Care Quality Commission

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

Springfield University Hospital

Quality Report

61 Glenburnie Road
London
SW17 7DJ
Tel: 020 8682 6000
Website: www.swlstg-tr.nhs.uk/

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Contents

Summary of this inspection	Page
Overall summary	3
The five questions we ask and what we found	5
What we found about each of the main services at this location	19
What people who use the location say	24
Areas for improvement	24
Good practice	24
Detailed findings from this inspection	
Our inspection team	25
Background to Springfield University Hospital	25
Why we carried out this inspection	26
How we carried out this inspection	26
Findings by main service	27
Action we have told the provider to take	80

Summary of findings

Overall summary

Springfield University Hospital is part of South West London and St George's Mental Health NHS Trust. It provides a range of mental health inpatient and outpatient services including, acute, rehabilitation, older people, eating disorder and forensic services. The trust is responsible for providing all the community and hospital-based psychiatric services to the London Boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.

We found that the services at Springfield University Hospital were safe, the wards were clean and staff were aware of risks. There were ways to report and learn from incidents, but improvements were needed in assessing and managing risks to people's safety.

Staff interacted with people who used the service in a caring and compassionate way. People and their relatives were involved in planning their own care, although records did not always reflect this. People were engaged in activities they felt were meaningful and therapeutic. Ward staff listened to people's feedback and involved them in making positive changes.

The Mental Health Act responsibilities were being discharged appropriately. Some actions from previous Mental Health Act monitoring visits had not been fully resolved.

We saw good examples of learning from audits and incidents being shared, and changes to practice being made as a result.

All staff we spoke to on the ward told us they received training for safeguarding children and vulnerable adults as part of their annual mandatory training. They also said they would be confident in reporting safeguarding – either internally or to the local authority.

Staff told us they felt supported by the management on the ward and their immediate managers. Some staff told us they did not always feel involved in conversations about their roles, particularly when organisational changes were taking place.

We found that the recording of rapid tranquilisation on some wards was not being done well. We saw routes of administration being recorded incorrectly, doses of medicines being recorded in progress notes but not on medicines administration records, and patients who were administered these medicines did not have a reason for the use in their progress notes.

We visited the following wards at Springfield University Hospital as part of this inspection:

Ward 1

Core service provided: Psychiatric Intensive Care Unit (PICU)

Male/female/mixed: male

Capacity: 13 beds

Ward 2

Core service provided: Acute admission ward

Male/female/mixed: mixed

Capacity: 18 beds

Ward 3

Core service provided: Acute admission ward

Male/female/mixed: mixed

Capacity: 20 beds

Jupiter Ward

Core service provided: Acute admission ward

Male/female/mixed: mixed

Capacity: 23 beds

Bluebell Ward

Core service provided: Acute admission ward for deaf adults

Male/female/mixed: mixed

Capacity: 16 beds

Corner House

Core service provided: Specialist assessment and treatment unit for deaf children and adolescents aged 8 to 18

Male/female/mixed: mixed

Summary of findings

Capacity: 6 beds

Avalon

Core service provided: Eating disorder service

Male/female/mixed: mixed

Capacity: 18 beds

Wisteria Ward

Core service provided: Young poeples eating disorder service

Male/female/mixed: mixed

Capacity: 10 beds

Crocus Ward

Core service provided: Services for older people

Male/female/mixed: mixed

Capacity: 21 beds

Haswell Ward

Core service provided: Medium secure forensic ward

Male/female/mixed: male

Capacity: 16 beds

Hume Ward

Core service provided: Low secure forensic ward

Male/female/mixed: male

Capacity: 16 beds

Phoenix Ward

Core service provided: Secure rehabilitation ward

Male/female/mixed: mixed

Capacity: 18 beds

Ruby Ward

Core service provided: Medium secure forensic ward

Male/female/mixed: female

Capacity: 10 beds

Turner Ward

Core service provided: Medium secure forensic ward

Male/female/mixed: male

Capacity: 18 beds

Seacole Ward

Core service provided: Inpatient OCD service

Male/female/mixed: mixed

Capacity: 13 beds

Aquarius Unit

Core service provided: Child and adolescent mental health service (CAMHS)

Male/female/mixed: mixed

Capacity: 10 beds

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Mental Health Act responsibilities

Arrangements to ensure authorised leave were in place. A standardised system was used to authorise and record leave of absence under Section 17 of the Mental Health Act.

We found three instances of restrictive practice. One person who had been formally detained since October 2013 told us that they had been requesting to go home to collect their belongings since they had been admitted. There was no evidence that this request had been fully considered. Another person on the ward informally told us that they felt imprisoned and was not aware that they could leave the hospital. People on another ward told us that a swipe card system was in place to access the bedroom corridors and expressed frustration that they were not provided with a card.

Environmental risks were found in the seclusion room in use on Ward 1. We observed a safety issue where a person using the service was able to stand and jump from a window ledge in this facility during our visit.

Acute admission wards

The trust used a computerised Electronic notes system (EPN). Records we checked on wards contained evidence of care planning and patients confirmed they were given a copy of care plans. However, some patients felt they had not contributed to their care plans and were not always given an updated copy after reviews.

We saw patients were supported with comprehensive risk management plans and offered a multi-disciplinary assessment at an early stage. Both risks to themselves and others were assessed.

Staff said they would be confident enough to report safeguarding issues.

Staff on all wards told us they felt their managers were knowledgeable, supportive and approachable. We found that most wards' managers were aware of the support needs of both staff and patients.

Psychiatric intensive care units

We saw that systems ensured incidents were reported to the trust's risk department, which provided feedback. Completed incident forms indicated actions that had been taken and by whom, and these had been added to the incident reporting system with clear and complete notes about the incident.

Although most people who used the service told us they felt safe on the ward, one person said they were intimidated by other people and afraid to leave their room. There was no clear strategy in place to help this person participate in activities and social life.

Where incidents raised concerns in relation to safeguarding people from abuse, we saw that the ward had taken appropriate action. We saw how the system automatically notified the ward manager of safeguarding information, which meant they were alerted to incidents if staff failed to escalate them.

Parts of the ward were not clean or well-maintained. People who used the service said they had to request clean bedding and toilet rolls and one person showed us their bedroom floor was sticky and dirty. This was because outside contractors were responsible for cleaning, which was done on a timetabled basis rather than as and when it was required to meet people's needs. A number of repairs had been requested at a recent community meeting and we were told that the person responsible for ensuring these were carried out was on leave. There were no arrangements in place to cover this role at the time of our visit.

Summary of findings

Long stay/forensic/secure services

We found that, although some learning from incidents took place, this was not consistent and risks to people remained. Risks within the environment had not always been identified or plans implemented to ensure people were safe.

There was evidence that learning from incidents that had occurred in the forensic services. However, we found that while some staff were aware of a recent incident within another part of the trust, effective practices had not been implemented on all of the wards, and people were therefore not protected against potential risks of self-harm.

People who use the service said they generally felt safe on the wards, and knew how to raise an alarm if they felt at risk of harm.

The training records confirmed that staff had received training in safeguarding and that this was regularly updated. The staff we spoke with understood safeguarding issues and their responsibilities to report concerns.

Staff had a good awareness of relational security issues, with regard to professional boundaries, the mix of people who use the service, and external communication (ie, people who use the service having access to the internet.

Some wards had vacancies for nurses and healthcare assistants, and we were shown evidence that regular bank and agency staff were used to ensure a consistent level of service while recruitment was taking place.

However, within the therapies service the staff told us they felt under pressure, with one occupational therapist to one ward of 18 people, where they said they felt unable to fulfil their role and provide an appropriate level of service to all the people. Some people on the wards did highlight to us that there was not always something to keep them occupied, and at times they felt “bored”.

