May and 65% in June 2018. The recording of staff supervision in Lewisham older adult CMHT was inaccurate and resulted in under reporting. It was difficult for the team manager to be sure about the frequency of supervision taking place.
- Although care plans covered all aspects of patients' needs including social, physical and mental health needs and were usually shared with patients, they were not easily accessible to patients with dementia to enable their understanding.
- Although staff in the eating disorders service had received some specific training related to their role the service did not have a formal eating disorders competency framework for staff. There was risk that staff did not have all the specialist skills they needed to care for a patient with an eating disorder.

## Are services caring?

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

- We rated all six services core services that we inspected as good for caring.
- Most staff treated patients and carers with kindness and compassion. Patients reported that staff treated them well and described staff as friendly, caring and supportive. Staff treated people with dignity and respect and gave them the opportunity to make choices and have control of decision-making. Staff communicated well with patients so that they understood their care and treatment and found effective ways to convey information to patients with communication difficulties.

# Summary of findings

- Staff had good understanding of patients' individual needs, including their personal, social and religious needs. Staff developed care plans in collaboration with patients to support them with these needs.
- Staff involved patients and those close to them in decisions about their care, treatment and the service. Patients in most services reported that staff had offered them a copy of their care plan and that they felt involved in their care and treatment.
- Staff encouraged patients to give feedback about the service to identify areas for improvement. Most wards held regular community meetings so that patients could raise any concerns they had. Staff acted on the issues raised. Each forensic ward had a patient representative, who attended regular meetings with senior managers, to help bring about improvements across the service. Staff in the health-based place of safety had produced a specific survey for patients to feedback about their time in the service.
- Staff involved carers appropriately and provided them with support when needed. Staff in the eating disorders service delivered a two-day carers' workshop and families and carers were invited to attend meals with patients and engage in family therapy. Some services had an identified carers involvement lead. Four acute wards held monthly carers' forums. The trust facilitated service user and carer advisory groups as a way of involving them in the development of the services.
- Services provided access to independent advocacy support for patients. Details of how to contact the advocate were displayed where people could see them.

However:

- Although patients and carers were encouraged to provide feedback about the service in a patient experience survey, there were no alternative feedback methods designed to be accessible for patients living with dementia.
- While most staff cared for patients with kindness and compassion, feedback from patients on two wards was less positive. On one acute ward patients reported that some staff did not seem to care about them or were too busy to help them. Some patients on one PICU reported poor treatment by staff during episodes of restraint and seclusion.
- In two wards, confidential patient information written on a white board in the ward office was visible to other patients and visitors outside the office.

## Are services responsive?

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

- At this inspection we rated responsive as good in five of the six core services that we inspected and one as inadequate. When these ratings were combined with the other existing ratings from the previous inspections, one was inadequate, one was requires improvement and 11 services were rated as good.
- The trust had made improvements to service environments since the inspection in 2015. The trust had introduced a single centralised health-based place of safety, purpose built to a high specification. The health-based place of safety had dedicated facilities for children and young people that included the provision for parents to stay overnight. ES1, a psychiatric intensive care unit, had a new sensory room that had received a national award for its design. Patients could use the space to calm themselves. The trust had worked in partnership with a charity to commission art work for the ward, which created helped create a therapeutic, and much improved environment and experience for patients. Community services provided pleasant waiting areas and had the necessary space to carry out consultations and group activities. The trust had improved seating in the outpatient department waiting area at premises in Lambeth.

# Summary of findings

- Forensic wards had made improvements to the quality of meals provided to patients. The catering provider met regularly with patients and staff to discuss menus. Some wards were beginning to introduce self-catering, which enabled patients to choose their own food and facilitated greater independence.
- Services took account of patients' individual needs. Staff were proactive in addressing the needs of people with protected characteristics. Staff enabled access for people with physical disabilities, took account of patients' cultural and religious needs and provided information in an accessible format. Lambeth and Southwark memory service were working to increase accessibility to the service for black and minority ethnic people, in line with the trust's equality priorities for 2017-2020. Staff were inclusive of and welcoming to LGBT+ patients. They were sensitive to the way they phrased questions about significant relationships and linked LGBT+ people with community groups and resources.
- The forensic service had worked with colleagues in the South London Partnership to bring back 37 forensic patients from around the country so that they could be closer to their communities and families.
- The services treated concerns and complaints seriously, investigated them and shared lessons learned with staff. Patients and carers knew how to complain, and give feedback about the service.

However:

- Although most people could access the service they needed to, the flow of patients into and out of the acute care pathway was poor. Bed occupancy was above 100% on most of the acute wards. There was not always a bed available for someone who needed one. The trust had placed almost 300 patients in out-of-area beds in the year from February 2017 to January 2018 because of a lack of available beds within the acute wards and PICU. At the time of the inspection, 29 patients were placed out of the area due to a lack of beds being available.
- There was not always a bed available for patients returning from leave. In the last 12 months, four patients returning from leave or recalled to hospital and 27 patients returning from being absent without leave slept on sofas, in seclusion rooms and in other areas of the wards until a bed could be found. There was not always a bed available promptly for patients who needed a transfer to a psychiatric intensive care ward. This led to patients being secluded in unsuitable environments, such as bedrooms, whilst waiting for a transfer.
- Although the trust had recently taken steps to address the issue of delayed patient discharges with local health and system partners, 20% of patient discharges from acute wards were delayed. Staff on the acute wards were not proactive in planning for patients' discharge or addressing barriers to discharge.
- In the health-based place of safety, although staff had significantly reduced patient length of stay since 2017, 23% of patients admitted to the health-based place of safety breached the 24-hour target length of stay for assessment in May 2018. The trust monitored breaches closely to ensure further improvements were made.
- Following the inspection of community-based mental health services for working age adults in July 2017, we rated this core service requires improvement overall, requires improvement for safe, effective and responsive and good for caring and well-led. We asked the trust to make improvements to quality of patient risk assessments and care plans; the length of time patients waited for a Mental Health Act assessment; and the long waiting times for patients referred to the Croydon assessment and liaison team. We have not yet returned to re-inspect this core service to see whether improvements have been made.

## Are services 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.

# Summary of findings

We rated the trust 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 make the necessary changes to provide high quality care to their local communities.
- The trust was participating very effectively in local care systems to drive progress to achieve integrated care. This was most developed in Lambeth but was also in progress in the other boroughs. The trust's active participation in the South London Partnership was delivering new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home.
- The trust's strong academic and research links meant that many patients had access to innovative treatment. The trust had been at the forefront of developing new evidence based practice, such as the use of talking therapies for patients with psychosis, leading to improvements in treatment nationally and internationally.
- The trust was making progress with their quality improvement programme and had set ambitious targets for the next three years. The early adopters of this work were understandably from higher performing teams. However, this needed to be embedded in more challenged teams as a way of facilitating improvements.
- Staff engagement was (as shown in the staff survey) better than many other similar trusts. An ambitious programme of leadership walkabouts was promoting good communication. The trust promoted staff to speak up through the Freedom to Speak Up Guardian, although some teams were not yet aware of how to access this support. The trust was aware that there were teams and individuals where deep-seated concerns still needed to be resolved.
- The trust was working with the BME network to implement a range of measures to improve career progression and address discrimination for BME staff. It was recognised that this would take more time to fully implement.
- The trust had many excellent examples of working with people who use services and carers. This was supported by an active involvement register and also a wide range of opportunities for volunteers. The trust was also looking to extend the number of peer workers.
- The governors were performing their role well and holding non-executive directors to account. This had significantly improved since the last inspection and reflected the desire of the board to be open and transparent.
- The trust had systems in place to identify risk and the board assurance framework had recognised the pressures on the acute care pathway. In addition, a system was in place to identify the performance of wards and teams using a range of indicators. However, there was a disconnect between these systems and the front-line services. This meant that where services needed to improve across the acute care pathway, targeted support had not been delivered.
- The quality of the investigation reports following a serious incident were of a high standard and provided the necessary insight into where improvements were needed. Further work was, however, needed to ensure this learning was embedded with teams across the trust.
- The trust was actively engaged in pioneering and developing digital innovations. This included the piloting of electronic clinical observations and a personal health record to engage patients digitally in their care.

However:

- At the time of the inspection, 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. These unwarranted variations in standards of care impacted on the largest group of patients receiving care and treatment from the trust.

# Summary of findings

- The quality of leadership at a ward and team level was variable and was a key factor in whether the service was operating well. The trust was aware of these variations and that some leaders needed more support to enable them to deliver a high-quality service. The trust had not ensured that packages of support had been put into place. The trust anticipated that the recently introduced restructure of the operational directorates, resulting in smaller spans of control and increased levels of professional input, would deliver the support needed to make these improvements.
- There had been a breach of fundamental standards of care on the acute inpatient wards, which had not been appropriately escalated to senior leaders in the trust. Some patients were sleeping on couches or in seclusion rooms rather than in a bed. This was unsafe and compromised the dignity of the patients. In the previous year there were over 30 incidents of this happening. Governance systems had not identified this unacceptable practice, or a few other serious shortfalls such as physical health checks not taking place after all cases of patients being administered intramuscular rapid tranquilisation.
- The communication with wards and teams did not always happen effectively. Whilst the governance system included the expectation that each ward or team would have a quality governance meeting, these were not always happening regularly or including all staff. Information was not always shared consistently, which meant there were teams who did not have access to adequate learning from incidents, complaints or other methods of assurance such as clinical audits.

## 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 five services we inspected:

- 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

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 14 things the trust must put right in relation to breaches of these four regulations. In addition, we found 47 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.

# Summary of findings

## Action we have taken

We took enforcement action and issued a warning notice in respect of regulation 17 Good governance. We issued requirement notices in respect of the three other regulations that had been breached. Our action related to breaches of three legal requirements at a trust-wide level and twelve legal requirements in two 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

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

- ES1, the female PICU, won the Project of the Year award at the Design in Mental Health Awards 2018 for their sensory room. The room had bean bag seating, a projector which displayed soothing scenes on the wall and calming music. Two rainbow light bars changed the colour of the room at the touch of a button and there were liquid floor tiles and a water bubble tube. The room was mainly for supervised use but patients could use it on their own and staff hoped it would become an alternative to medication use and seclusion.

### Forensic inpatient/secure wards

- All wards across the service had implemented the 'four steps to safety' programme. The programme has four areas of intervention: proactive care, patient engagement, teamwork and environment. Multiple interventions sit under each area. The aim of the programme is to reduce violence and aggression on the wards. Staff all spoke positively about 'four steps to safety' and understood its purpose. The approach had been instrumental in reducing violence and aggression on the wards and consequently the use of restraint and seclusion had reduced.
- Managers used a zoning system to demonstrate where incidents occurred and what time of day or night they happened. The information was colour coded on a map of the ward, which enabled the manager and staff to see 'at a glance' where problem areas were. This information was used to monitor any trends and make adjustments to how the ward was run as necessary. For example, Thames Ward introduced a new system for meal times, to reduce the number of violent incidents which occurred in the dining area when meals were served. The manager reported a significant reduction in incidents since the changes had been implemented.
- The forensic service ran a restorative justice programme for some patients. The programme, called 'Sycamore Tree', aimed to promote victim awareness so that patients could learn to take responsibility for their actions. Staff and patients reported that participation in the programme allowed the patient to gain insight into the crime they had been convicted for.
- The forensic service was part of the South London Partnership with two neighbouring mental health trusts. The trust had been able to bring back 37 patients to south London from services in other parts of the country, meaning they could receive care closer to their communities, families and friends.

### Mental health crisis services and health based place of safety

# Summary of findings

- The trust introduced the crisis assessment team in October 2017. The team operated in a car with a mental health nurse and a police officer and went out to assess people in crisis in the community. Data showed that the intervention of the crisis assessment team had reduced patients being taken to the emergency department of the local acute hospital by the ambulance service, by 89%, amongst those seen.
- The health-based place of safety had dedicated facilities for children and young people that included the provision for parents to stay overnight.

## Community-based mental health services for older people

- Staff, including the patient and public involvement lead, were proactively engaging with patients from black and minority communities in Lambeth and Southwark to increase awareness of dementia and the service. This work promoted access to timely treatment and therefore the best possible outcomes for the whole local population, regardless of their background. As part of this work staff from the memory service had piloted sessions on dementia in schools. The aim was to educate the young people about dementia and help them to recognise when someone may have dementia. Children gave positive feedback about what they had learned from the session. The service had plans to roll out the sessions to other local schools.
- The care home intervention team had developed a wellbeing and health for people with dementia pilot in Lambeth (WHELD-L), which was evidence based. The programme provided training and support for dementia champions in two care homes in Lambeth. Staff at the care home intervention team provided the champions with experiential learning, coaching and mentoring to enable them to engage in more effective and meaningful interaction with people with dementia in their care home. A key outcome of the pilot was for care home residents to have a one-page profile or life story in place. Feedback from dementia champions was extremely positive.
- Staff within older adults services had developed a tool called Medicheck, which made it easy to check more than 2000 medicines in terms of their anti- cholinergic effect on cognition (AEC). The tool calculated a score, which indicated further steps for professionals to take. Once the score for each prescribed medicine was added together guidance was provided on reviewing the medicine to see whether it could be withdrawn or replaced with another medicine, which had less of a negative impact on memory. New NICE guidelines included the need to review the ACE burden on patients and this tool helped professionals to do this. This tool was available on the internet and had recently been launched as a mobile telephone application. The website had been accessed by users world-wide

## Specialist eating disorder services

- Staff were involved in various quality improvement and research projects, including ICASK and Triangle, and applied findings into practice to improve care delivered on the ward.
- The ward was in the process of making adaptations and modifications for patients with autism for example, the environment and dietetic input.
- Staff in the trust's eating disorder service had developed an early intervention service for young people aged 16-25 years experiencing a first episode eating disorder. The service provided rapid access to evidence based care tailored to individual needs, with an emphasis on family involvement, promoting early change and full recovery. Outcomes showed that the service had been effective in helping patients with anorexia nervosa re-gain weight and led to a 35% reduction in the need for day care and inpatient treatment. The model had been used at three other sites in the UK and was working towards national roll out. The team had won the British Medical Journal prize for mental health team of the year in 2017.