Child and adolescent mental health services

There was an 'air lock' at the entrance to the Aquarius unit and Corner House providing a safe environment to young people. This meant unwanted visitors were unable to access the unit and young people were unable to leave the unit without a member of staff supporting them. There were adult services on site and therefore staff accompanied young people when they were off the unit in order to maintain their safety. The garden areas on the Aquarius unit and Corner House were secure and they were not overlooked by adult services.

The Aquarius unit was unable to maintain appropriate gender segregation in line with the recommended guidance. There was one bedroom area and the females had to pass through the male corridor to access their rooms. The males had to pass through the female corridor to access the unit’s garden area. Staff were being used to manage these difficulties and maintain the safety of the young people.

There were processes in place to learn from incidents that occurred at the service. There had been previous incidents regarding the Aquarius unit and the children’s services provided by the local authority. In response to this, a piece of joint work was undertaken to review the services' roles and how they deliver services.

Multi-agency discussions took place when required, depending on each incident, to ensure appropriate action and management strategies were put in place.

All staff were aware of who the safeguarding lead was for the trust and consulted them when further advice was required. Safeguarding concerns were discussed during handover and during governance meetings.

Staff were aware of the whistleblowing policy and processes.

Services for older people

Staff told us that when they report incidents, they do not get regular reports back from the team who logs the incidents centrally. One member of staff told us that serious incidents are reported back, but otherwise they are not.

Summary of findings

We saw an audit that had taken place in July 2013 which reported a lot of good practice; it also identified some irregular practices and confirmed that not all incidents were reported in line with the provider's policy.

The staffing levels were at their full complement when we visited. The healthcare assistants (HCAs) on duty were provided through NHS Professionals. They had worked on the ward before and were familiar with the people there, and able to meet their needs.

One member of staff told us that sometimes there was only one male HCA on duty and this could be difficult when they needed to respond to emergencies. This meant that, while the skill mix was maintained, the gender mix was not always appropriate to meet the needs of patients.

Staff had a good understanding of safeguarding and knew who to contact if they had a concern. We saw that all staff had undertaken safeguarding training.

Specialist eating disorder services

We found that Wisteria ward was a safe and secure unit. It ensured appropriate levels of security while caring for children and young people in the least restrictive way. Potential ligature points were managed as part of both ward and individual risk assessments.

Risks in the environment were generally well managed on Avalon ward. However, we found an unlocked small dining room which had a number of ligature points and three items of equipment, including a toaster and fan, with long flexes. Although the risks had been identified in an audit of ligature points in July 2013, the audit report did not identify how the specific risks in the environment would be safely managed.

Staff had undertaken training in safeguarding children and vulnerable adults and knew how to respond appropriately to any allegation of abuse. People who use the service told us they felt safe on the wards.

All staff we spoke with were aware of the whistleblowing process. They knew how to raise concerns and how to escalate these if necessary.

The wards had good links with the local acute hospital and were able to obtain the results of blood tests promptly. This enabled them to quickly identify concerns and respond to changes in people's physical health.

On Avalon ward staffing levels had recently been increased to seven staff on each day shift and five staff at night. Additionally, the skill mix of staff had been changed to ensure there were three qualified staff on duty on each day shift. Staff told us the ward had "felt safer" since the introduction of more staff. However, when we visited the ward on 18 March 2014 we found there were six staff on duty as a nurse had called in sick at short notice. On 20 March 2014 we found there were six staff on duty in the morning, only one of whom was a qualified nurse, rather than the required three. This was reported to be due to unexpected staff sickness. The modern matron came to the ward to provide additional cover.

On the afternoon of 20 March 2014 we observed that staff only found out about a shortfall in staffing levels for the afternoon shift 10 minutes before it began. Attempts were then made to obtain a replacement. When we reviewed the staffing rotas for the first three weeks of March 2014 we found that, while there were seven or more staff on duty on the majority of shifts, there were fewer than three qualified nurses on duty on 16 occasions, which was 40% of shifts. This meant the trust was not meeting the staffing requirements for the ward that they had determined were necessary to provide safe and effective care.

Other specialist services

The trust used an electronic patient notes system (EPN). We reviewed records on the ward and these contained evidence of care planning and patients confirmed they were given a copy of care plans.

Summary of findings

We saw patients were supported with comprehensive risk management plans and offered a multi-disciplinary assessment at an early stage. Both risks to themselves and others were assessed.

Most staff on the wards told us they felt the level of staff and skills mix was adequate. However, they also said they could always do with more staff. The manager on the ward was in an acting position due to a secondment of the substantive manager, and this was until August 2014.

Are services effective?

Mental Health Act responsibilities

The majority of records reviewed showed that people were being legally detained under the Mental Health Act 1983; however, we noted two instances during our inspection where individual section papers had expired on one ward.

We found that there were gaps in staff members' understanding and application of the Mental Health Act and Mental Capacity Act 2005.

We looked at the arrangements in place around people receiving Electro-Convulsive Therapy (ECT) and found these to be satisfactory with the appropriate documentation maintained.

Acute admission wards

We were told some staff on ward 3 had additional therapeutic qualifications, such as cognitive behaviour therapy (CBT) for psychosis and solution focused therapy skills. Staff on this ward attended a 'reflective practice' session every week which was facilitated by the ward consultant.

We saw people's physical healthcare needs were assessed using nationally agreed standards – National Early Warning Scores (NEWS).

The ward managers told us they completed a monthly monitoring tool called SIREN. They said they reported against staffing levels/mix, safeguarding, complaints, incidents, care plans and risk assessments.

We observed the daily handover meeting, which was attended by the senior nurse, ward doctor, support volunteer and the trainee GP. They took account of people's physical health needs as well as mental health.

All staff told us they had access to regular mandatory training. We saw evidence on the wards' 'dashboards' to confirm most staff were up to date.

Most staff told us they had regular supervision. However, nursing staff on ward 2 told us supervision did not happen very often. A doctor on the ward said that although the nurses were quite competent, they felt they could be supervised more regularly. Healthcare assistants on various wards also told us they did not have regular one-to-ones.

Psychiatric intensive care units

Staff told us about evidence-based therapies used on the ward. We found several examples of evidence-based tools used to assess and monitor people's needs. National guidance, such as National Institute for Health and Care Excellence (NICE) guidelines, was used to inform practice.

Staff told us they attended regular reflective practice groups with the multi-disciplinary team and were able to access peer supervision. Some staff recognised that the ward had some work to do in this area but felt that there had been a positive cultural shift towards collaborative working.

We identified some concerns around key information being communicated among those responsible for people's care. For example, staff did not know whether one person was dependent on alcohol or whether they should observe them for withdrawal symptoms.

Staff told us about regular reflective meetings where they discussed as a team what they could improve and how they could learn from things that did not go well. Community meetings were also used in this way to gather feedback from people who used the service. We saw several examples of audits, mostly around safety.

Some staff had attended care planning training that was led by people who had used services. However, they had not received all the training they wanted because of limited resources. This included training in delivering psychosocial interventions. We were told a nurse consultant had been seconded onto the ward to develop a competency framework for nurses. This was positively and enthusiastically received by staff.

Long stay/forensic/secure services

There was some good practice that took place in accordance with national guidelines, benchmarking and best practice.

We saw evidence of collaborative multi-agency working and people had access to a range of therapies that they appreciated.

Staff received mandatory training, as well as more service-specific training. However, this was not captured at ward level or by the trust, so it was unclear how they assured themselves that staff were appropriately trained to meet people's needs.

The medium and low secure wards of Springfield Hospital were members of the Quality Network for Forensic Mental Health Services. The most recent audit was carried out in November 2013, where the services achieved a score of 75%, and we saw an action plan developed for areas where the service needed to improve.

Each ward had a dedicated team of professionals which included nurses, a consultant psychiatrist, psychologist, social worker and occupational therapist. In the ward round reviews and Care Programme Approach meetings we saw that each discipline was represented and contributed to the support people needed.

We saw records to demonstrate that staff received regular individual and group supervision in their work, and an annual appraisal. Staff said they felt well supported in their work and that the managers within the service were approachable.

Child and adolescent mental health services

National best practice guidance was used to establish the models of care used across the specialist child and adolescent mental health services (CAMHS).

The deaf child, young person and family service was represented on the national care pathway group, which discussed the use of NICE guidelines. This group worked with NICE to adapt existing guidelines to meet the needs of deaf children and young people.

The specialist deaf CAMHS used the Children's Global Assessment Scale and the Health of the Nation Outcome Scale for Children and Adolescents to review the effectiveness of their service and monitor the progress children and young people make while using the service.

Corner House had recently been awarded a Quality award and the Signature award. The service was nominated for both awards by the children and young people, and their families.

The Aquarius unit had started to analyse their outcome data and were in the process of registering with the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS to join their routine outcome measurement service and compare performance nationally.

The deaf child, young person and family service worked closely with the schools in London as that was where most of their referrals came from. As well as supporting and treating the child, the team worked with the teachers to provide them with advice on how to support the child in the classroom.

Summary of findings

Services for older people

We spoke with nursing and medical staff who understood clinical guidelines well; for example, NICE guidelines on the use of psychotropic medication for people with dementia.

Staff told us about the systems they use to report incidents on the ward. We looked at records to see how incidents, such as falls which resulted in harm, were recorded. They were not consistently recorded.

Medical staff on the ward also worked in community mental health teams and provided medical input to the respective specialist home treatment teams. These teams worked with those who had behaviours which challenged the services providing care to them and memory services.

We saw that most staff had completed their mandatory training. Staff told us they had not received specific training related to dementia, and if they wanted specific training in this area, they had to look for it themselves.

Specialist eating disorder services

People's care and treatment reflected relevant research and guidance. Goals around restoring people's weight were individually planned and agreed with the person following NICE guidelines.

There was a good pathway of care for the most physically unwell people using the service, which involved liaison and partnership working with the local acute hospital. Staff followed ‘Management of really sick patients with anorexia nervosa’ (MARSIPAN) and ‘Management of really sick patients with anorexia nervosa under 18’ (junior MARSIPAN) national guidance to ensure high standards of physical healthcare.

We saw evidence of effective multi-disciplinary team working. People who use the service had access to nursing and medical staff as well as psychologists, psychotherapists, occupational therapists, social workers, a dietitian and a family therapist. We saw that care plans included advice and input from different professionals involved in people's care. People who used the service and carers told us that they were supported by a number of different professionals on the wards.

We were shown the 'clinical dashboard system' used to monitor clinical and workforce performance measures, including current staff compliance with statutory and mandatory training requirements.

Avalon ward had conducted a self-assessment of the ward against the Royal College of Psychiatrists' Quality Network for Eating Disorders pilot standards in November 2013. The assessment showed an overall compliance with expected standards of 97% and highlighted where improvements could, and were, being made.

Nurses were trained how to provide nasogastric feeding safely and the competence of nurses was tested to ensure they were able to place nasogastric feeding tubes correctly. Additional specialist training and discussion of complex cases were provided during the overlap period between shifts.

Other specialist services

We were told that some staff had additional qualifications in training such as Cognitive Behavioural Therapy (CBT) and psychosocial interventions. They also had a peer supervision session most weeks which is run by an external facilitator.

All staff we spoke with told us they had access to regular mandatory training. The manager told us all staff on the wards were up to date with their mandatory training.

Summary of findings

Are services caring?

Mental Health Act responsibilities

People using the service were aware of their rights. We found that individuals were being informed of their rights under the Mental Health Act 1983 and care records reviewed showed that they were regularly reminded of their rights by staff. There was good availability across wards of independent mental health advocates (IMHAs) and information was displayed throughout the hospital for people on how to access an advocate.

The majority of people said they were aware of their care plan and said they had been involved in its development.

Acute admission wards

Most patients were positive about the staff and the care they had received.

Records we checked on wards contained evidence of care planning and patients confirmed they were given a copy of their care plans. However, some patients felt they had not contributed to the care plans and were not always given an updated copy after reviews.

We were told patients had access to advocacy services and all patients we spoke with were aware of these services.

We noted that staff on all wards did not have a good understanding of the Mental Capacity Act.

Staff on all wards told us team meetings occurred weekly. They said they discussed patients' care packages.

We were told that community meetings are held weekly on the wards we visited and saw notes from some of these meetings. The agenda included activities, hygiene on the ward and health and safety of patients.

Most staff had a good understanding of the needs of the patients on the wards.

We observed staff treating patients with dignity throughout our visit. Patients said that staff respect their privacy and dignity.

Care plan review meetings and one-to-ones were held in designated rooms to ensure people's privacy was maintained.

All staff we spoke with told us they had been trained to use restraint. However, they said it was only used as a last resource.

Psychiatric intensive care units

We saw examples of how the ward worked with the local community to meet people's needs, such as planning to engage Afro-Caribbean hairdressers for people who required the service.

Progress notes were very detailed and clear, giving a lot of information about people's care and progress towards recovery.

There was evidence of collaborative work with adolescent services in preparation for transferring a person under the age of 18 who was using the service.

The ward held regular community meetings for people who used the service to express their views.

Long stay/forensic/secure services

People generally felt respected by the staff and listened to. People felt they received the support they needed from the therapies services.

We asked people who use the service if they felt involved in their care and decisions about treatment.

We saw that people's needs had been assessed and care plans developed that detailed their treatment and support needed.

Summary of findings

During our inspection we saw that staff communicated with people who use the service in a calm and professional way.

We saw that the therapies programme enabled people to get involved in activities that interested them and supported their recovery.

People said that they generally felt their privacy and dignity was respected by staff and the other people who use the service.

Child and adolescent mental health services

Young people across all services were aware of their care plan, and had either been involved in the development of it or were happy for the staff to develop it for them.

The staff working within the services for deaf children were required to access British Sign Language (BSL) training to help them communicate and support the children and young people accessing the service. The majority of staff working in the deaf child, young person and family service were at Level three, showing a high competency in BSL.

Each young person at the Aquarius unit and on Corner house had their own bedroom.

People described that 'Prone restraint' was being used on Corner House and the Aquarius unit. The trust has provided additional evidence that the term was used incorrectly to to describe other forms of restraint.

Services for older people

We saw that people who used the service and staff interacted together positively, and that staff responded to people with patience, kindness and ensured that they were treated with dignity.

We saw that people were asked about their preferences for activities and that when people did not wish to engage in activities or were not able to, they were offered one-to-one time with staff.

We looked at care plans and saw that they lacked personal detail and information, particularly biographical information.

We saw that there was a “You said, We did” board on the ward which indicated areas where the staff on the ward had taken action to change the care on the basis of feedback.

Most people told us they were treated with dignity and respect by staff on the ward. We saw that staff ensured that people’s privacy was respected when providing personal care to people by ensuring they knocked on people’s doors before entering rooms and kept the doors closed when delivering personal care.

Specialist eating disorder services

People told us they felt respected and involved in making decisions about their care. Assessments were made in respect of a person's capacity to make specific decisions.

We observed a ward round and saw that people using the service were treated with consideration and respect. They were included in a review of their care plans and their views were recorded.

People who use the service told us they felt well informed about their treatment. They felt able to ask questions about their care and information was provided in a way they understood. Independent advocacy services were available to people.

People's needs were assessed and care was delivered in line with their individual care plans.

Care plans were detailed and included the views and comments of people who use the service. People told us they were involved in developing their care plans and they were reviewed and updated regularly. People gave examples of how their religious and other individual needs were met.