## Areas for improvement

# Summary of findings

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 three legal requirements trust wide and eleven legal requirements in one core service. (There were an additional nine requirements outstanding from inspections in 2017 and 2015 in three core services that we did not inspect in 2018).

### Trust wide

- The trust must ensure fundamental standards of care are understood and implemented across the trust. This must include ensuring that patients always have a bed when receiving inpatient care.
- The trust must identify and provide timely support to wards and teams where standards of care need to improve.
- The trust must have effective systems in place to ensure information is shared consistently with wards and teams.

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

- The trust must identify and provide timely support to wards and teams where standards of care need to improve.
- The trust must ensure that governance processes are sufficiently robust so that they identify where improvements need to be made and ensure that action is taken to make the required improvements.
- The trust must ensure that all patients can have direct access to drinking water on the psychiatric intensive care units.
- The trust must ensure that staff carry out physical health checks on patients after they receive rapid tranquilisation
- The trust must ensure that all environmental risks are recorded on environmental risk assessments, that staff are aware of these risks and know how these risks are mitigated. This includes all ligature anchor points, blind spots and the use of plastic bin liners.
- The trust must continue to implement plans to reduce the number of patients being restrained and make sure all staff are aware of the actions they need to take.
- The trust must ensure that staff record all incidents appropriately and are aware of incidents from the service and across the trust, and the lessons learned from investigations into these incidents.
- The trust must ensure that all wards plan effectively for patients' discharge and are pro-active in addressing barriers to discharge.
- The trust must ensure that patients are able to access a bed when they return from authorised or unauthorised leave and are not required to sleep on sofas or in other temporary facilities.
- The trust must ensure that all staff receive regular managerial and clinical supervision in line with trust policy.
- The trust must ensure that all emergency equipment is replaced prior to the expiry date.

## **Community-based mental health services for working age adults** (from inspection in July 2017)

- The trust must ensure that risk assessments and risk management plans are always completed and reviewed after changes in patients' circumstances and risk events, and stored where other staff can find them easily.
- The trust must ensure that each patient has a care plan, which is person-centred and includes information about how staff will support them.

# Summary of findings

- The trust must 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 ensure that patients referred to the Croydon assessment and liaison team, receive an assessment within trust target timescales.

## **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.

## **Long stay/rehabilitation mental health wards for adults of working age** (from inspection in September 2015)

- The trust must ensure that at Heather Close and McKenzie ward that where there are still high-risk ligature points or patients who may harm themselves, that the appropriate steps to mitigate these risks are in place and staff are able to clearly articulate how these are managed.
- The trust must ensure that at Heather Close and the Tony Hillis unit blanket restrictions are not imposed that do not reflect the needs of people using the service.
- The trust must ensure that at Heather Close fire safety precautions are all in place.
- The trust must ensure senior management support local staff and address issues of staffing.

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

We told the trust that it should take action to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These 47 actions related to the whole trust and six services. (There were an additional 53 actions outstanding from inspections in 2017 and 2015 related to six core services that we did not inspect in 2018).

### **Trust wide**

- The trust should ensure that leadership development opportunities are available for aspirant and current ward and team managers.
- The trust should complete the work needed to consult on and launch the refreshed strategy.
- The trust should continue to take steps to further improve the results of the workforce race equality standards. They should also continue to support the staff networks to ensure staff with protected characteristics have their diversity and human rights protected and promoted.
- The trust should continue to promote the work of the Freedom to Speak Up Guardian and ensure advocates are selected openly and offered training to perform their role.
- The trust should continue the work to improve the retention of staff.
- The trust should complete the work to ensure adequate arrangements are in place for emergency planning and business continuity.
- The trust should continue the work to embed the accessible information standard.
- The trust should continue to embed quality improvement and support staff from across the trust to participate in the work.

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

- The trust should ensure staff receive training in autism.

# Summary of findings

- The trust should ensure that staff carry out observations on patients and keep accurate records of this, including for patients who are on intermittent observations.
- The trust should ensure all patient restraints are recorded in sufficient detail.
- The trust should ensure that all patients have care plans to meet their physical and mental health needs.
- The trust should ensure that staff take a pro-active approach in supporting patients with their physical health needs, including taking regular blood tests when required, and ensuring they act on concerns identified in food and fluid intake monitoring.
- The trust should ensure that all bathroom and toilet areas are kept clean.
- The trust should continue to address the high number of nursing vacancies on some wards through active recruitment and retention strategies to improve the consistency of care.
- The trust should consider recruiting more permanent, rather than interim, ward managers to increase stability on the wards and improve the consistency of care.
- The trust should ensure that patient information is not visible to other patients and visitors in Nelson Ward.
- The trust should ensure that staff on Ruskin/AL2 and Croydon PICU always demonstrate kindness and compassion in their interactions with patients.

## **Forensic inpatient/secure wards**

- 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**

- 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 patient's 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.
- 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**

- The trust should enable more effective mobile working in all teams through the provision of appropriate technology.

# Summary of findings

- 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**

- 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**

- 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.
- 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.

## **Community-based mental health services for working age adults** (from inspection in July 2017)

# Summary of findings

- The trust should continue to take action to reduce the caseloads of care coordinators in the early intervention teams, so that they can consistently provide effective support to patients experiencing a first episode of psychosis.
- The trust should ensure that staff complete all mandatory training including annual basic life support, infection control and fire safety training.
- The trust should ensure that staff clearly record patient involvement in their care records, and offer each patient a copy of their care plan.
- 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 patients have access to psychological therapies without undue delay in line with best practice guidance.
- The trust should continue to develop more effective working relationships between the community teams, home treatment teams and inpatient wards; and improve the quality and frequency of contact between community staff, ward staff and patients admitted to the wards.
- The trust should continue to address barriers to effective patient movement along the care pathway.
- The trust should ensure that staff clearly understand their roles and responsibilities, clarify referral criteria and thresholds, ensure specialist teams can accept referrals, and support community staff to make more effective placement funding applications.
- The trust should ensure that quality management systems are further improved to ensure that significant gaps in the quality of risk assessments and care plans, and unreasonable waiting times for patients are addressed swiftly.

## **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.

# Summary of findings

- 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.

## **Long stay/rehabilitation mental health wards for adults of working age** (from inspection in September 2015)

- The trust should ensure that staff are clear about the observation of patients at 3 Heather Close.
- The trust should ensure that at Heather Close and the Tony Hillis unit maintenance and repairs are carried out in a timely fashion.
- The trust should ensure recruitment processes are ongoing to reduce the dependence on temporary staff who may not all know the services.
- The trust should implement measures to monitor patients who go AWOL. This includes clearly recording for patients on section 17 leave what time they are expected to return. Also consider having photos of patients to share with the police if they are missing.
- The trust should ensure that staff have considered the vulnerability of patients on mixed gender wards where patients of the opposite gender could enter bedroom areas.
- The trust should ensure that staff at Heather Close can access a defibrillator in a timely manner in the event of an emergency.
- The trust should ensure care plans are reviewed regularly and reflect patient risks and the support they need.
- The trust should ensure that across the rehabilitation wards staff are able to clearly articulate the model of care and how they are promoting patients' rehabilitation.
- The trust should ensure on Tony Hillis and Heather Close that staff understand how to apply the Mental Health Act.
- The trust should ensure there is adequate space for therapeutic activities at Heather Close.
- The trust should ensure patients across all the wards can make phone calls in private.
- The trust should ensure food across the wards is consistently of a good quality and quantity and there are facilities to access hot drinks and snacks 24 hours a day.
- The trust should ensure at Heather Close that patients are aware of how to make a formal complaint and the findings are recorded and shared for learning.
- The trust should ensure there is a positive culture of staff engagement at Heather Close.

## **Child and adolescent mental health wards** (from 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 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 and 2017 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.

We rated the trust 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 make the necessary changes to provide high quality care to their local communities.
- The trust was participating very effectively in local care systems to drive progress to achieve integrated care. This was most developed in Lambeth but was also in progress in the other boroughs. The trust's active participation in the South London Partnership was delivering new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home.

# Summary of findings

- The trust's strong academic and research links meant that many patients had access to innovative treatment. The trust had been at the forefront of developing new evidence based practice, such as the use of talking therapies for patients with psychosis, leading to improvements in treatment nationally and internationally.
- The trust was making progress with their quality improvement programme and had set ambitious targets for the next three years. The early adopters of this work were understandably from higher performing teams. However, this needed to be embedded in more challenged teams as a way of facilitating improvements.
- Staff engagement was (as shown in the staff survey) better than many other similar trusts. An ambitious programme of leadership walkabouts was promoting good communication. The trust promoted staff to speak up through the Freedom to Speak Up Guardian although some teams were not yet aware of how to access this support. The trust was aware that there were teams and individuals where deep-seated concerns still needed to be resolved.
- The trust was working with the BME network to implement a range of measures to improve career progression and address discrimination for BME staff. It was recognised that this would take more time to fully implement.
- The trust had many excellent examples of working with people who use services and carers. This was supported by an active involvement register and also a wide range of opportunities for volunteers. The trust was also looking to extend the number of peer workers.
- The governors were performing their role well and holding non-executive directors to account. This had significantly improved since the last inspection and reflected the desire of the board to be open and transparent. The trust had systems in place to identify risk and the board assurance framework had recognised the pressures on the acute care pathway. In addition, a system was in place to identify the performance of wards and teams using a range of indicators. However, there was a disconnect between these systems and the front-line services. This meant that where services needed to improve across the acute care pathway, targeted support had not been delivered.
- The quality of the investigation reports following a serious incident were of a high standard and provided the necessary insight into where improvements were needed. Further work was, however, needed to ensure this learning was embedded with teams across the trust.
- The trust was actively engaged in pioneering and developing digital innovations. This included the piloting of electronic clinical observations and a personal health record to engage patients digitally in their care.

However:

- At the time of the inspection, 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. These unwarranted variations in standards of care impacted on the largest group of patients receiving care and treatment from the trust.
- The quality of leadership at a ward and team level was variable and was a key factor in whether the service was operating well. The trust was aware of these variations and that some leaders needed more support to enable them to deliver a high-quality service. The trust had not ensured that packages of support had been put into place. The trust anticipated that the recently introduced restructure of the operational directorates resulting in smaller spans of control and increased levels of professional input would deliver the support needed to make these improvements.
- There had been a breach of fundamental standards of care on the acute inpatient wards, which had not been appropriately escalated to senior leaders in the trust. Some patients were sleeping on couches or in seclusion rooms rather than in a bed. This was unsafe and compromised the dignity of the patients. In the previous year there were over 30 incidents of this happening. Governance systems had not identified this unacceptable practice, or a few other serious shortfalls such as physical health checks not taking place after all cases of patients being administered intramuscular rapid tranquilisation.

## Summary of findings

- The communication with wards and teams did not always happen effectively. Whilst the governance system included the expectation that each ward or team would have a quality governance meeting, these were not always happening regularly or including all staff. Information was not always shared consistently, which meant there were teams who did not have access to adequate learning from incidents, complaints or other methods of assurance such as clinical audits.