Summary of findings

All staff we spoke with reported that the quality of food was poor and unappetising. People on both wards were required to eat one-and-a-half standard sized hospital meals at each meal time in order to obtain sufficient nutrition.

Other specialist services

We were told that some staff had additional qualifications in training such as Cognitive Behavioural Therapy (CBT) and psychosocial interventions. They also had a peer supervision session most weeks which is run by an external facilitator.

The care and treatment of people with Obsessive Compulsive Disorders does reflect relevant research and guidance.

All staff we spoke with told us they had access to regular mandatory training. The manager confirmed that all staff on the wards were up to date with their mandatory training.

Are services responsive to people's needs?

Mental Health Act responsibilities

People using the service were being involved in the day-to-day running and development of the wards through regular patient forums and community meetings.

We saw evidence of discharge planning on the wards visited. Plans to discharge the patient or move them towards less secure environments were included as part of the care planning process.

Acute admission wards

All patients knew how to make a complaint and most said if they had a complaint they would probably go to their ward manager or allocated nurse in the first instance. People gave us examples of complaints they had made.

Staff on the wards told us they encourage patients, family and friends to give feedback via the 'real time' feedback system. We saw evidence that patients had used this to make comments.

On one ward we were told patients were sent a questionnaire about what activities they want. Patients told us staff listened to what they said about activities and as a result they were offered more choice.

The trust employed staff with sign language skills to communicate with people with who were hearing impaired.

Some patients told us some staff did not respect their cultural needs and that no staff reflected their ethnic background. We noted that, while staff teams on all wards were diverse, they did not reflect the ethnic background of some of their patients.

We were told complaints were recorded by the team managers and forwarded to the trust's complaints team. They would then investigate and respond directly to the complainant and send a copy to the ward managers.

Psychiatric intensive care units

We saw examples of how the ward worked with the local community to meet people's needs, such as planning to engage Afro-Caribbean hairdressers for people who required the service.

Progress notes were very detailed and clear, giving a lot of information about people's care and progress towards recovery.

There was evidence of collaborative work with adolescent services in preparation for transferring a person under the age of 18 who was using the service.

The ward held regular community meetings for people who used the service to express their views. Minutes from the meetings showed that actions were agreed where people raised concerns. We saw "You Said, We Did" boards that showed how the ward had responded to people's concerns, complaints and requests.

Summary of findings

Long stay/forensic/secure services

There was not clear pathways of care need or purpose for each ward, so people were not always in the right environment for their specific needs.

People's diversity needs were addressed by the service and care plans implemented to support these, where appropriate.

Complaints were investigated and responded to appropriately.

During our inspection we identified some positive examples of staff responding to people's needs and increasing the support for a person where required.

Staff told us that if people's first language was not English then they were encouraged to bring a relative to meetings to translate for them, or an interpreter could be arranged by the ward.

We found that the service supported people with learning disabilities through the use of a wide range of easy read documents and posters that covered different topics, such as food, activities and occupation therapy information.

The care records contained evidence of how the service worked with different agencies to support people with their needs. This included the Ministry of Justice, the Multi Agency Public Protection Authority (MAPPA) and the prison service, as well as the forensic mental health community team.

We looked at the records of some complaints received and the correspondence relating to these. We found that complaints were taken seriously and responded to promptly. The complainant was provided with written information about the outcome of their complaint, and given contact details of other bodies they could raise a complaint with if they were dissatisfied with the outcome of the complaint.

Child and adolescent mental health services

The deaf child, young person and family service remained involved during a young person's admission to an inpatient unit and were involved in assessing when the young person could be discharged and suitably supported in the community.

There had been difficulties on the Aquarius unit with delayed discharges because of problems with accessing funding for social care placements. The interaction with social care services varied across the five London boroughs.

The community and inpatient services for deaf children and young people worked closely to meet the needs of people using the service. The community service remained involved in a person's care while they accessed inpatient services to keep updated on their progress and provide consistency in care when they were discharged back to the community. The community services worked closely with schools, colleges and the child or young person's GP to ensure they had the necessary information to support the young person when they were discharged back to the GP's care.

The trust's complaints process was on display and accessible to children and young people at each of the service's we visited. The trust's complaints process had recently changed and now all complaints (formal and informal) were reported to the trust's complaint's department.

Services for older people

We asked staff how they ensured that people's cultural and religious needs were met on the ward. We also asked people who used the service if they felt their needs were met in terms of culture, language, religion and sexuality. Most people told us they were treated with respect by the ward staff.

Staff told us the ward had a chaplain available to meet the spiritual needs of people who used the service. Staff told us that they could book interpreters when people who did not speak English were on the ward and we saw that the staff had booked an interpreter for a ward round meeting.

The service had not received recent complaints, although 77% of people who used the service provided feedback on it.

Specialist eating disorder services
The wards provided a national service to people with eating disorders and often admitted people whose needs could not be met in their own local area. Most people had undergone treatment in their local areas before being considered for admission to the service.

Staff on Wisteria ward, which was a national service, identified some difficulties in the care pathway and in ensuring a smooth discharge for young people. They told us that many intensive outpatient services had closed recently which made it difficult to ensure young people received the services they needed when discharged.

There were good links with local adult eating disorders outpatient and day hospital services.

There was a system in place to learn from any complaints made. People who used the service told us that they knew how to raise concerns and make a complaint. They could raise concerns in community meetings and this was usually effective.

The trust had not responded promptly to concerns raised by staff about the quality of food provided to people who used the eating disorders service. People on both wards were required to eat one-and-a-half standard hospital meals at each meal time in order to obtain sufficient nutrition.

Staff had raised concerns with senior managers in the trust about the lack of appropriate space in which to nasogastric feed young people on Wisteria ward, when this was necessary. Young people continued to receive nasogastric feeding in their bedrooms, the ward lounge or the occupational therapy kitchen, which did not ensure their privacy and dignity were respected.

Other specialist services
The wards provided a national service to people with obsessive compulsive disorders and all people admitted were people whose needs could not be met in their own local area. Most people had undergone treatment in their local areas before being considered for admission to the service. Many people had complex needs with additional mental health needs.

Seacole ward, which is a national service, identified a care pathway which assisted with discharge planning.

The ward held regular community meetings for people who used the service to express their views. Minutes from the meetings, which were clearly displayed on the ward noticeboard, showed that actions were agreed where people raised concerns.

We were told that there is no advocacy provision for this ward as it was a national service; however, patients did not know how to access it from their local area.

Staff knew how to tell patients about making complaints and they felt that there was a system in place to allow learning from these.

Are services well-led?

Mental Health Act Responsibilities
A framework for monitoring the provider's duties under the Mental Health Act 1983 was in place at the hospital. A Mental health Act Manager and a team of administrators were responsible for ensuring compliance with the Act.

We saw that a clear process was in place to scrutinise Mental Health Act statutory paperwork to avoid unlawful detentions with regular audits taking place. 'Dashboards' were available, providing near to real time information about the numbers and types of detentions.

Summary of findings

A Mental Health Law Governance Group met quarterly to monitor the trust's performance in exercising its responsibilities under the Mental Health Act and produced a report annually for the Board.

The Associate Hospital Managers quarterly meeting was in place chaired by the non-executive director with lead responsibility for this function. The lead associate hospital manager and the Mental Health Act manager were members of the trust Mental Health Law Governance Group that had responsibility for the monitoring and assurance around the discharge of powers. The steering group of Associate Hospital Managers undertook sample audits of hearing reports and we noted good practice around ensuring hearings were person centred.

Acute Admission Wards
Staff on all wards told us they felt their managers were knowledgeable, supportive and approachable. We found that most wards' managers were aware of the support needs of both staff and patients.

Most staff felt disconnected from the senior managers at the trust and could not comment on whether they felt the trust was well-led. One ward manager told us the trust's chief executive had visited their ward a few times and they felt they were generally leading the trust in the right direction.

Some patients told us they felt the real-time feedback was a good way of talking to the senior managers. However, most said they had not met any senior managers from the trust. They felt they could always feedback to ward managers.

Psychiatric intensive care units and health-based places of safety
Staff felt there was an open culture on the ward and small problems could easily be raised and resolved. They appreciated this openness and honesty from managers. They said there was a vision for them to work towards and were able to relate this to the vision and values of the wider organisation.

We spoke to senior staff, who had a clear vision of what a good PICU should look like.

Staff said they were confident to raise any concerns they had and knew how to take issues elsewhere in the organisation if they were not resolved on the ward. However, they had not had to do this and found their managers supportive. Staff said they all got the chance to have their say.

Staff told us they were unsettled by changes to shift patterns but that the changes had been well managed at ward level. Senior staff praised the ward staff for coping very well under difficult circumstances.

Staff felt that leadership was visible and managers were approachable, including senior managers. Staff were able to access regular supervision. The ward manager gave several examples of changes they had made where problems had been identified.

Long stay/forensic./secure services
At service level there was effective leadership and some innovative practice that took place.

There were systems for the service to capture information and report this to senior managers within the trust. However, a few of the staff we spoke with did not feel that senior managers communicated with them, or cascaded information appropriately about changes that affected them.

There was a lack of engagement by senior managers with the people who use the forensic services, and there were limited opportunities where people could provide feedback about the service.

The forensic services are members of the Quality Network for Forensic Mental Health Services (QNFMHS), which is a combination of self audit and peer review of services. In November 2013 the Royal College of Psychiatrists carried out a visit in accordance with the standards of the QNFMHS, to the low and medium secure units. By being part of QNFMHS they are able to see how they compare against others similar types of wards nationally.

We saw that people could raise issues through the community meetings on each ward, and the recovery meeting which was held within the Shaftesbury Clinic, with a representative from each ward attending this.

We were also shown the 'Realtime' feedback tablet positioned in the reception area of Shaftesbury Clinic, so that people could answer a short number of questions. However, we found this was only available to people who were able to leave the ward, with no alternative for people who remained on the wards.

Child and adolescent mental health services

Governance arrangements were in place to monitor the quality of service provision within the specialist CAMH services. The Specialist CAMHS governance group met monthly and included representation from the Tier 4 and specialist CAMH services, as well as representation from the local community teams and representation from each professional group.

There was a programme of audits undertaken in response to identified areas of concern across the trust and also to monitor the care and treatment provided to young people at the Aquarius unit. The audits undertaken included: monitoring consent and capacity arrangements, monitoring completion of physical health assessments including Venous Thromboenbolism (VTE) risk assessments, and adherence to the Care Programme Approach (CPA).

Weekly business meetings were held for the young people to feedback about the service. These included obtaining their thoughts and opinions on the food, the environment, any concerns regarding the staff supporting them and to get their input into the activities offered on and off the unit.

A parents' support group was set up to provide additional peer support to parents who had children you required treatment from the Aquarius unit or All Ages Occupational Therapy.

'Listening into action' was introduced as a means to engage staff throughout the trust. As part of this initiative the staff on Aquarius unit were not using the trust's electronic patient records system and were developing the young people's care plans, crisis and contingency plans on paper. This was because the care planning template on the electronic records is too complicated and not meaningful to young people and their families.

A virtual CAMHS directorate had been established to review the CAMH services across the trust. This included reviewing national services, local services and links with out-of-area placements. The directorate was going through a transition with a focus on care pathways and referrals.

The majority of staff were aware of the leadership structure in place for specialist CAMH services within the trust. This included operational management, support through the line management structure, and clinical support from the head of nursing and the CAMHS clinical lead. However, some staff were unclear of the operational leadership structure above the operational manager.

Staff reported that the chief executive officer was approachable and accessible, and there was clear communication and information from themselves and the medical director.

Services for older people

The ward manager told us they attended a monthly ward manager meeting where broader governance issues were discussed. Staff told us that the director of nursing was accessible and they frequently met to ensure that issues which needed to be discussed could be raised. Staff told us that they felt supported by their managers and able to raise concerns.

The ward had regular community meetings where issues which were raised by people who use the service could be addressed. People were consulted about the service and their feedback was sought and this was used to improve and develop the service.

Summary of findings

Staff told us they felt that engagement with the senior management had improved with the new chief executive and the change in the executive level leadership. They told us the modern matron and nurse consultant were visible and approachable.

Most staff told us they felt supported at the local level and felt proud to work for the provider. However, some staff told us they did not feel older people's services were a priority to the organisation as a whole and sometimes they did not feel that the services in this area had a strong voice within the organisation as a whole.

Specialist Eating Disorder Services

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Staff from all disciplines told us they considered the trust senior management did not fully understand the needs and complexity of the eating disorders service. They said the trust wanted the service to fit into standard trust systems some of which failed to acknowledge the complex needs of people with eating disorders.

The service regularly asked people, carers and staff for their opinions about the service provided. Several people told us they were encouraged to give feedback either via written surveys or a real-time feedback device, located on the wards.

The culture on the wards was open and encouraged staff to reflect upon their practice. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by the multi-disciplinary team and line managers.

Other specialist Services

Staff felt there were clear governance structures and an open culture on the ward, problems were seen to be resolved easily.

We spoke to the consultant psychiatrist, Cognitive Behavioural Therapy (CBT) therapists and nursing staff who all felt that the ward was well run, which enabled and supported them to provide this national service.

Patients had a regular community meeting which patients chaired; these minutes were accessible and clearly showed actions that came out of the meetings.

The handover is multi-disciplinary and the therapist often joined these meetings. Nurses also with the patients permission sit in the CBT sessions to allow for greater sharing of the therapeutic work.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

We reviewed the care records for 14 people using the service across 10 wards at Springfield University Hospital. All of the patients reviewed were legally detained under sections of the Mental Health Act 1983.

We saw that people were informed of their rights when they were admitted and then reminded of these rights throughout their period of detention.

For people who were detained and required treatment under the special rules in the Mental Health Act, these were in place to ensure that treatment was properly and legally authorised.

There were arrangements in place to ensure that leave under section 17 of the Mental Health Act was authorised and reviewed appropriately.

The trust has in place a Mental Health Act framework for monitoring its duties under the Mental Health Act 1983.

We found that the staff and managers were providing services to people under the Mental Health Act in safe, caring, effective, well-led and responsive ways. However, we felt that improvements were needed to ensure that appropriate action was completed following our Mental Health Act monitoring visits.

Acute admission wards

The trust used a computerised Electronic notes system (EPN). Records we checked on wards contained evidence of care planning and patients confirmed they were given a copy of their care plans. However, some patients felt they had not contributed to the care plans and were not always given an updated copy after reviews.

We saw patients were supported with comprehensive risk management plans and offered a multi-disciplinary assessment at an early stage. Both risks to themselves and others were assessed.

Staff said they would be confident enough to report safeguarding issues. They understood the types of behaviors that could trigger on incident and they described effective behaviour management approaches to de-escalate and manage potential or presented conflict.

Ward managers told us some staff had additional therapeutic qualifications, such as cognitive behavior therapy (CBT) for psychosis and solution focused therapy skills. Staff on some wards attended a ‘reflective practice’ session every week which was facilitated by the ward consultant.

We observed the daily handover meeting attended by the senior nurse, ward doctor, support volunteer and the trainee GP. They took account of people’s physical health needs as well as mental health.

Staff on all wards told us they felt their managers were knowledgeable, supportive and approachable. We found that most wards' managers were aware of the support needs of both staff and patients.