## 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<br>→←<br>Oct 2018 | Good<br>→←<br>Oct 2018 | Good<br>→←<br>Oct 2018 | Good<br>→←<br>Oct 2018 | Good<br>→←<br>Oct 2018 | Good<br>→←<br>Oct 2018 |

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<br>↔<br>Oct 2018 | Requires improvement<br>↔<br>Oct 2018 | Good<br>↔<br>Oct 2018        | Inadequate<br>↓↓<br>Oct 2018          | Inadequate<br>↓<br>Oct 2018  | Inadequate<br>↓<br>Oct 2018           |
| Long-stay or rehabilitation mental health wards for working age adults           | Requires improvement<br>↔<br>Jan 2016 | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016        | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016        | Good<br>↔<br>Jan 2016                 |
| Forensic inpatient or secure wards                                               | Good<br>↑<br>Oct 2018                 | Good<br>↔<br>Oct 2018                 | Good<br>↔<br>Oct 2018        | Good<br>↑<br>Oct 2018                 | Good<br>↔<br>Oct 2018        | Good<br>↑<br>Oct 2018                 |
| Child and adolescent mental health wards                                         | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016        | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016        | Good<br>↔<br>Jan 2016                 |
| Wards for older people with mental health problems                               | Requires improvement<br>↔<br>Jun 2017 | Good<br>↔<br>Jun 2017                 | Good<br>↔<br>Jun 2017        | Good<br>↔<br>Jun 2017                 | Good<br>↔<br>Jun 2017        | Good<br>↔<br>Jun 2017                 |
| Wards for people with a learning disability or autism                            | Good<br>↔<br>Jan 2016                 | Outstanding<br>↔<br>Jan 2016          | Outstanding<br>↔<br>Jan 2016 | Good<br>↔<br>Jan 2016                 | Outstanding<br>↔<br>Jan 2016 | Outstanding<br>↔<br>Jan 2016          |
| Community-based mental health services for adults of working age                 | Requires improvement<br>↔<br>Oct 2017 | Requires improvement<br>↔<br>Oct 2017 | Good<br>↔<br>Oct 2017        | Requires improvement<br>↔<br>Oct 2017 | Good<br>↔<br>Oct 2017        | Requires improvement<br>↔<br>Oct 2017 |
| Mental health crisis services and health-based places of safety                  | Good<br>↑<br>Oct 2018                 | Good<br>↔<br>Oct 2018                 | Good<br>↔<br>Oct 2018        | Good<br>↔<br>Oct 2018                 | Good<br>↔<br>Oct 2018        | Good<br>↔<br>Oct 2018                 |
| Specialist community mental health services for children and young people        | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016        | Good<br>↔<br>Jan 2016                 | Good<br>↔<br>Jan 2016        | Good<br>↔<br>Jan 2016                 |
| Community-based mental health services for older people                          | Good<br>↑<br>Oct 2018                 | Good<br>↔<br>Oct 2018                 | Good<br>↔<br>Oct 2018        | Good<br>↔<br>Oct 2018                 | Outstanding<br>↑<br>Oct 2018 | Good<br>↔<br>Oct 2018                 |
| Community mental health services for people with a learning disability or autism | Good<br>↔<br>Jan 2016                 | Outstanding<br>↔<br>Jan 2016          | Outstanding<br>↔<br>Jan 2016 | Good<br>↔<br>Jan 2016                 | Outstanding<br>↔<br>Jan 2016 | Outstanding<br>↔<br>Jan 2016          |
| Specialist eating disorder service                                               | Good<br>Oct 2018                      | Good<br>Oct 2018                      | Good<br>Oct 2018             | Good<br>Oct 2018                      | Good<br>Oct 2018             | Good<br>Oct 2018                      |
| Specialist neuropsychiatric service                                              | Good<br>Oct 2018                      | Good<br>Oct 2018                      | Good<br>Oct 2018             | Good<br>Oct 2018                      | Good<br>Oct 2018             | Good<br>Oct 2018                      |
| <b>Overall</b>                                                                   | Requires improvement<br>↔<br>Oct 2018 | Good<br>↔<br>Oct 2018                 | Good<br>↔<br>Oct 2018        | Good<br>↔<br>Oct 2018                 | Good<br>↔<br>Oct 2018        | Good<br>↔<br>Oct 2018                 |

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.

# Forensic inpatient or secure wards

Good  

## Key facts and figures

South London and Maudsley NHS Foundation Trust provides eight forensic wards, seven of which are based at the Bethlem Royal Hospital. Six of these wards are part of the River House unit, and one ward, Chaffinch, is located just outside the main River House building. Ward in the Community is based at Lambeth Hospital.

We visited the following wards at the Bethlem Royal Hospital:

- Brook Ward – 16 beds, male medium secure ward
- Chaffinch Ward – 19 beds, male low secure ward
- Effra Ward - 16 beds, male medium secure ward
- Norbury Ward – 12 beds, male medium secure psychiatric intensive care unit
- Spring Ward – 15 beds, female medium secure ward
- Thames Ward – 15 beds, male medium secure ward
- Waddon Ward – 15 beds, male medium secure forensic intensive psychological treatment service (FIPTS)

And at Lambeth Hospital:

- Ward in the Community - 11 beds, male low secure ward

At the last comprehensive inspection in September 2015, the service was rated as requires improvement for being safe and responsive and good for effective, caring and well-led. We issued two requirement notices following that inspection, concerning patient risk assessments and the quality of patient food.

Our inspection of forensic inpatient/ secure wards in July 2018 was short notice announced (staff knew we were coming). This was in line with CQC guidance, because we inspected five core services in the same week, and it would have been impractical to make the inspection unannounced.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited each of the wards, looked at the quality of the physical environment, and observed how staff communicated with patients
- spoke with 37 patients
- received 37 completed comments cards
- spoke with all the ward managers and the modern matron
- spoke with the service director for River House

# Forensic inpatient or secure wards

- spoke with 57 other members of staff including nurses, support workers, occupational therapists, doctors, student nurses, social workers, and clinical psychologists
- looked at 45 care and treatment records
- undertook a specific check of the medicines management on each of the wards
- looked at policies, procedures and other documents relating to the running of the services
- attended ward rounds and handovers

## Summary of this service

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

- At the last inspection in September 2015, we rated the service as requires improvement because of concerns about the completion of patient risk assessments and the quality of meals provided to patients. At this inspection, we found that the trust had made improvements and addressed both concerns.
- The service managed patient risk well. Staff had completed individual patient risk assessments and kept these updated. Staff were aware of areas of the ward where incidents took place and managers adjusted how the ward was run in order to mitigate risks.
- The service had a strong focus on relational security and staff were committed to minimising the use of restrictive practices such as restraint and seclusion. Staff used the 'four steps to safety' approach to reduce incidents of violence and aggression and consequently the need for physical restraint and seclusion.
- Although patients had somewhat mixed views about the meals provided, there had been an improvement in quality after a new meal provider had been contracted. Patients and staff gave regular feedback to the contractor about meals and their views were considered. Patients on some wards could self-cater and made their own choices about which meals to prepare.
- The service engaged and involved patients in the care they received. This included a focus on collaborative risk assessments. Staff responded to issues raised by patients in community meetings. Each ward had a patient representative who attended regular meetings with senior managers to discuss issues that mattered to patients on individual wards. As a result of feedback from patients, mobile phone access had been arranged for patients on the wards.
- The service provided a range of evidence based therapies. Patients had access to social activities and a fully equipped gym and sports hall. Staff supported patients to develop the skills they needed to live independently. Patients had the opportunity to work in the unit shop, café, or library and were paid for this.
- Patients told us that most staff treated them with respect, kindness and compassion. This was supported by our observations of staff interactions with patients. Staff across the service, including the senior management team, had a good understanding of the individual needs of specific patients. Staff understood safeguarding procedures and took steps to protect patients from possible abuse.
- The service met the cultural, religious and spiritual needs of patients. Patients had access to interpreters, when needed, and information was available in community languages.
- Patients and staff spoke positively about the senior management team within the service. Staff reflected the trust values in their work, and recovery was a strong theme of the service.

# Forensic inpatient or secure wards

- The forensic service was part of the South London Partnership with two neighbouring mental health trusts. The trust had been able to bring back 37 patients to south London from services in other parts of the country, meaning they could receive care closer to their communities, families and friends. Overall, the South London Partnership had repatriated 63 patients to south London from other parts of the country.

However:

- Although the trust was actively involved in recruiting new staff, some wards had high numbers of vacancies and shifts were not always filled by bank or agency staff. On 22 occasions in a six-month period this led to patients' leave being cancelled due to staff shortages.
- Although the number of restraints carried out by staff had reduced considerably, staff did not record patient restraints in sufficient detail to enable further learning and development and keep an accurate record of events.
- Nursing and support staff on Effra Ward were not invited to the ward's monthly business meeting. This meant there was a risk they were not effectively learning lessons from incidents that occurred on the ward or in the service as a whole, which were discussed at this meeting.
- Where clinical audits identified areas for improvement staff had not always put action plans in place to address these areas.

## Is the service safe?

**Good**  

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

- Staff assessed and managed patient risk well. At the previous inspection in September 2015, we found that staff had not completed clinical risk management assessments (HCR-20) for all patients within three months of admission and they had not consistently reviewed the patients' HCR-20 every six months in accordance with national guidance. During the current inspection, we found that there had been significant improvements in the completion of all types of patient risk assessments. All patient risk assessments were completed and up to date.
- The wards had successfully implemented 'four steps to safety' a programme aimed at reducing violence and aggression on the wards. This had resulted in a significant decrease in the use of seclusion, restraint and rapid tranquilisation, and a decrease in overall incidents across the wards.
- Spring Ward had reduced seclusion to the point that they had not used seclusion for 18 months prior to the inspection.
- The wards were visibly clean, tidy and well maintained. Ligature risks had been identified, documented and staff were aware of the risks and what precautions to take to keep patients safe.
- Staff had improved safeguarding procedures. Staff put protection plans in place to keep patients safe. Staff had received training in safeguarding, knew how to recognise potential abuse and made appropriate referrals to the local authority safeguarding team.
- Staff were competent to carry out their roles. Most staff had completed all of their statutory and mandatory training.

However:

- Although the use of restraint and seclusion had decreased on the wards, staff did not record in sufficient detail what had taken place during a restraint, the staff involved, the holds used or duration.

# Forensic inpatient or secure wards

- There were a high number of staff vacancies especially on Norbury and Waddon wards. Shifts were filled with temporary staff, where needed. Sometimes shifts could not be filled and on 22 occasions in a six-month period this had led to escorted patient leave being cancelled.
- Although most staff on the wards were aware of lessons learned from incidents across the service there was a risk that nursing and support staff on Effra Ward missed opportunities for learning. They were not routinely invited to business meetings where these issues were discussed.

## Is the service effective?

Good  ➡ ➡

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

- Staff completed a comprehensive physical health assessment on each patient shortly after they were admitted to hospital and used a recognised tool to monitor patients' physical health and identify any deterioration. Patients were encouraged to live healthier lives. Staff encouraged patients to reduce or stop smoking and supported patients to eat healthily and take exercise.
- The service provided evidence-based care and treatment in line with national guidance. The service measured outcomes for patients to determine the effectiveness of treatment.
- Care plans were personalised, holistic and recovery oriented for most patients. Patients' recovery goals were determined by their needs.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They supported patients to make decisions about their care.
- Managers made sure staff had the necessary skills to carry out their role safely and effectively. Managers held supervision meetings with staff to provide support and encourage professional development. Staff were completing a new annual performance appraisal recently implemented by the trust.

However:

- Where clinical audits identified areas for improvement, action plans were not always in place.

## Is the service caring?

Good  ➡ ➡

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

- Staff treated patients with kindness and compassion. Patients reported that staff treated them well and described staff as friendly, caring and supportive.
- Staff involved patients in decisions about their care and treatment. Each ward held weekly community meetings so that patients could provide feedback about the service and raise any concerns they had. Staff acted on issues raised and gave feedback on progress. Each ward had a patient ward representative, who attended regular meetings with service management to help bring about improvements across the service.
- Following feedback from patient ward representatives, the trust had arranged for mobile phones (without internet access) to be provided to facilitate contact with friends and family.

# Forensic inpatient or secure wards

- Staff informed and involved families and carers in patients' care if this is what the patient wished. Staff invited families and carers to attend meetings to review patients' individual progress, support the patient and be involved in developing the patient's care plan.
- The service provided access to independent advocacy support for all patients. Details of how to contact the advocate were displayed in all the wards.

## Is the service responsive?

**Good** ● ↑

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

- The service had worked with colleagues in the South London Partnership to bring back 37 forensic patients from around the country so that they could be closer to their communities and families. Staff on all the wards proactively planned for patients' discharge.
- Although patients had mixed views about the quality of the food provided, the overall quality of meals had improved. The trust had changed the catering contractor since the previous inspection in 2015. The catering provider met regularly with patients and staff. Some wards were introducing self-catering for patients. This enabled patients to choose their own meals and facilitated greater independence.
- Patients could access pastoral and spiritual support, and faith leaders attended wards to support patients' spiritual observance.
- Patients had a range of activities available to them. They had access to gym facilities, an art room, horticulture, and wood work facilities. Patients attended coproduced courses at the trust's recovery college. Patients could work in the unit shop, cafe and library for small payment, and to develop skills for future employment.
- The trust had developed new information leaflets for patients, which were easier to understand. Leaflets were available in different languages as well as an easy to read format.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. Almost all patients knew how to make a complaint.

## Is the service well-led?

**Good** ● → ←

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

- Ward managers were skilled and knowledgeable. They were committed to improving safety and providing high quality care. The ward managers were accessible to patients and staff.
- Staff described good morale and said that they felt valued and supported. They said they were happy in their role. Staff came from diverse backgrounds.
- There was an effective system of governance and senior managers and clinical leaders had sight of areas of practice requiring improvement.

# Forensic inpatient or secure wards

- There was a clear framework to structure ward business meetings. This framework included a range of quality indicators and discussions regarding learning from incidents and complaints. Managers had good access to information about the performance of their ward.
- The forensic service used a systematic approach to continually improve the quality of care and treatment provided to patients. Some staff had been trained in quality improvement approaches.

## Outstanding practice

We found four examples of outstanding practice in this service.

- All wards across the service had implemented the 'four steps to safety' programme. The programme has four areas of intervention: proactive care, patient engagement, teamwork and environment. Multiple interventions sit under each area. The aim of the programme is to reduce violence and aggression on the wards. Staff all spoke positively about 'four steps to safety' and understood its purpose. The approach had been instrumental in reducing violence and aggression on the wards and consequently the use of restraint and seclusion had reduced.
- Managers used a zoning system to demonstrate where incidents occurred and what time of day or night they happened. The information was colour coded on a plan of the ward, which enabled the manager and staff to see 'at a glance' where problem areas were. This information was used to monitor any trends and adjust how the ward was run. For example, Thames Ward introduced a new system for meal times, to reduce the number of violent incidents, which occurred in the dining area when meals were served. The manager reported a significant reduction in incidents since the changes had been implemented.
- The forensic service ran a restorative justice programme. The programme, called 'Sycamore Tree', aimed to promote victim awareness so that patients could learn to take responsibility for their actions. Staff and patients reported that participation in the programme allowed the patient to gain insight into the crime they had been convicted of.
- The service had worked with colleagues in the South London Partnership to bring back 37 forensic patients from around the country so that they could be closer to their communities and families.

## Areas for improvement

We found four areas for improvement in this service.

- 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 patient 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.

# Specialist eating disorder service

Good 

## Key facts and figures

Tyson West 2 Ward is an eating disorders ward provided by South London and Maudsley NHS Foundation Trust, at the Bethlem Royal Hospital. The unit is a specialised tertiary inpatient ward, part of the Eating Disorder Service for the South London and Maudsley NHS Foundation Trust (SLaM). The trust offers a wide range of outpatient, day care, inpatient treatment and the Step Up to Recovery programme.

The ward has 18 beds for females only and is part of a national service so it accepts patients from across the country as well as locally. The Step Up to Recovery service is the day programme that runs from the ward (8am-8pm, seven days a week) and can support up to 10 local patients.

CQC previously inspected this ward unannounced in February 2018 in response to concerns received regarding the service. We found the service was in breach of regulation 12 (Safe care and treatment). Staff did not record all known patient risks in risk assessments and did not always complete required physical health monitoring checks on patients.

The current inspection was announced (staff knew we were coming). This was in line with CQC guidance, because we inspected five core services in the same week, and it would have been impractical to make the inspection unannounced.

During our inspection, we found there were 18 patients on the ward, five of whom were detained under the Mental Health Act. There were five patients using the Step Up to Recovery service.

During the inspection visit, across both services the inspection team:

- visited the ward and day service and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 18 patients and carers
- spoke with the deputy director of specialist services, head of specialist pathways, clinical services manager, team leader and 16 staff including administration, clinical pharmacist, clinical researcher, clinical support workers, consultant psychiatrist, dietitian, family therapist, junior doctor, nurses, occupational therapists, psychotherapist and social worker
- attended and observed a nursing handover, ward round, nursing forum and psychology group
- carried out a specific check of the medicines management on the wards
- reviewed 11 electronic patient care records and 15 physical health monitoring charts
- looked at a range of policies, procedures and other documents relating to the running of the service

## Summary of this service

This was the first comprehensive inspection of this service. We rated it as good because:

# Specialist eating disorder service

- Staff had made improvements on the ward since our responsive inspection in February 2018 and were no longer in breach of regulations. Staff completed patients' risk assessments and risk management plans and updated them when required. Staff completed patients' physical health monitoring charts when required.
- Since the previous focused inspection in February 2018 the service had made improvements in several areas. This included improvements in systems, which supported the sharing of lessons learned from incidents with all staff; ensuring patients received regular individual time with a nurse; making sure staff were aware of feedback from patient satisfaction surveys; better communication with patients' care coordinators; and providing more activities for patients at the weekend.
- The service managed environmental and patient risks well. The trust had completed a new ligature risk assessment for the ward. Staff knew how to manage the identified risks and protect patients from avoidable harm.
- The service had enough staff to provide the right care and treatment to patients and their families. The service had reduced staff vacancies by recruiting new staff since the previous inspection in February 2018. The trust had made improvements to how bank and agency staff were booked. Bank and agency staff received a better induction when they first worked in the service. The service provided mandatory training in key skills to all staff and made sure they completed it.
- Patients gave positive feedback about permanent staff. Staff were supportive and kind when interacting with and caring for patients. Records showed patients were involved in decisions about their care. Staff offered families and carers support and skills training.
- Staff worked to meet the diverse needs of patients on the ward. The ward was accessible to patients with physical disabilities. Staff ensured patients had access to appropriate spiritual support and facilitated access to places of worship. Staff could obtain the support of interpreters when this was needed. Staff supported LGBT+ patients on the ward.
- Staff were positive about the support they received from their colleagues and the trust. The trust provided staff with training and professional development opportunities. Senior managers were visible in the service.
- The service was committed to providing high quality evidence-based care to patients. Staff were involved in various quality improvement and research projects and applied findings to practice improving the care delivered to people with eating disorders both on the ward and in community settings. The service was innovative and had devised new models of care for people with eating disorders, which were being rolled out nationally. One community based team had won a national award. The ward was accredited with the Quality Network for Eating Disorders.

However:

- Although the service provided staff with specific training related to their role, the service did not have a formal eating disorders competency framework for staff. Consequently, there was a risk that staff did not have all of the specialist skills they needed to care for a patient with an eating disorder.
- Staff did not always record incidents of restraint to include information about the type of restraint, position of restraint, members of staff involved, length of time and that the patient received a physical check for any injuries.
- The ward had not increased the dietitian and social worker input on the ward since our last inspection. They were reviewing the roles to determine how best to fill any gaps identified.
- Some staff had not received regular monthly supervision. Although 87% of staff received supervision as planned in March and April 2018, the figure had fallen to 70% in May and 65% in June, below the trust target for clinical supervision compliance of 85%.

# Specialist eating disorder service

- Some patients felt they were not as involved in their care as they would have liked. Staff did not give all patients a copy of their care plan or an induction to the ward on admission. Some patients said staff did not always respond or act on their feedback about improvements needed to their care or the ward.
- Although staff completed weekly audits in a number of key areas, it not clear how staff used audit findings to make improvements.

## Is the service safe?

**Good** 

The service had been inspected before but not rated. We rated safe as good because:

- At the last inspection in February 2018, staff did not record all known risks affecting patients in their risk assessments and risk management plans or store them consistently. During this inspection, we found that staff completed patients' comprehensive risk assessments and risk management plans and updated them following a change in risk.
- At the last inspection in February 2018, there were gaps and errors in the physical health monitoring charts (the modified early warning score), which might have prevented appropriate escalation of patients to see a doctor when needed. During this inspection, we found that staff were carrying out and recording physical health monitoring as needed.
- At the last inspection in February 2018, the current ligature risk assessments and management plan was not available on the ward so staff could understand how to mitigate against these risks. During this inspection, we found that the trust had completed a new ligature risk assessment and management plan and staff knew how to manage ligature risks and protect patients from avoidable harm.
- At the last inspection in February 2018, staff could not give examples of learning that had taken place in response to incidents. During this inspection, we found that staff discussed incidents in the weekly nursing forum and business meeting.
- At the last inspection in February 2018, there had been a high turnover of staff on the ward, which impacted on the staff team and patient care, and involved high levels of bank or agency staff working on the ward. During this inspection, we found that the trust had recruited five qualified nurses to the ward and a further four qualified nurses were due to start. Where possible the ward used regular bank staff, who were familiar with the service.
- At the last inspection in February 2018, patients did not have the opportunity to meet with their primary nurse at least weekly. During this inspection, we found that patients met with their primary nurse weekly.

However:

When staff recorded an incident of patient restraint they did not always record information about the type of restraint, position of restraint, members of staff involved, length of time the restraint took and whether the patient received a physical check for any injuries afterwards.

## Is the service effective?

**Good** 

The service had been inspected before but not rated. We rated effective as good because:

# Specialist eating disorder service

- At the last inspection in February 2018, staff had not completed care plans for all patients on the ward. During this inspection, staff had completed patient care plans and reviewed these regularly. Care plans were personalised, holistic and recovery oriented.
- At the last inspection in February 2018, new bank or agency staff had not completed the dining room induction. During this inspection, we found that new bank or agency staff completed and signed an induction pack.
- Patients were supported by a skilled multidisciplinary team of health professionals who met regularly. The team worked well with day care and outpatient services, GPs and care coordinators from around the country.
- All patients received a comprehensive assessment and the service offered evidence-based individual, group and family therapies in line with national guidance
- Staff had received training in the Mental Health Act and Mental Capacity Act and knew how to apply the legislation to their work with patients.

However:

- Although the service provided staff with specific training related to their role such as training from a dietitian, attendance at the carer's workshop and other ad hoc in-house training, the service did not have a formal eating disorders competency framework for staff. There was risk that staff did not have all the specialist skills they needed to care for a patient with an eating disorder.
- At the last inspection in February 2018, staff and patients indicated that dietitian and social worker input on the ward was not always sufficient. During this inspection, we found that although the level of dietitian and social worker input had remained the same, staff were reviewing patients' needs and looking at ways to address the gaps. However, further work was needed in this area.
- All staff had not received regular monthly supervision. In March and April 2018 87% of staff working on the inpatient ward had received supervision, but this had fallen to 70% in May and 65% in June. The trust's target for clinical supervision compliance was 85%.

## Is the service caring?

**Good** 

The service had been inspected before but not rated. We rated caring as good because:

- At the last inspection in February 2018, ward staff were not aware of the results of recent patient satisfaction surveys. During this inspection, we found that the ward displayed results of recent patient surveys. Managers emailed outcomes of the survey to staff and it was an agenda item at the weekly business meeting.
- Staff cared for patients with compassion. Most patients gave positive feedback about permanent staff, saying they were kind and caring. Staff communicated well with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.
- Staff involved family and carers with patients' care and regularly delivered a two-day carers' workshop. Visiting hours had been increased at the request of patients. Families and carers were invited to attend meals with patients and engage in family therapy.

However:

- Some patients said they had not received a copy of their care plan. Staff did not always record that they had shared the plan with the patient.

# Specialist eating disorder service

## Is the service responsive?

**Good** 

The service had been inspected before but not rated. We rated responsive as good because:

- At the last inspection in February 2018, we found limited communication between ward staff and patients' community-based care coordinators. During this inspection, we found that staff invited care coordinators to every patient review meeting and sent letters to care coordinators following the meetings to update them on the patient's progress.
- At the last inspection in February 2018, some patients complained about insufficient activities available to them at weekends, when the occupational therapy building was closed. During this inspection, we found that staff provided activities for patients during weekends. For example, staff had facilitated pamper nights, bingo and quizzes.
- Patients worked with the dietitian and catering team to make sure they had a range of food options and to improve food quality and choice.
- Staff worked to meet the diverse needs of patients on the ward. The ward was accessible to patients with physical disabilities. Staff ensured patients had access to appropriate spiritual support and facilitated access to places of worship and/or faith representatives. Staff supported LGBT+ patients on the ward but had not received any specific training around this.
- The service had received very few complaints and patients said they knew how to make a complaint.

## Is the service well-led?

**Good** 

The service had been inspected before but not rated. We rated well-led as good because:

- At the last inspection in February 2018, we found that there were some gaps in communication between staff on the wards, the availability of health and safety documentation, and consistent implementation of improvements agreed for the ward. During this inspection, we found that communication had improved between staff, health and safety documents were available and up to date and the ward implemented agreed improvements.
- At the last inspection in February 2018, learning from incidents was not embedded in ward systems; staff were not aware of learning from recent incidents. During this inspection, we found that staff had embedded the discussion of incidents and lessons learned in their weekly team meetings.
- Staff were positive about the support they received from their team and the trust. The trust provided staff with training and professional development opportunities. Senior managers were visible in the service.
- Staff were involved in various quality improvement and research projects and applied findings into practice to improve care delivered on the ward and had an impact nationally. The findings from research carried out within the trust had led to the development of new ways of working with patients with eating disorders and their carers. These interventions were now included in national guidance. The first episode and rapid early intervention for eating disorders team (also known as FREED) had won the British Medical Journal prize for mental health team of the year in 2017.
- The ward was accredited with the Quality Network for Eating Disorders which was due for renewal in September 2018.

# Specialist eating disorder service

However:

- Although staff completed audits of key areas, it was unclear how staff used audit outcomes effectively to identify learning and make improvements in service delivery.

## Outstanding practice

We found three examples of outstanding practice in this service:

- Staff were involved in various quality improvement and research projects, including ICASK and Triangle, and applied findings into practice to improve care delivered on the ward.
- The ward was in the process of making adaptations and modifications for patients with autism for example, in the environment and dietetic input.
- Staff in the trust's eating disorder service in the community had developed an early intervention service for young people aged 16-25 years experiencing a first episode eating disorder. The service provided rapid access to evidence based care tailored to individual needs, with an emphasis on family involvement, promoting early change and full recovery. Outcomes showed that the service had been effective in helping patients with anorexia nervosa re-gain weight and led to a 35% reduction in the need for day care and inpatient treatment. The model had been used at three other sites in the UK and was working towards national roll out. The team had won the British Medical Journal prize for mental health team of the year in 2017.

## Areas for improvement

Action the provider SHOULD take to improve

- The trust should put in place a formal eating disorders competency framework for staff to ensure that they 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 check for any injuries after the restraint.
- The trust should ensure that the service continues to review the dietitian and social worker input to the ward, as well as on 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.

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

Inadequate  

## 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 intensive 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 this inspection we visited the following wards:

The Bethlem Royal Hospital:

Croydon PICU – 10 bed male only 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 psychiatric intensive care unit

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

John Dickson – 20 bed male acute admission ward

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

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

Lambeth Hospital:

Eden Ward – 12 bed male psychiatric intensive care unit

Rosa Parks Ward – 18 bed mixed acute admissions ward

Luther King – 18 bed male acute admissions ward

Nelson – 18 bed female acute admissions ward

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

Ladywell Unit:

Johnson PICU - 10 bed male psychiatric intensive care unit

Clare - 17 bed mixed acute admissions ward

Powell – 18 bed male acute admissions ward

Wharton – 18 bed female acute admissions ward

# 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 January and February 2017. At that inspection, we found that the trust had breached regulations. We issued the trust with four requirement notices for acute wards for adults of working age and psychiatric intensive care units. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

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

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

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

The current inspection was announced (staff knew we were coming). This was in line with CQC guidance, because we inspected five core services in the same week, and it would have been impractical to make the inspection unannounced.