Psychiatric intensive care units and health-based places of safety

The long stay/forensic/secure services of South West London and St George's Mental Health NHS Trust are based on the site of Springfield Hospital. The Shaftesbury Clinic contains three medium secure wards and one low secure ward. Three of the wards are situated within a designated medium secure unit, while the other ward is located within the main hospital buidings. There is a long stay rehabilitation ward within the hospital as well as three low support hostels within the hospital grounds for more independent living.

We inspected all of the three medium secure wards, and the low secure ward. The four wards are Ruby, Turner, Halswell wards which are medium secure and Hume ward which is a low secure ward.

Summary of findings

Ruby ward is a 10-bed ward for female patients only. Turner ward is an 18-bed assessment and treatment ward for males, which included five beds designated for the support of long-term medium secure patients. Halswell ward is a 16-bed male only ward providing admissions assessments and rehabilitation to patients. Hume ward is a 16-bed male only low secure unit. It is located outside of, but is part of, the Shaftesbury Clinic of Springfield Hospital. The ward provides assessment, treatment and rehabilitation to people, with the aim to move people through their care pathway to a less restrictive/ secure environment.

We inspected Phoenix ward which is a long stay rehabilitation ward based within the main hospital buildings. The ward is an 18-bed mix gender (takes five females) low secure ward. We also inspected the Forensic Outreach Service which supports people living in the community.

Long stay/forensic/secure services

We found a number of positive areas to the service that people received from the long stay/ forensic/ secure services. People generally felt well respected by the staff and felt the staff understood their needs.

People appreciated the wide range of therapies available to them, and felt that it supported their recovery.

There was some good practice that took place in accordance with national guidelines and best practice.

People felt safe on the wards and felt the staff listened to them. Complaints were investigated and responded to promptly.

There were a number of areas where the service needs to make improvements. This includes improving security and the risks within the environment.

Clear pathways of care need to be implemented, along with a clearly defined purpose for each ward, so that people are in the most appropriate environment for their needs.

People need to be more involved in decisions about their care and treatment, particularly in meetings, such as Care Programme Approach meetings and ward round reviews.

Child and adolescent mental health services

The specialist child and adolescent mental health services (CAMHS) at South West London and St George's supported children and young people with complex health needs and often at times of crisis. The staff spoken with were mindful to maintain a person's safety and were consistently reviewing the risks presented to the young person to themselves, others or the environment. There were processes in place regarding risk management and learning from incidents.

The services were following national guidelines to provide recommended treatment to children and young people. The treatment provided was tailored according to individual needs. The services monitored the quality and effectiveness of their service through the completion of routine outcome measures. The staff at the service were competent and highly skilled; however, there were concerns regarding the quality of agency staff.

Children and young people spoken with felt involved in decisions about their care. They were well informed about their treatment options and were invited to regular review meetings to discuss their progress. The majority of young people told us they were able to speak to staff and received the support they required.

There was a multi-disciplinary and multi-agency approach towards transitions, ensuring that young people's needs were met in a timely manner and there was consistency in the care they received. However, there were some concerns raised regarding the process of referral from deaf CAMHS to deaf adult mental health services.

Summary of findings

At a service level, staff felt well engaged and informed about the service and felt the teams were well-led. However, there were concerns that staff were not as engaged as they could be regarding the development of the CAMHS directorate and the tier 3 transformation programme. There had been recent changes regarding middle management and there was some confusion regarding people's roles and responsibilities.

Services for older people

We found that people who used the service were provided with care that was informed by staff who knew and understood their roles. Staff had a good understanding of safeguarding processes. However, we found that some records relating to falls and pressure ulcer management were not collated consistently and had not necessarily led to ongoing learning and understanding of the causes. This meant that there was a risk that incidents might not be addressed comprehensively.

Staff had a good understanding of relevant clinical guidelines such as National Institute for Health and Care Excellence guidance, which was embedded in practice on the ward. The ward conducted some internal audits of their performance and had benchmarked some areas, such as falls, against other trust services; however it was not clear that this lead to an improvement in practice.

Most of the feedback from people who used service and their family members was positive. We observed kind, thoughtful and respectful care during our visit. We saw that staff knew the people on the ward well and were developing systems, like the personal profile, that ensured people would have a more personalised care. However, we saw that there was little involvement from people in their care plans and information about people's history and biography was not always accessible to staff providing them with care. This meant that there was a risk that care would not be adapted to individuals.

We saw that staff from different disciplines worked together to provide appropriate care and support to people who used the service and that the staff had an understanding of meeting people's needs relating to their culture, language, religion, sexuality and gender.

Most staff on the ward told us they felt supported by their management team and that they were able to raise concerns if they had them. We did not see evidence that supervision was taking place consistently; however staff told us they could approach their managers informally if necessary.

Specialist eating disorders services

Staff on both wards had good understanding of safeguarding processes and were able to protect people at risk of abuse. Wisteria ward was a safe and secure unit where individual and environmental risks to the young people were managed effectively. There were sufficient staff to care for young people on the ward. On Avalon ward, however, although most environmental risks were being managed, we found one area where ligature risks, although identified, were not being managed. We noted from analysis of staffing rotas on Avalon ward that although the numbers of staff on duty were consistent with the trust's assessment of staffing needs, there were many occasions when there were fewer than the required three qualified staff on duty.

The care and treatment of people with eating disorders reflected relevant research and guidance. There was a good pathway of care for the most physically unwell people using the service which involved liaison and partnership working with the local acute hospital and staff followed nationally agreed guidance. Wisteria ward was accredited nationally through the Royal College of Psychiatrists Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC). A recent detailed evaluation of the service showed that there were overall improvements between assessment and discharge in a range of measures indicating the effectiveness of the service. A self-assessment of Avalon ward against the Royal College of Psychiatrists Quality Network for Eating Disorders pilot standards in November 2013 identified a high

degree of compliance with expected standards. Permanent staff were skilled in, and knowledgeable about, eating disorders and received support and supervision which enabled the delivery of safe and effective care. However, both staff and people who use the service recognised that many bank and agency staff lacked knowledge and experience of eating disorders.

Most feedback from people who use the service about the care and treatment provided was positive. People were involved in developing their care plans and well informed about their treatment. They felt able to ask questions about their care and information was provided in a way they understood. The service used a recovery approach to working with people and recovery goals were clearly stated in people's care plans. We observed caring and compassionate interactions between staff and people who use the service. Staff were non-judgemental in their approach and treated people respectfully. However, the occasional use of inappropriate rooms for nasogastric feeding failed to maintain young people's privacy and dignity on Wisteria ward at all times. The provision of meals, although meeting people's nutritional needs, failed to take account of the specific needs of people, for whom eating sufficient amounts of nutritious food was already particularly difficult.

The wards provided a national service to people with eating disorders and often admitted people whose needs could not be met in their own local area. Many people had complex needs with additional mental health needs. There was an effective system in place to manage and learn from complaints. People knew how they could make complaints and raise concerns and said they were listened to by staff. However, staff on the wards had raised concerns about the quality of food and lack of a treatment room of an appropriate size on Wisteria ward and these concerns had yet to be addressed by the trust.

We found that Wisteria ward, in particular, was well-led. The ward manager worked proactively within trust's governance systems to influence and bring about changes that benefitted young people with eating disorders. People who use the service were encouraged to give feedback about their care and treatment and had ways of influencing how it was provided. The culture on the wards was open and encouraged staff to reflect upon their practice. However, staff from all disciplines told us they considered the trust's senior management did not fully understand the needs and complexity of the eating disorders service. Clinicians in particular did not feel listened to by senior trust manager and experienced a disconnection from the trust board.