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 manager, modern matron and clinical nurse lead for each ward or hospital
- Attended 33 meetings including multidisciplinary team meetings, shift handovers, bed management meetings, community meetings and patient planning meetings
- Reviewed 77 completed comment cards
- Spoke with 173 staff including nurses, healthcare assistants, occupational therapists, consultant psychiatrists, pharmacists and junior doctors
- Spoke with 80 patients
- Spoke with nine carers
- Reviewed all, or specific parts, of 113 care records
- Reviewed 136 medicine administration records
- Reviewed other documents and policies relating to the running of the service

## Summary of this service

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

- The trust had failed to make improvements in relation to some matters we said the trust must address at the last inspection in January and February 2017. The trust had systems in place to identify wards who may need additional support, but had not ensured this support was in place to enable wards to make the necessary improvements in the quality of care and treatment.

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

- The trust had not ensured that all environmental risks relating to ligature anchor points, blind spots and the use of plastic bin liners were included in environmental risk assessments and that staff were aware of these risks and how to mitigate them.
- The trust had not embedded plans to reduce patient restraint and prone restraint, in particular. Staff in many of the wards were not using the 'four steps to safety' approach, which had been adopted as a quality improvement initiative to reduce violence and aggression and associated restrictive practices, including restraint.
- Staff did not always carry out physical health checks after administering intra-muscular medicines for rapid tranquilisation. Patients receiving rapid tranquilisation are at risk of seizures, airway obstruction, excessive sedation and cardiac arrest. The failure to carry out checks in line with national guidelines and trust policy put patients at risk of avoidable harm.
- The service had a high number of delayed patient discharges. On some wards, staff failed to effectively plan for patients' discharges and failed to work pro-actively to ensure that patients could be discharged as soon as they were ready. In the past 12 months, the trust had not been able to provide a bed for four patients returning from authorised leave and 27 patients returning from unauthorised leave. Thirty one patients altogether had had to sleep on sofas or in other temporary facilities.
- Staff did not always appropriately record patient safety incidents. Many staff were not aware of serious incidents that had taken place on other wards or across the trust or learning from these incidents. Team meetings where incidents and complaints were discussed had not taken place consistently across all the wards.
- The service did not provide adequate support to staff to ensure they had the necessary skills to support patients effectively. Although staff had access to training in caring for people with learning disabilities this did not include patients with autism, although staff told us that patients with autism were admitted to the wards. Managers had not held supervision meetings with staff as frequently as they should to provide support and monitor the effectiveness of their work.
- Some wards had high levels of staff vacancies, a high turnover of managers or interim managers. This had an impact on the stability of teams, consistency of care provided and patient experience.
- Staff did not always provide adequate support to patients with specific physical health needs. We found examples of staff not taking regular blood tests when these were required and staff failing to act on concerns that a patient was not drinking enough. Patients on Johnson PICU did not have unrestricted access to drinking water, creating a risk of dehydration, particularly in hot weather. Some emergency equipment was out of date and although this was recognised by staff, they had not identified it in time to replace the equipment before the expiry date.

However:

- The trust had made improvements in many areas identified at the previous inspection. These areas included providing information about fire safety procedures and evacuation, carrying out fire drills, improved pest control, and a reduction in patients going absent without authorised leave.
- The trust had improved safeguarding procedures since the previous inspection in 2017. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training in how to recognise and report abuse and knew how to apply it in their everyday work.
- The trust provided statutory and mandatory training in key skills to all staff and made sure everyone completed it. There had been an increase in the number of staff who had completed training in the Mental Capacity Act. Most staff had completed the trust's new annual performance appraisal or were booked to do so. Staff at the Ladywell Unit had received specialist training in cognitive behavioural therapy to enable them to provide better support for people with emotionally unstable personality disorders.

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

- Although patients on two wards reported poor attitudes amongst some staff, most staff were kind and compassionate. We observed positive, caring and supportive interactions between staff and patients throughout the inspection.
- Many staff had received training in quality improvement and some wards were implementing creative and innovative approaches to care delivery. Innovations included using video conferencing to encourage community staff to become more engaged in multidisciplinary team meetings, the introduction of care planning surgeries, weekly health and well-being clinics and the introduction of electronic observation recording. The new sensory room, with light projection and soft furnishing, and art work on ES1 had won an award in 2018.
- Staff actively encouraged patients and carers to be involved in care planning and sought their views on a range of aspects of their care and treatment. Staff acted on feedback from patients and carers to make improvements to the service. Some wards had identified staff who took a lead on carers' involvement. Four wards held monthly carers' forums. The trust facilitated service user and carer advisory groups as a way of involving them in the development of the service.

## Is the service safe?

**Requires improvement**   

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

- Staff did not always provide safe care and treatment to patients. Staff did not consistently carry out and record physical health checks on patients following the administration of rapid tranquilisation. This was contrary to national guidelines and trust policy. Patients on one ward did not have direct access to drinking water and cups putting them at increased risk of dehydration. On another ward, staff had not completed an appropriate assessment of a patient who experienced frequent falls nor obtained the necessary equipment to help them move safely around the ward. On a third ward staff failed to record observations of a patient, who required intermittent monitoring, for a two-hour period.
- Several wards had not completed environmental risk assessments thoroughly or, where risks had been identified, had not mitigated them adequately. Some wards had failed to include the use of plastic bin bags in bathrooms, blind spots, and ligature points in their environmental risk assessments.
- Following our last inspection in February 2017, we told the trust to develop clear plans to reduce the number of restraints in the prone position. Although we found the trust did have an overarching plan in place, on some wards, staff were unaware of initiatives to reduce the level of prone restraint. Recording of patient restraints was generally good with prompts to ensure particular details were included. However, of 32 records of patient restraint we reviewed on AL3, Ruskin/AL2 and John Dickson wards, none of these recorded details of the holds used by staff during the restraint or the number of staff involved.
- Staff did not always identify and report patient safety incidents. We found incidents on three wards that had not been reported but should have been. As a result, managers either failed to investigate them, or there were delays in investigation. Although managers shared lessons learned from incidents with their teams in some wards, in others, teams had not met together for several months. Staff on those wards were not aware of incidents that had occurred in the service or trust as a whole or the learning identified from them.
- Although the service generally controlled infection risk well and equipment was clean. Some of the wards were not clean. Patients and carers told us they were unhappy with the cleanliness of the wards, especially in bathrooms and toilets.

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

- While the wards had suitable equipment available, in one hospital, 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.
- The service did not always have enough staff with the right qualifications, skills and training. At our last inspection in February 2017, we found there were a high number of nursing vacancies on some wards. At this inspection, although the overall vacancy rate had improved to 19% across the service there were seven vacancies on Tyson West 1, seven vacancies for nurses on Nelson Ward and five vacancies on Gresham 1. Staff turnover rates were above 25% on Rosa Parks Ward, ES1 and Nelson Ward. Staff and patients on these wards, told us that sometimes patients' leave was postponed or cancelled when staff were not available. This information was not always recorded so it was not possible for managers to understand or measure the impact of staff shortages on patient care and treatment.

However:

- At our last inspection in February 2017, we found staff did not always recognise potential abuse and report safeguarding concerns appropriately. At this inspection, we found there was an improvement. 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. We found examples on all wards of how safeguarding concerns had been reported and escalated appropriately.
- At our last inspection in February 2017, we found that information about fire safety procedures and evacuation were not up to date and that fire drills were not taking place regularly. At this inspection, we found the service planned for emergencies, reviewed procedures and ensured drills took place. Staff understood their roles if an emergency should happen.
- Since the last inspection in January 2017, the trust had taken steps to reduce the number of patients leaving the wards without authorisation and made sure patients on Clare Ward were not unnecessarily restricted when transferred to the ward at the weekend.
- Ward teams generally assessed and managed patient risks well. Staff mostly completed patients' risk assessments without delay. Overall, risk assessments were comprehensive, up to date and had associated risk management plans in place. Staff reviewed patient risk at multidisciplinary team meetings each day.
- Staff prescribed, administered, recorded and stored medicines appropriately. Patients received the right medicines at the right dose at the right time. Where staff found fridge and clinic room temperatures were above acceptable limits they escalated this finding to the pharmacy department. The expiry dates of medicines were shortened to allow for the effects of adverse temperatures.
- The trust provided statutory and mandatory training in key skills to all staff and made sure everyone completed it. Staff compliance with statutory and mandatory training had improved since the last inspection.

## Is the service effective?

**Requires improvement**   

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

- At the last inspection in January 2017, we found that staff supervision rates were low. At this inspection, we found that supervision rates continued to be low with 52% of staff receiving supervision in accordance with the trust's policy in the year from March 2017 to February 2018. Although this improved between April to June 2018 to 75%, nearly one quarter of the acute wards had completed less than 65% of planned staff supervision in that period. This made it difficult for managers to provide support to staff and address their development needs.

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

- Although staff completed a comprehensive assessment of patients' needs and associated care plans, the quality of patient care plans varied and in a few cases, did not always reflect patients' needs. For example, needs related to patients' physical health or autism.
- Staff did not always carry out physical observations of patients with specific physical health needs. For example, staff had not completed blood glucose monitoring consistently on one ward. On Ruskin/AL2 Ward staff were not consistently completing food and fluid charts for a patient. Staff had not taken action to address a patient's recorded low fluid intake.
- Following the last inspection in February 2017, we said the trust should ensure that staff on acute wards had training in working with patients with learning disabilities and autism. At this inspection, 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.

However:

- Staff completed comprehensive mental and physical health assessments promptly when patients were admitted to the wards.
- Staff supported patients to live healthier lives. The trust provided very good support for patients who wanted to stop smoking. A ward at the Ladywell Unit had introduced a weekly health and well-being clinic. This had led to an increase in patients referred for smoking cessation and gym membership. Staff used technology to support patients effectively. On ES2 ward staff had completed a quality improvement project where patient's physical observations were monitored electronically. This had had positive outcomes in improving patient care.
- Staff at the Ladywell Unit had received specialist training in cognitive behavioural therapy to enable them to provide better support for people with emotionally unstable personality disorders. A psychotherapist held a regular reflective practice session for staff on the psychiatric intensive care wards.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other in the provision of care and treatment. Handover meetings we observed were comprehensive and covered all the details about patients that staff coming onto the shift needed.
- Following our last inspection in February 2017, we said the trust should increase the number of staff who had completed training in the Mental Capacity Act. At this inspection, we found that staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care. Doctors recorded capacity assessments for all patients in relation to admission and treatment.

## Is the service caring?

Good   

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

We observed positive, caring and supportive interactions between staff and patients on most wards throughout the inspection. Staff provided patients with help, emotional support and advice at the time they needed it. When patients were distressed, staff supported them in a calm and sensitive manner. Staff treated people with dignity and respect and gave people the opportunity to make choices and have control of decision-making. Most patients said most staff were caring and respectful.

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

- Staff actively encouraged patients to be involved in care planning at ward rounds and sought their views on a range of aspects of their care and treatment in these meetings. Patient involvement in care planning on psychiatric intensive care units had improved since the last inspection. On some wards, the service employed specialist nurses to support communication with patients with a learning disability.
- Staff acted on feedback from patients to make improvements to the service. Wards held community meetings each week, recorded patients' comments at these meetings and acted on concerns that were raised.
- Staff involved patients' families in their care appropriately and provided them with support. Staff listened to feedback from carers, were sensitive to people's individual needs and were responsive to these. For example, staff on Clare Ward had adjusted the visiting policy for a patient with learning difficulties, so that their family member could support them at a time the patient preferred. Some wards had identified staff who took a lead on carers' involvement. Four wards held monthly carers forums. The trust facilitated service user and carer advisory groups as a way of involving them in the development of the service.

However:

- While most staff cared for patients with kindness and compassion, feedback from patients on two wards was that some staff did not seem to care about them, were disrespectful towards them or too busy to help them promptly. Some patients on one PICU reported poor treatment by staff during episodes of restraint and seclusion. This was being investigated by the trust.
- At our last inspection in February 2017, we said that the trust should ensure that confidential patient information was not visible to other patients and visitors. Although this had been addressed in most wards, on Nelson Ward, we found that confidential information was visible to people standing outside the nurses' office.

## Is the service responsive?

**Inadequate** ● ↓↓

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

- The flow of patients into and out of the service was poor. Bed occupancy was above 100% on most of the wards. There was not always a bed available for someone who needed one. The trust had placed almost 300 patients in out-of-area beds in the year from February 2017 to January 2018 because of a lack of available beds within the acute wards and PICU. At the time of the inspection, 29 patients were placed out of the area due to a lack of beds being available.
- Twenty percent of patient discharges from hospital were delayed. Staff were not always proactive in addressing barriers to patients being discharged. In some wards, there was very little discharge planning reflected in patients' care plans.
- There was not always a bed available for patients returning from leave. This meant that four patients returning from leave or recalled to hospital and 27 patients returning from being absent without leave slept on sofas, in seclusion rooms and in other areas of the wards until a bed could be found. There was not always a bed available for patients who needed a transfer to a psychiatric intensive care unit. This led to patients being secluded in unsuitable environments such as bedrooms, sometimes for many hours, whilst they were waiting to be transferred.

However:

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

- Staff and patients had access to a full range of rooms, that had suitable furnishings and were well-maintained, to support care and treatment. ES1 had a new sensory room that had received a national award for its design. Patients could use the space to calm themselves. The trust had worked in partnership with a charity to commission art work for the ward, which created helped create a therapeutic, and much improved, environment and experience for patients.
- 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 service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Patients knew how to complain. When patients complained or raised concerns, they received a full response. The ward manager on Powell Ward held a weekly surgery where patients and their family members could meet to discuss any concerns they had. Staff acted on the findings of complaints' investigations.

## Is the service well-led?

**Inadequate** ● ↓

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

- Whilst governance systems and processes could identify the wards at risk of not delivering high quality care and treatment, appropriate support had often not been put into place. This led to variations in the quality and safety of care and treatment being delivered between wards. The variation was apparent between different wards on the same hospital site and patient experiences of care was largely dependent upon the quality of local ward leadership. Some concerns identified in previous inspections in 2015 and 2017 had not been fully addressed or had been addressed on some wards, only to become apparent on others.
- There had been a breach of fundamental standards on the acute inpatient wards, which had not been appropriately escalated to senior leaders in the trust. Some patients were sleeping on couches or in seclusion rooms rather than in a bed. This was unsafe and compromised the dignity of the patients. In the previous year there were over 30 incidents of this happening. Governance systems had not identified or addressed this unacceptable practice, or a few other serious shortfalls such as physical health checks not taking place after all cases of patients being administered intra-muscular rapid tranquilisation.
- Many wards did not have a permanent ward manager and/or there had been several changes of ward manager in the last year, which led to a lack of stability. Eight of the ward managers were in acting up or locum positions. One consultant was employed on a locum basis.
- Staff felt they were working under pressure due to high use of bank and agency staff, incidents of violence and aggression and a lack of permanent ward managers. Most staff did not feel connected to the wider organisation and said that each hospital site worked in isolation. Staff morale on some wards was low. Staff sickness absence rates were above the overall rate for the trust.
- The senior leaders in the service had not yet been successful in implementing changes to consistently improve the quality of the service. For example, they had introduced the 'four steps to safety' as a quality improvement initiative to reduce violence and aggression and associated physical interventions, but this had not been adopted across all the wards.

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

- Ward managers had information that would enable them to monitor the performance of the service. However, they did not always have the skills or confidence to access or use this information to make the necessary improvements.

However:

- Staff felt well supported by their immediate colleagues.
- Innovations were taking place in the service, such as the introduction of care planning surgeries, video conferencing to improve involvement in multidisciplinary team meetings and the introduction of electronic observation recording. The new sensory room on ES1 had won an award at the Design in Mental Health Awards 2018.

## Outstanding practice

We found one example of outstanding practice in this service:

ES1, the female PICU, won the Project of the Year award at the Design in Mental Health Awards 2018 for their sensory room. The room had bean bag seating, a projector which displayed soothing scenes on the wall and calming music. Two rainbow light bars changed the colour of the room at the touch of a button and there were liquid floor tiles and a water bubble tube. The room was mainly for supervised use but patients could use it on their own and staff hoped it would become an alternative to medicine use and seclusion.

## Areas for improvement

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

- The trust must identify and provide timely support to wards and teams where standards of care need to improve.
- The trust must ensure that governance processes are sufficiently robust so that they identify where improvements need to be made and ensure that action is taken to make the required improvements.
- The trust must ensure that all patients can have direct access to drinking water on the psychiatric intensive care units.
- The trust must ensure that staff consistently carry out physical health checks on patients after they receive rapid tranquilisation in line with trust policy.
- The trust must ensure that all environmental risks are recorded on environmental risk assessments, that staff are aware of these risks and know how these risks are mitigated. This includes all ligature anchor points, blind spots and the use of plastic bin liners.
- The trust must continue to implement plans to reduce the number of patients being restrained, and make sure all staff are aware of the actions they need to take.
- The trust must ensure that staff record all incidents appropriately and are aware of incidents from the service and across the trust, and the lessons learned from investigations into these incidents.
- The trust must ensure that all wards plan effectively for patients' discharge and are pro-active in addressing barriers to discharge.
- The trust must ensure that patients are able to access a bed when they return from authorised or unauthorised leave and are not required to sleep on sofas or in other temporary facilities.
- The trust must ensure that all staff receive regular managerial and clinical supervision in line with trust policy.
- The trust must ensure that all emergency equipment is replaced prior to the expiry date.

Action the provider **SHOULD** take to improve

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

- The trust should ensure staff receive training in autism.
- The trust should ensure that staff carry out observations on patients and keep accurate records of this, including for patients who are on intermittent observations.
- The trust should ensure all patient restraints are recorded in sufficient detail.
- The trust should ensure that all patients have care plans to meet their physical and mental health needs.
- The trust should ensure that staff take a pro-active approach in supporting patients with their physical health needs, including taking regular blood tests when required, and ensuring staff act on concerns identified in food and fluid intake monitoring.
- The trust should ensure that all bathroom and toilet areas are kept clean.
- The trust should continue to address the high number of nursing vacancies on some wards through active recruitment and retention strategies to improve the consistency of care.
- The trust should consider recruiting more permanent, rather than interim, ward managers to increase stability on the wards and improve the consistency of care.
- The trust should ensure that patient information is not visible to other patients and visitors in Nelson Ward.
- The trust should ensure that staff on Ruskin/AL2 and Croydon PICU always demonstrate kindness and compassion in their interactions with patients.

# Wards for people with a learning disability or autism

Good 

## Key facts and figures

The specialist neuropsychiatric service (the Lishman Unit), provided by South London and Maudsley NHS Foundation Trust is based at the Bethlem Royal Hospital. It is a 15 bedded, mixed gender unit, for adult patients requiring neuropsychiatric treatment and rehabilitation from across the UK. There are two treatment pathways on the ward: one for patients with significant brain injury, with physical effects and psychological reactions, and another for patients with severe functional neurological disorders, where physical symptoms are thought to be a reflection of psychological issues. Patients are usually admitted for a 12-week programme, which includes nursing, physiotherapy, occupational therapy, clinical psychology, medical input and where relevant, speech and language therapy.

This was the first comprehensive inspection of this service. We carried out this inspection unannounced (staff did not know we were coming).

During the inspection visit, the inspection team:

- visited the unit, looked at the quality of the physical environment, and observed how staff communicated with patients
- spoke with eight patients and two relatives of patients during the visit, and in phone calls shortly after the inspection
- spoke with the senior nurse on duty, and the pathway lead
- spoke with eight other members of staff including a doctor, nurses, a rehabilitation support worker, occupational therapist, pharmacist, and clinical psychologist
- looked at eight patient care and treatment records
- undertook a specific check of the medicines management on the ward
- looked at six staff supervision records
- looked at policies, procedures and other documents relating to the running of the services
- attended a ward round.

## Summary of this service

We rated it as good because:

- Staff completed a comprehensive mental and physical health assessment on each patient shortly after they were admitted. Care plans were personalised, holistic and recovery oriented, and included patients' views and multi-disciplinary input from the ward team. Staff completed patient risk assessments promptly when patients were admitted to the ward, and put in place detailed management plans. These were updated after incidents.
- Staff interacted with patients in a positive, respectful and discreet manner, and there was a calm and relaxed atmosphere on the ward. Most patients reported that staff treated them well and described staff as friendly, caring and supportive.

# Wards for people with a learning disability or autism

- Staff were clear about the criteria for admission to the unit and actively planned for patients' discharge from the time of admission. They worked collaboratively with community mental health teams, rehabilitation teams and local social services. Delayed discharges were monitored and escalated when necessary.
- Although there remained staff vacancies on the ward, the trust had undertaken a recruitment campaign to attract nurses with a range of different skills to work on the ward and ensure safe staffing levels. The trust had recruited learning disability nurses, physical health nurses and registered mental health nurses. Multidisciplinary staff received the specialist training they needed to provide effective care and treatment to patients. The staff team had an in-depth knowledge of the patient group. It was anticipated that the ward would be fully staffed by September 2018.
- Staff stored medicines securely and administered them in accordance with national guidelines. They recognised, reported and investigated medicines incidents, and shared learning from incidents to reduce the number of future medicines errors.
- The service-controlled infection risk well. Staff kept equipment and the premises clean. The ward was visibly clean, tidy and well maintained.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. Patients knew how to make a complaint.
- Governance structures in the service helped ensure that learning from incidents and complaints was shared effectively with staff and information was passed from ward to trust board and vice versa. Managers maintained oversight of the quality of the service.

However:

- Although staff told us that they were receiving regular supervision, there were many gaps in records of their clinical supervision, indicating that they did not always receive the support needed in carrying out their duties effectively. This may have impacted on the quality of care provided to patients.
- Although the service had suitable premises and equipment, some areas of the ward, identified as a risk due to poor visibility, were not consistently monitored by staff to mitigate the risks to patients. Staff had not identified expired items in one of the ward's clinic rooms, indicating that staff were not checking these regularly. It should be noted that almost all patients on this ward were informal, and would not normally be considered at high risk of suicide or self-harm.
- No patients were given keys to their bedrooms on the ward, which meant that they had to rely on staff to lock and unlock their rooms.
- There were limited opportunities for patients and their family members to give feedback about the service they received. This was a missed opportunity to involve patients and carers in making improvements to the patient experience.
- Incidents relating to the service were not always categorised accurately, to ensure that appropriate learning was shared with staff within the trust.

## Is the service safe?

**Good** 

We rated it as good because:

# Wards for people with a learning disability or autism

- Staff planned care for patients to ensure their safety. Staff completed risk assessments with detailed management plans promptly when patients were admitted to the ward, and they updated these after incidents.
- The ward was visibly clean, tidy and well maintained. Ligature risks had been identified, documented and staff made aware of the risks and what precautions to take to keep patients safe.
- Managers had taken steps to address staffing gaps on the ward. They covered staffing vacancies with bank and agency staff. Although there remained vacancies on the ward, the trust had undertaken a recruitment campaign to attract nurses with a range of skills to work on the ward. The trust had recruited learning disability nurses, physical health nurses and registered mental health nurses. It was anticipated that the ward would be fully staffed by September 2018.
- Staff knew how to raise concerns, safeguarding and incidents. The ward had an allocated social worker who gave staff advice and support regarding safeguarding issues. Staff knew what incidents to report and how to do so, and escalated incidents in line with trust policy. Staff gave examples of learning from when things had gone wrong.
- Staff stored medicines safely and securely and administered them in accordance with national guidelines.

However:

- The ward layout made it hard for staff to observe patients. Some areas of the ward, identified as a risk due to poor visibility, were not consistently monitored by staff to mitigate the risks to patients. It should be noted that almost all patients on this ward were informal, and would not normally be considered at high risk of suicide or self-harm.
- Staff did not check expiry dates on all items in the ward's clinic room. We found wound dressings and blood test equipment stored despite being past their expiry dates.
- The ward imposed inappropriate blanket restrictions. No patients had keys to their bedrooms, which meant that they had to rely on staff to lock and unlock their rooms.
- Staff had not completed all the mandatory training they needed to. This included training in basic life support (76%) and immediate life support (75%), against a trust target of 85% where further training sessions were planned due to the high physical health needs of some patients on the ward.
- Although staff recorded incidents when they needed to they did not always categorise incidents appropriately, such as some medicines incidents, to ensure that appropriate learning was shared with staff within the trust.

## Is the service effective?

**Good** 

We rated it as good because:

- Staff of different kinds worked together as a team to benefit patients. Patients received multi-disciplinary support from a team including occupational therapy, psychology, and physiotherapy.
- Staff delivered neuropsychiatric treatment and rehabilitation in accordance with national guidance. The patient pathways offered a range of medical and psychological approaches to support patients. Patients received specialist neuro-psychology, specialist cognitive behavioural therapy, psycho-education, behavioural monitoring and management.
- Staff completed a comprehensive mental and physical health assessment on each patient shortly after they were admitted. Care plans were personalised, holistic and recovery oriented. Patients' recovery goals were determined by their needs and effective outcomes were delivered for patients.

# Wards for people with a learning disability or autism

- Multidisciplinary staff received specialist training relevant to working with patients with neuropsychiatric conditions, which enabled them to develop the specific skills they needed to provide the most effective care and treatment.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff had received training in the Mental Health Act and Mental Capacity Act and maintained appropriate records to protect patients' rights in line with these Acts.

However:

- Records indicated that there were gaps in clinical supervision provided to staff, which may have impacted on the care provided to patients.

## Is the service caring?

**Good** ●

We rated it as good because:

- Staff interacted with patients in a positive, respectful and discreet manner, and there was a calm and relaxed atmosphere on the ward. Most patients reported that staff treated them well and described staff as friendly, caring and supportive.
- Staff had a good understanding of patients' individual needs, including personal, social and religious needs. They developed care plans with patients to support them with these needs.
- Staff involved patients in decisions about their care and treatment. They supported patients to give their views on defined objectives and goals to support them with their recovery and rehabilitation, and these views were reflected in their care plans.
- The service provided access to independent advocacy support for all patients. Details of how to contact the advocate was displayed.

However:

- There were few opportunities for patients and their family members to give feedback about the service they received. Patients did not have regular opportunities to meet as a group and feedback on the service. Staff did not encourage visiting family members to give feedback.
- Information about patients that was recorded about patients on a whiteboard in the staff office were visible from outside that room. This compromised patient confidentiality when other patients or visitors could see the details.

## Is the service responsive?

**Good** ●

We rated it as good because:

- The unit was a national service in addition to serving the four local London boroughs. Staff planned all admissions and completed initial assessments for patients prior to their being admitted.
- Staff actively planned for patients' discharge from the time of admission and worked collaboratively with community mental health teams, rehabilitation teams and local social services. Delayed discharges were monitored and escalated when necessary.

# Wards for people with a learning disability or autism

- The unit facilities promoted patients' comfort, dignity and privacy. The ward had multiple communal areas and activity rooms. The ward had a dedicated lounge area for female patients in addition to a visitors' room. Patients could access outside space in the garden or whilst on escorted/unescorted leave.
- The service took account of patients' individual needs. The ward could meet the needs of patients with limited mobility. It had specialised rooms that catered for patients with mobility access needs and communal spaces were accessible for those patients in a wheelchair.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Patients knew how to make a complaint.