Other specialist services inspected

We spoke with staff, including doctors, nurses, managers, healthcare assistants and therapists. We spoke with people who used the service. We observed a handover between shifts as well as interactions between staff and people who use the service. We looked at care and treatment records.

On our initial visit we spoke to 10 patients in a group setting, who all felt that the ward did not offer them the treatment and care that they needed, they felt it was not following national guidelines and that they were not involved in their care. On this occasion, we were unable to speak to enough staff to support this information, so we therefore decided to make a further unannounced visit as part of our comprehensive inspection.

We found that Seacole ward was an open ward and all patients were informal. We were told that there were sufficient staff to care for the patients on the ward. We noted from analysis of staffing rotas on Seacole ward the numbers of staff on duty were consistent with the trust's assessment of staffing needs.

The care and treatment of people with Obsessive Compulsive Disorders does reflect relevant research and guidance and this was confirmed by the Consultant psychiatrist, nursing team and also by the inspection team

The trust used a computerised database system called 'RiO'. Records we checked on wards contained evidence of care planning and patients confirmed they were given a copy of care plans.

Summary of findings

We saw patients were supported with comprehensive multi-disciplinary risk management plans. Risks to themselves and others were assessed; these were updated at regular intervals and formulations were undertaken by the Cognitive Behavioural Therapists and these were available in patients' notes.

Feedback from people who use the service about the care and treatment provided was mixed. People were aware of their care plans, however felt less included in their production and reviewing of these. They were all aware of their daily regime and their anxiety ratings plan. People did not feel included in their ward rounds and felt that this was a process they were rarely involved in. When we spoke to staff they confirmed that patients are not always present or invited to be present when discussions were taking place about their care.

Staff felt that people understood their care plans and were involved in them; however there was acknowledgement that, due to the nature of their illness, this information is not always absorbed by them.

The staff informed us that staff have the opportunity to receive supervision and peer support which are run by external parties.

Summary of findings

What people who use the location say

We left comment cards at Springfield University Hospital but none of these were completed during our time on site. The comments from people using the service have been included throughout the report.

Areas for improvement

Action the provider MUST take to improve

- Ensure that where required comprehensive risk management plans are in place for people using the service where a risk to themselves or others had been identified.
- Ensure that suitable storage, recording and monitoring systems are in place to ensure medications are handled safely and appropriately.
- The Aquarius unit was unable to maintain appropriate gender segregation in line with the recommended guidance. There was one bedroom area and females had to pass through the male corridor to access their rooms. The males had to pass through the female corridor to access the unit's garden area. The trust must ensure that these arrangement comply with Delivering same sex accommodation in mental health and learning disability service: Briefing from the NHS Confederation (January 2010).

Action the provider SHOULD take to improve

- Ensure that specialist training is provided to all staff working in older persons service areas of the trust.
- Ensure that those services that are not same sex are monitored to ensure that the privacy and dignity of the people using service is maintained at all times.
- Ensure that the environment where nasogastric feeding is required is reviewed to ensure that the process is done in a suitable environment that is clean and hygienic and maintains the privacy and dignity of the individual.
- Develop the electronic patient notes system to ensure that it supports and evidences true patient involvement in the planning of their care.
- Consider the food supplied to the eating disorder service to ensure that the nutritional content is delivered in a portion size that meets the needs of the people using the service.

Good practice

Our inspection team highlighted the following areas of good practice:

- There were good systems in place for receiving detention papers when patients were first admitted under the Mental Health Act and ensuring that individuals are explained and reminded of their rights throughout the period of their detention.
- Staff empowered patients and carers to be at the heart of planning their care and treatment.
- The staff demonstrated a good knowledge and awareness of local safeguarding and whistleblowing reporting procedures.
- We saw people using the service and staff interacting well together.
- We saw good involvement of each person in the planning and review of their care, and collaborative multi-disciplinary team working.

Care Quality Commission

Springfield University Hospital

Detailed Findings

Services we looked at:
Mental Health Act responsibilities; Acute admission wards; Psychiatric intensive care units and health-based places of safety; Long stay/forensic/secure services; Child and adolescent mental health services; Services for older people; Specialist eating disorder services; Other specialist services inspected

Our inspection team

Our inspection team was led by:

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

Team Leader: Nicholas Smith Care Quality Commission

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

Background to Springfield University Hospital

Springfield University Hospital is a location of South West London and St George's Mental Health NHS Trust. A range of mental health inpatient and outpatient services are provided at this location including acute, rehabilitation, older people, eating disorder and forensic services. The trust is responsible for providing all community and hospital based psychiatric services to the London Boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.

We visited the following wards at Springfield University Hospital as part of this inspection:

- Ward 1 - a 13 bed male PICU with a two bed Section 136 Suite facility for males and females.
- Ward 2 - a 18 bed acute admission ward for males and females.
- Ward 3 - an acute admission ward.
- Jupiter Ward - an acute admission ward for people from the Merton area.
- Bluebell ward - an admission ward for deaf adults.
- Jupiter Ward - an acute admission ward.
- Corner House - a six bed national specialist assessment and treatment unit for deaf children and adolescents, males and females aged eight to 18.
- Avalon - an 18 bedded unit including a five bedded high dependency intensive treatment facility for males and females suffering from eating disorders.
- Wisteria Ward - a 10 bedded unit for young people between the ages of 11 and 18 with severe eating disorders.
- Crocus Ward - a ward for elderly people with mental health illnesses.
- Halswell Ward - a 16 bed male medium secure ward.
- Hume Ward - a 16 bed male secure service.
- Phoenix Ward - a secure psychiatric rehabilitation ward.
- Ruby Ward - a 16 bed female medium secure ward.
- Turner Ward - a medium secure ward.
- Seacole Ward 0 an inpatient OCD service.
- Aquarius Unit - a service for young people aged 12 to 18 who have serious mental ill health.

Detailed Findings

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

We held a public listening event on the 10 February 2014 and also met with community groups on 7 and 12 March 2014. During our time on site we also met with individuals who asked to speak with the inspection team.

We carried out an announced visit between 17 and 21 March 2014. We undertook site visits at all the hospital locations. We inspected all the acute inpatient services and crisis teams for adults of working age and older people. We also visited all of the long stay/forensic/secure wards, child and adolescent mental health service (CAMHS) and all of the learning disability community teams. We also visited the specialist inpatient services and a sample of the community teams.

During the visit we held focus groups with a range of staff in the location, including nurses, doctors, therapists and allied health professionals. We talked with people who use services and staff from all areas of each location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences on the services received from the provider.

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

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

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

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

Mental Health Act responsibilities

Information about the service

Springfield University Hospital is a location of South West London and St George's Mental Health NHS Trust. A range of mental health inpatient and outpatient services are provided at this location including acute, rehabilitation, older people, eating disorder and forensic services. The trust is responsible for providing all the community and hospital based psychiatric services to the London Boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.

Summary of findings

We reviewed the care records for 14 people using the service across 10 wards at Springfield University Hospital. All of the patients reviewed were legally detained under sections of the Mental Health Act 1983.

We saw that people were informed of their rights when they were admitted and then reminded of these rights throughout their period of detention.

For people who were detained, and required treatment under the special rules in the Mental Health Act, these rules were in place to ensure that treatment was properly and legally authorised.

There were arrangements in place to ensure that leave under section 17 of the Mental Health Act was authorised and reviewed appropriately.

The trust has in place a Mental Health Act framework for monitoring its duties under the Mental Health Act 1983.

We found that the staff and managers were providing services to people under the Mental Health Act in safe, caring, effective, well-led and responsive ways. However, we felt that improvements were needed to ensure that appropriate action was completed following our Mental Health Act monitoring visits.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

Physical healthcare

We saw that physical health assessments had been carried out and reviewed for each person using the service. Access to healthcare was facilitated as required with out of hours cover provided.