However:

- Three patients felt that ward leisure activities were limited, and that patients watched a lot of daytime chat shows, which were quite loud. This meant that they could not stay in the communal lounge area due to the noise levels.

## Is the service well-led?

**Good** 

We rated it as good because:

- Senior managers and clinical leaders knew the ward and understood the areas of practice requiring improvement. The management structures supporting the ward had recently changed but knowledge and understanding of it had been maintained.
- There was a clear framework to structure governance meetings. This framework included a range of quality indicators and discussions regarding learning from incidents and complaints.
- The service had many staff with extensive experience and an in-depth knowledge of the patient group who provided leadership. The ward manager had left in May 2018, and in the interim, the band 6 nurses shared day to day management, with support from the head of pathway. A new ward manager had been appointed.
- Staff reviewed information to ensure they delivered good care. They audited care plans, risk assessments, medication and infection control regularly.

However:

- Managers were not monitoring the frequency and quality of supervision provided to staff, and there were some gaps in monitoring the safety of patients on the ward.

## Areas for improvement

We found the following areas for improvement in this service.

### SHOULDs:

- 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.

# Wards for people with a learning disability or autism

- 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 regards to no patients having keys to their bedrooms, which meant that they had 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.
- 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.

# Community-based mental health services for older people

Good   

## Key facts and figures

We inspected three community-based mental health teams for older adults, three memory services, one home treatment team for older people and a care home intervention team.

The community-based mental health teams for older adults in Croydon, Lambeth and Lewisham provide specialist assessment, diagnosis, treatment and support to older adults living with progressive memory problems, such as dementia and functional mental health problems.

The Lambeth and Southwark Care Home Intervention Team provides a community in-reach service for older adults who express behavioural and psychological symptoms of dementia or challenging behaviour in the context of mental illness, living in care homes in the London boroughs of Lambeth and Southwark.

The Lambeth, Southwark and Lewisham Home Treatment Team provides care for people aged over 65, who have severe mental illness, and people of any age who have a diagnosis of dementia, who would benefit from assessment and treatment at home as an alternative to hospital. The team provides care for people who live in the London boroughs of Lambeth, Southwark and Lewisham.

Lambeth and Southwark Integrated Memory Service and Croydon and Lewisham Memory Services offer comprehensive assessment, treatment and support options to anyone over the age of 18 with mild to moderate memory problems likely to indicate dementia. The teams work in collaboration with the Alzheimer's Society and offer a comprehensive assessment.

Following assessment, the teams coordinate individualised care planning. This may include prescribing medicines if appropriate, post diagnostic support and signposting, problem solving strategies, and individual or group therapy, which is offered for both patients and carers.

We last inspected the service in September 2015. Following that inspection, we rated the service as good overall, with a rating of requires improvement for safe and good for effective, caring, responsive and well-led. We issued the trust with one requirement notice. This related to the safe transportation of medicines, medical waste and sharps; and inconsistent completion of patient risk assessments and risk screens.

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information. Our inspection was short notice announced (staff knew we were coming). This was in line with CQC guidance, because we inspected five core services in the same week, and it would have been impractical to make the inspection unannounced.

During the inspection visit, the inspection team:

- Interviewed 25 staff including nurses, consultant psychiatrists, occupational therapists, clinical psychologists, administrators, a recovery support worker and student nurses.
- Interviewed eight team managers and the clinical service manager
- Spoke with eight patients
- Spoke with 11 carers
- Received feedback from service user and carer groups and five completed comment cards
- Attended four home visits

# Community-based mental health services for older people

- Spoke with staff in three care homes visited by the care home intervention team
- Reviewed 27 patient care and treatment records
- Attended two multidisciplinary team meetings
- Attended one team business meeting
- Attended one morning planning meeting
- Toured the premises of each service we visited and conducted a check of the clinic rooms, medication and clinical equipment where appropriate
- Reviewed a range of other documentation, policies and procedures related to the services we visited.

## Summary of this service

Our overall rating for community-based mental health services for older people stayed the same. We rated it as good because:

- The leadership, governance and culture of the service actively encouraged the delivery of person-centred care. The service had capable managers at all levels with the right skills and abilities to run a service providing high-quality, compassionate, sustainable care.
- Services were very well-led and allowed staff to be creative and innovative in their approach to care and treatment. Evidence was used to develop new tools and effective services. Quality improvement initiatives and research had led to the development of new ways of working. Innovations had been shared with other health services and professionals both nationally and internationally.
- Services took account of the diverse needs of patients and carers. The memory service in Lambeth and Southwark was working towards increasing the number of black and minority ethnic people being referred to the service. Staff from the service had piloted an innovative series of sessions on dementia for children in schools as a way of raising awareness among local communities. Staff were sensitive to the needs of LGBT+ patients. Premises were accessible to people with mobility problems and staff saw patients at home when this was more appropriate.
- Staff worked actively to reduce prescriptions of anti-psychotic medicines and medicines that had an adverse effect on memory.
- Staff were compassionate, respectful and responsive to the needs of patients and carers. Feedback from patients and carers was very positive and staff were continuing to consider ways in which they could involve patients and carers in decisions about the services.
- Staff of different kinds worked together as a team to benefit patients. A full range of experienced professionals worked across the teams and were able to provide the necessary interventions to patients. Staff worked well together both within their teams and with other teams to ensure that patients received the support they needed in a timely manner. Teams referred patients to other services when this was appropriate.
- The service had enough staff with the right, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Staff had manageable caseloads and were able to respond promptly when an urgent assessment was needed. Work had been done to improve the waiting times for an assessment at Croydon memory service. All memory services were working hard to decrease their referral to diagnosis times, so that they could reach a six-week referral to treatment target by 2020.

# Community-based mental health services for older people

- The service had made improvements to the quality of patient risk assessments since our last inspection in September 2015. Staff used a comprehensive risk assessment tool, which prompted them to cover all areas of risk in sufficient detail including how to safely manage the identified risks. Risk assessments were easily accessible to staff and stored in an appropriate place on the electronic patient record. Teams managed patient risk well. They used regular zoning meetings to identify and focus on patients at high risk.
- Staff had made improvements to the way they transported medicines and disposed of sharps. Although a few staff in one team did not always follow trust policy in respect of the disposal of clinical waste this was promptly addressed by managers.
- Similarly, improvements had been made in lone working procedures, the application of the Mental Capacity Act, compliance with safeguarding procedures and to patient waiting areas in Lambeth. Work had also taken place to improve patient crisis plans. These were now in place and patients knew who to contact in an emergency.

However:

- Whilst the trust was using technology to support mobile working in some teams this had not yet been rolled out across all the teams. Staff told us that they had to return to the office at the end of the day to complete patient care and treatment records, which was not an effective use of their time and may have had a negative impact on the quality of record keeping.'
- Whilst patient care plans identified all aspect of patients' care, they were not particularly accessible to patients who were living to dementia. The trust was in the process of improving care plans in terms of accessibility to their patient group during the time of our inspection. Similarly, standard methods for giving feedback about the service did not take into account the particular needs of patients with dementia or offer them suitable alternatives.
- The recording of staff supervision in Lewisham older adult CMHT was inaccurate and resulted in under reporting. It was difficult for the team manager to be assured about the frequency of supervision taking place in the team without access to full records.
- Teams were not routinely discussing incidents and complaints at their business meetings as a way of learning and promoting improvements.

## Is the service safe?

Good  

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

- At our last inspection in September 2015, we found that staff did not safely transport medicines when travelling on home visits. At this inspection, we found that staff now carried medicines in standard lockable bags.
- At our last inspection in September 2015, we found that risk assessments were completed inconsistently. During this inspection, we found that the quality of risk assessments and risk management plans had improved. Staff used a new template, which prompted them to complete these records in detail. Staff continually reviewed individual patient risk using an effective zoning system. Teams managed risk well.
- At our last inspection in September 2015, we found that the lone working procedures were not being consistently followed across the teams. During this inspection, we found that lone working procedures were robust and consistently followed by staff.

# Community-based mental health services for older people

- The teams had sufficient staff and had manageable caseloads. New posts had been created at Croydon memory service to make waiting times for the service shorter. The teams responded promptly to urgent referrals and provided timely assessments of patients. Teams were able to allocate patients to a care coordinator immediately, when appropriate.
- At our last inspection in September 2015, we found that patients did not always have crisis plans in place, informing them of actions to take if they experienced a mental health crisis. During this inspection, we found that patients had crisis plans in place and staff were prompted by the electronic records system to ensure these were completed.
- At our last inspection in September 2015, we found that staff were not always clear about how to raise a safeguarding concern. During this inspection, we found 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.

## Is the service effective?

**Good**   

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

- Staff in most teams had good access to information held about patients by other providers, which enabled more effective care and treatment. This included a secure portal that allowed staff in Lambeth, Lewisham and Southwark to review patients' physical health investigation results directly.
- A full range of professional disciplines worked within the teams and staff offered treatment interventions in line with professional and national guidance. Staff made referrals to specialists outside of the team, such as speech and language therapists, when necessary.
- Staff used a range of evidence-based, validated tools to complete comprehensive assessments for each patient. Some tools were available in other languages and more culturally appropriate versions to enable effective assessments of all patients.
- Staff provided a range of evidence-based care and treatment interventions and were knowledgeable in respect of relevant national guidelines. Outcomes for patients were measured using appropriate tools to monitor the effectiveness of the interventions prescribed.
- Staff were experienced in caring for older adults with mental health problems and cognitive impairments. Staff had undertaken specialist training and some staff had postgraduate qualifications in dementia care. Staff received an annual performance appraisal, which helped identify areas for professional development.
- The older people's CMHTs and HTT worked well together and with other teams and agencies. The care home intervention team supported local care home staff to effectively care for and manage residents with dementia.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They supported those who lacked the capacity to make decisions about their care.

However:

- The recording of staff supervision in Lewisham older adult CMHT was inaccurate and resulted in under reporting. It was difficult for the team manager to be assured about the frequency of supervision taking place in the team without access to full records.

# Community-based mental health services for older people

## Is the service caring?

Good  → ←

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

- Patients and carers were overwhelmingly positive about their experiences of using the services. They made particularly positive comments about their relationships with staff and how compassionate and supportive staff were. Staff maintained the privacy and dignity of patients at all times and understood each patient's individual needs well.
- Staff signposted patients to other services including day centres and third sector organisations that met their needs. Staff considered patients cultural and diverse needs in their care and when allocating care coordinators.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff collaborated with patients and their carers in discussions about their care and treatment and made sure they received copies of their care plans. A service user and carer advisory group took place each month within the directorate. Local teams were considering ways they could involve patients and carers locally in team meetings and in peer support groups.

However:

- Although patients and carers were encouraged to provide feedback about the service in a standard survey, there were no alternative feedback methods designed to be accessible for patients living with dementia.

## Is the service responsive?

Good  → ←

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

- People could access the service when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice. Staff had taken steps to successfully reduce the waiting time for the Croydon memory service. The memory services were exploring ways to further reduce the time from referral to treatment to six weeks by 2020. There were no waiting lists for CMHTs and people were seen within expected time frames.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. The service had received very few complaints in the last year. Written information about how to complain was made available, and staff were on hand to support patients and carers who wished to make a complaint.
- Services provided pleasant waiting areas and had the necessary space to carry out consultations and group activities. The trust had improved seating in the outpatient department waiting area at Lambeth with the addition of suitable seating.
- Staff supported patients to engage with the wider community and referred patients to third sector organisations that supported patients to integrate into the local community.
- Services were aware of the diverse needs of the local populations and took account of individual differences when providing care and treatment. Services were proactive in addressing the needs of people with protected

# Community-based mental health services for older people

characteristics. Lambeth and Southwark memory service were working to increase accessibility to the service for black and minority ethnic people, in line with the trust's equality priorities for 2017-2020. Staff were inclusive of and welcoming to LGBT+ patients. They were sensitive to the way they phrased questions about significant relationships and linked LGBT+ people with community groups and resources.

## Is the service well-led?

**Outstanding** ☆ ↑

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

- The leadership, governance and culture of the service actively encouraged the delivery of person-centred care. The service had capable managers at all levels with the right skills and abilities to run a service providing high-quality, sustainable care. Leaders prioritised safe, compassionate care and promoted equality and diversity.
- The service had a systematic approach to continually improving the quality of its services and encouraged creativity and innovation. Evidence-based innovation included a project to improve the wellbeing of people living with dementia in care homes through the training and support of care home staff, designing a tool to measure the anticholinergic effect on cognition of medicines and support the review and reduction of prescriptions of these medicines, and the use of creative approaches to improve awareness of dementia within local black and minority ethnic communities.
- The service engaged proactively with staff and patients. A trust wide patient experience team collated all forms of patient and carer feedback to help improve services and share areas of good practice. Service user and carer groups met regularly and actively participated in service development. Representatives from the group took part in staff recruitment panels. The service was looking at ways to enable more feedback from people living with dementia.
- The culture of the teams we visited was very positive. Staff felt able to raise concerns and challenge each other. Staff were well supported by their colleagues and managers. Leaders demonstrated a genuine commitment to their work and a detailed understanding of the services they provided.
- A system of governance was in place, which enabled the effective flow of communication and performance data from the trust board to the teams and vice versa. Team managers had good oversight of key performance indicators.
- The service had effective plans for coping with the unexpected. Business continuity plans were in place and had been put into action effectively when Lewisham older adult CMHT experienced a flood, thus limiting the negative impact on patients.

However:

- Most teams did not yet have access to portable computers or tablets to enable them to update care and treatment records during home visits. Staff needed to return to the office to complete patient records. This was a missed opportunity in terms of enabling more accurate and contemporaneous record keeping and involving patients and carers actively in care planning.
- Although staff knew about incidents that had taken place in the service, teams were not routinely discussing incidents and complaints at their business meeting as a way of learning and promoting improvements.

## Outstanding practice

We found three examples of outstanding practice in this service.

# Community-based mental health services for older people

- Staff, including the patient and public involvement lead, were proactively engaging with patients from black and minority communities in Lambeth and Southwark to increase awareness of dementia and the service. This work promoted access to timely treatment and therefore the best possible outcomes for the whole local population, regardless of their background. As part of this work staff from the memory service had piloted sessions on dementia in a local school. The aim was to educate the young people about dementia and help them to recognise when someone may have dementia. Children gave positive feedback about what they had learned from the session. The service had plans to roll out the sessions to other local schools.
- The care home intervention team had developed a wellbeing and health for people with dementia pilot in Lambeth (WHELD-L), which was evidence based. The programme provided training and support for dementia champions in two care homes in Lambeth. Staff at the care home intervention team provided the champions with experiential learning, coaching and mentoring to enable them to engage in more effective and meaningful interactions with people with dementia in their care home. A key outcome of the pilot was for care home residents to have a one-page profile or life story in place. Feedback from dementia champions was extremely positive.
- The mental health of older adults and dementia consultant pharmacist, in collaboration with clinicians, developed a tool called the anti- cholinergic effect on cognition (AEC) scale, which enables staff to quantify the anti-cholinergic effects of 2000 medications in order to complete evidence-based medication reviews for people with dementia. The tool has been incorporated into a website [Medicheck.com](https://www.medicheck.com) and a mobile phone application was being developed. New NICE guidelines included the need to review the AEC burden on patients and the Medicheck tool helped professionals to do this.

## Areas for improvement

We found these areas for improvement in this service:

- 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 reflect the supervision taking place.
- The trust should ensure that learning from incidents and complaints is discussed at team and business meetings to support improvements.

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

Good   

## Key facts and figures

We visited all of the teams that form part of the trust's crisis services as detailed below:

The home treatment teams (HTT) in Croydon, Lambeth, Lewisham and Southwark. The HTTs provide assessment and treatment at home, which can help patients avoid an admission to hospital. It also supports patients who are being discharged from hospital.

The health-based place of safety is a place where patients experiencing a significant deterioration in their mental health are taken, usually by the police, for an assessment by a team of mental health professionals. The health-based place of safety is based at the Maudsley Hospital in Southwark.

The crisis services and health-based places of safety were last inspected in January 2015, when the overall rating for the service was good. Safe was rated as requires improvement, and effective, caring, responsive and well-led were rated as good. We issued one requirement notice following the 2015 inspection, in relation to Regulation: 12 Safe care and treatment. We had concerns at that time about the condition of the environments in the health-based places of safety, the consistency and accessibility of patient risk assessments, and the functioning of alarms in one team base. The trust has since opened a purpose-built health-based place of safety at the Maudsley Hospital and closed the other health-based places of safety.

Our inspection of mental health crisis services and the health-based place of service between 2 July and 4 July 2018, was announced (staff knew we were coming). This was in line with CQC guidance, because we inspected five core services in the same week, and it would have been impractical to make the inspection unannounced.

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

During the inspection visit, the inspection team:

- spoke with the managers of each home treatment team and of the health-based place of safety
- spoke with 30 staff members including nurses, consultant psychiatrists, clinical psychologists, social workers and support workers
- spoke with the deputy and service director for Lewisham
- looked at the quality of the environment at each location
- reviewed 28 care and treatment records
- spoke with 14 patients and five carers face to face and via telephone calls
- observed six handover meetings and one multidisciplinary team meeting
- observed one home visit and two outpatient appointments.

## Summary of this service

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

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

- During this inspection, we found that services had addressed all of the issues that caused us to rate it as requires improvement in safe following the September 2015 inspection.
- Staff completed full risk assessments for patients and managed risk well. Staff developed crisis care plans with patients. Staff kept patient risks under continuous review at twice daily team meetings. Staff completed documentation, including initial risk assessments and physical health assessments to a good standard.
- The service had introduced a purpose-built health-based place of safety since the 2015 inspection, which provided patients with a high-quality environment. There was a dedicated staff team, 24 hours per day and seven days a week. There were good facilities for children and young people and parents could stay overnight.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training in how to recognise and report abuse and they knew how and when to report their safeguarding concerns.
- Staff supported patients to live healthier lives, and receive support for their physical health. Two nurses ran weekly physical health clinics in each home treatment team. Staff in the health-based place of safety received specialised physical health training to reduce admissions to emergency departments in local acute hospitals.
- The service had enough skilled and experienced staff to support patients in a crisis. Staff of different disciplines worked together as a team for the benefit of patients. The home treatment teams ran a specialist training programme for all staff, which included suicide prevention and family interventions.
- Patients were positive about staff and the service. For example, patients said staff provided good support when they were experiencing a crisis.
- Staff did all they could to keep patients at home during a crisis and prevent admission to hospital. The crisis assessment team, consisting of a nurse and a police officer, accepted referrals from the ambulance service and police. They had been successful in reducing admissions to acute hospital emergency departments of patients in crisis.
- Staff understood arrangements for working with other teams within the trust and externally to meet the needs of patients in crisis. The home treatment teams and health-based place of safety had multi-agency arrangements in place, to monitor and agree the governance of crisis services.
- Home treatment teams and the health-based place of safety staff worked towards improving quality within the service. Staff had implemented a quality improvement project introducing patient reported outcome measures to incorporate into patients' care planning.

However:

- Although staff usually managed patients' medicines safely, staff sometimes did not package and label the patient's medicines when they left them at the patient's home. Staff did not always follow the trust policy for assessing and recording the suitability of the patient's own medicines before these were administered.
- Although, there had been a significant decrease in the number of hours patients spent in the health-based place of safety, at the time of the inspection data showed that nearly a quarter of patients had breached the 24-hour target length of stay in May 2018. This was monitored very closely by the trust.
- The patient section 132 rights poster displayed in the health-based place of safety assessment rooms did not clearly explain patients' rights and could have been misleading.
- Capacity assessments for consent to treatment, in the health-based place of safety, lacked detail. Staff did not clearly demonstrate how they had arrived at their decision.
- Staff in some teams were not aware of the trust's Freedom to Speak Up Guardian or how to contact them.

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

## Is the service safe?

Good  

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

- The purpose-built centralised health-based place of safety provided a safe environment for patients. This was a significant improvement from the last inspection in September 2015. The health-based place of safety was visibly clean, had good furnishings and was well-maintained. It was permanently staffed on a 24-hour, seven day a week basis.
- At our previous inspection in September 2015, the trust did not ensure that risk assessments completed by the home treatment teams were stored consistently and accessible to care professionals who needed this information. At this inspection, we found that this issue had been addressed and improvements had been made. Staff stored risk assessments consistently.
- Staff managed risk well, completed and updated risk assessments for each patient and used these to understand and manage risks individually. Staff worked in collaboration with patients on their risk management plans and updated them after incidents. Staff discussed, categorised and managed patient risk in daily meetings to keep patients and others safe. Patients had clear crisis plans so they knew who to contact if their health deteriorated.
- Staff knew their roles and responsibilities for protecting patients from abuse and managers encouraged staff to raise safeguarding and other concerns. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with their teams.
- The home treatment teams had clear lone working protocols that staff followed. Staff knew how to summon assistance in an emergency.
- The service had enough staff with the right qualifications, skills, training and experience to provide safe care and treatment. A dedicated team staffed the health-based place of safety day and night. An advanced practitioner worked on every shift to ensure the safe running of the home treatment team at weekends and after 5pm. Home treatment teams had manageable caseloads.

However:

- Although medicines management arrangements in the service were mostly safe, staff did not always leave medicines in patients' home in the correct packaging and labelling. Staff did not always follow trust policy in respect of the assessment and recording of the suitability of patients' own medicines, before administration.

## Is the service effective?

Good   

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

- Staff of different kinds worked together as a team for the benefit of patients. Doctors, nurses, psychologists, support workers and team leaders supported each other to provide good care. All new staff received a thorough induction. The home treatment teams had implemented monthly reflective practice for staff to discuss complex cases.

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

- The service monitored the effectiveness of care and treatment and used the findings to improve them. Staff participated in clinical audit to provide assurance of the quality of care and treatment delivered to patients and drive improvement.
- The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff received specialist training to support them in their roles. Home treatment team staff received training in suicide prevention, family interventions and dialectical behaviour therapy to effectively support patients in a crisis.
- Staff ensured that patients had good access to physical healthcare. The home treatment teams ran a weekly physical health clinic to support patients with their physical health needs. Staff in the health-based place of safety received specialised physical health training to reduce the need for patients to go to the emergency department in the local acute trusts.
- Most patients' care plans were personalised, holistic and recovery-oriented. Staff considered goals and interventions with patients, reflecting their employment, education, housing, relationships and financial needs.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

However:

- The patient section 132 rights poster displayed in the health-based place of safety assessment rooms did not clearly explain patients' rights.
- Staff in the health-based place of safety had not completed mental capacity assessments for consent to treatment in sufficient detail. Assessments did not demonstrate clearly how staff arrived at their decision.

## Is the service caring?

Good  ➔ ➜

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

- We observed kind and respectful interactions between staff and patients. Staff provided emotional support to patients to minimise their distress.
- Staff demonstrated compassion and support for families and carers. The health-based place of safety had a designated children and adolescent assessment room with an additional private lounge so that parents could stay overnight.
- Staff involved patients and those close to them in decisions about their care, treatment and the service. Patients reported that staff had offered them a copy of their care plan and that they felt involved in their care and treatment. Patients provided feedback about their experience of the service, which staff used to improve the service. Staff in the health-based place of safety had produced a specific survey for patients to feedback about their time in the place of safety.
- Staff anticipated and responded to people's personal, cultural, social and religious needs.

## Is the service responsive?

Good  ➔ ➜

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

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

- The teams were multi-agency and responded to patients in crisis in the community. The service was accessible 24 hours a day and seven days a week. Urgent referrals were seen promptly by staff. The telephone crisis line had been extended to include a specific line for patients between the hours of 10pm-8am. The new crisis assessment team had reduced patients being taken to emergency departments by the ambulance service by 89%, amongst those seen, and was being extended.
- At the last inspection, in September 2015, three out of the four health-based places of safety did not provide an environment that promoted people's privacy and dignity. At this inspection, we found that improvements had been made. The trust now had one centralised health-based place of safety purpose built to a high specification. The health-based place of safety had dedicated facilities for children and young people that included the provision for parents to stay overnight.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the outcomes, which were shared with staff. Patients knew how to complain, and give feedback about the service.
- The service took account of patients' individual needs, including patients with protected characteristics. The service enabled access for people with physical disabilities, took account of patients' cultural and religious needs and provided information in an accessible format.

However:

- Although staff worked hard to ensure they met targets set out by the Mental Health Act and had significantly reduced lengths of stay since 2017, trust data showed that 23% of patients admitted to health-based place of safety breached the 24-hour legal length of stay for assessment in May 2018. The trust was monitoring this closely to ensure further improvements were made.

## Is the service well-led?

**Good**   

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

- The trust collected, analysed, managed and used information well to support its activities, using secure electronic patient record systems. Governance systems enabled managers to monitor the quality, performance and risk management of the home treatment teams and health-based place of safety.
- The trust was committed to improving services by learning from when things went well, when they went wrong, and promoting innovation. Teams worked towards improving quality within the service. Staff in home treatment teams had implemented a quality improvement project to collect patient reported outcome measures to incorporate into patients' care planning.
- Team managers had the skills, knowledge and experience to support patients when they were in a crisis. Managers understood how the teams within the acute pathway worked together to provide safe and effective care for patients.
- The service had effective systems for identifying risks, and mitigating or reducing them, and had plans for unexpected events.
- Managers in the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff described good morale in the service.

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

- The service engaged with patients and carers to develop services. Service users had contributed to the development of the centralised health-based place of safety and were very positive about the results.

However:

- Staff in the health-based place of safety and Lambeth home treatment team were not aware of the role of the trust's Freedom to Speak up Guardian and how to contact them.

## Outstanding practice

The trust introduced the crisis assessment team in October 2017. The team operated in a car with a mental health nurse and a police officer and went out to assess people in crisis in the community. Data showed that the intervention of the crisis assessment team had reduced patients being taken to the emergency department of the local acute hospital by the ambulance service, by 89%, amongst those seen.

The health-based place of safety had dedicated facilities for children and young people that included the provision for parents to stay overnight.

## Areas for improvement

Areas for improvement

Action the trust SHOULD take to improve

- 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 patient's own medicines before administering them.
- The trust should ensure that the patient s132 rights poster displayed in the health-based place of safety assessment rooms clearly explains patients' rights in line with the Mental Health Act.
- 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.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

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

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

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

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

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

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

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

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

# Our inspection team

Jane Ray, Head of Hospitals, led this inspection. An executive reviewer, Neil Thwaite, Chief Executive of Greater Manchester Mental Health Foundation Trust, supported our inspection of well-led for the trust overall.

The team included three inspection managers, 17 inspectors, two assistant inspectors, one executive reviewer, 20 specialist advisers, two Mental Health Act reviewers and eight 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.