Leave arrangements

Arrangements to ensure authorised leave were in place. A standardised system was used to authorise and record leave of absence under Section 17 of the Mental Health Act. Records demonstrated that leave was being appropriately recorded and included specified conditions where appropriate. The provider may find it useful to note that the leave form in use had no space to record the name of the Responsible Clinician (RC), only their signature. We additionally noted that the document only had space to allow escorted or unescorted leave with no space to show that people may be accompanied by family or friends.

Restrictive practices

Three instances of potentially restrictive practice however were found on two wards. One person who had been formally detained on Crocus Ward since October 2013 told us that they had been requesting to go home to collect their belongings since they had been admitted. There was no evidence in the records reviewed that this request had been fully considered and community leave granted for staff to facilitate this. Another individual on this ward, informally for the same period, told us that they felt imprisoned and were not aware that they could leave the hospital. People staying on Jupiter Ward told us that a swipe card system was in place to access the bedroom corridors and expressed frustration that they were not provided with these cards.

Risk assessments

Risk assessments were seen to be completed for people using the service. Care records we looked at demonstrated that individualised risk assessments were being documented, regularly reviewed and updated when needs or risks changed. Examples were seen in progress notes where staff had discussed risks with people using the service as part of actions required following their initial risk assessement.

Seclusion

We looked at the arrangements for seclusion which is the supervised confinement of a patient in a room, which may be locked. Its aim is to contain disturbed behaviour which is likely to cause harm to others. Environmental risks were found in the seclusion room in use on Ward 1. We observed a safety issue where a person using the service was able to stand and jump from a window ledge in this facility during our visit.

Are Mental Health Act responsibilities effective?

(for example, treatment is effective)

Detention papers

Detention papers were available for inspection on the provider's electronic information system. The majority of records reviewed showed that people were being legally detained under the Mental Health Act 1983, however two instances were noted during our inspection where individual section papers had expired on Aquarius Ward. The required certificates were found to be in place in relation to the administration of medication for detained patients.

Capacity and consent

Improvements were required around the assessment of individual capacity and consent. We found that there were gaps in staff understanding and application of the Mental Health Act and Mental Capacity Act 2005. Examples of entries seen included 'Lacks capacity to give informed consent to treatment', 'remaining on the ward under the Capacity Act in their best interest' and 'Lacks capacity in relation to the four point capacity test'. There was a lack of written evidence in progress notes about the discussions that had taken place with people, their response and the responsible clinicians judgement about what the person is unable to do in relation to the decision. The progress notes seen for one person stated they were unable to understand, retain, use/weigh up or communicate information relevant to treatment however no evidence was entered for any of the points tested.

Electro-Convulsive Therapy (ECT)

We looked at the arrangements in place around people receiving Electro-Convulsive Therapy (ECT) and found

Mental Health Act responsibilities

these to be satisfactory with the appropriate documentation maintained. It was noted that the waiting area could be made a more pleasant and relaxing environment for people to use prior to treatment.

Seclusions

The seclusion room in use on Ruby Ward was located adjacent to the office with observation carried out from a partitioned area within this main ward office. The privacy and dignity of people using the service could be compromised by this arrangement as any staff member or professional using the office would be able to look into the seclusion room. Dignity issues were also noted with the location of the other seclusion rooms on Shaftesbury Unit that as they were located off the wards so individuals would have to be taken there via communal corridors.

Privacy and dignity

We noted that there was no dedicated space for people staying on Wisteria Ward when receiving enteral feeding. This was being undertaken in shared or communal facilities which does not fully uphold the privacy and dignity of people using the service.

People using the service on Jupiter Ward spoke about not being able to see a consultant of their own gender and we were unable to identify a process for them to do this. Staff told us that they would have to ask the ward consultant but "they would probably not allow them to do this".

Are Mental Health Act responsibilities caring?

Rights under the Mental Health Act

People using the service who we spoke to were aware of their rights. We found that individuals were being informed of their rights under the Mental Health Act 1983 and care records reviewed showed that they were regularly reminded of their rights by staff. There was good availability across wards of Independent mental health advocates (IMHAs) and information was displayed throughout the hospital for people on how to access an advocate. We noted that the information displayed about how to contact the CQC was out of date on some wards. One instance was noted where out of date legal information was displayed on one ward.

Patients participation in care planning

The majority of people spoken to said they were aware of their care plan and said they had been involved in their development. Feedback however did vary between wards including people spoken to on Jupiter and Turner Wards telling us they were not feeling involved in the care planning process. Positive feedback was noted on Ruby, Hume and Aquarius Wards where people clearly had ownership of their care plan.

Are Mental Health Act responsibilities responsive to people's needs?
(for example, to feedback?)

People using the service were being involved in the day to day running and development of the wards through regular patient forums and community meetings. The practice of staff on Hume Ward in particular was commended by individuals saying they felt involved in the running of the service with meetings led by people using the service and actions followed through.

Feedback from people using forensic services was that activities were available but they would welcome more things to do, particularly at weekends, along with increased access to the gym.

Place of safety 136 suite

We visited the Section 136 Assessment facility which provide this facility across the five boroughs served by the Trust. Each of the two assessment suites was found to be environmentally suitable with practice adhering to the Code of Practice. Records showed evidence of pro-active discharge and crisis planning with a low inpatient admission rate for people using the service. Staff members raised issues around the availability of Eastern European interpreters and working with Police colleagues to introduce better contingency arrangements once the unit was full.

Discharge planning

We saw evidence of discharge planning on the wards visited. Plans to discharge the patient or move towards less secure environments were included as part of the care planning process. One person using the service told us about the recent meetings they had attended around

moving on to hostel accommodation. Other examples were noted of positive risk assessment with staff encouraging people to move on whilst providing support for them in doing this.

Patient involvement

People using the service were being involved in the day to day running and development of the wards through regular patient forums and community meetings. The practice of staff on Hume Ward in particular was commended by individuals saying they felt involved in the running of the service with meetings led by people using the service and actions followed through.

Activities

Feedback from people using forensic services was that activities were available but they would welcome more things to do particularly at weekends along with increased access to the gym.

Are Mental Health Act responsibilities well-led?

Mental Health Act framework and governance

A framework for monitoring the provider's duties under the Mental Health Act 1983 was in place at the hospital. A Mental Health Act manager and a team of administrators were responsible for ensuring compliance with the Act.

We saw that a clear process was in place to scrutinise Mental Health Act statutory paperwork to avoid unlawful detentions with regular audits taking place. Dashboards were available providing near to real time information about the numbers and types of detentions. Quarterly monitoring reports were completed detailing section activity for each borough and for specialist services. Performance around consent to treatment activity and defective section papers was also being monitored through these reports, with an annual summary report produced.

A Mental Health Law Governance Group met quarterly to monitor trust performance in exercising its responsibilities under the Mental Health Act and produced a report annually for the board. This group now reported quarterly to the trust Quality and Safety Committee (QSAC) and its terms of reference had recently been reviewed to ensure a more pro-active role in ensuring good practice.

The Associate Hospital Managers quarterly meeting was in place chaired by the non-executive director with lead responsibility for this function. The lead associate hospital manager and the Mental Health Act manager were members of the trust Mental Health Law Governance Group that had responsibility for the monitoring and assurance around the discharge of powers. The steering group of Associate Hospital Managers undertook sample audits of hearing reports and we noted good practice around ensuring hearings were person centred.

We noted however that the Scheme of Delegation setting out how the trust devolved responsibilities under the Mental Health Act had only recently been made available to staff members via the organisational intranet. We saw that this document would benefit from further review in terms of the detail provided. This had been approved by the trust board in February 2013.

Mental Health Act administration

We observed that Mental Health Act administration staff did not routinely spend time on wards with people using the service and the focus of their work was in the scrutiny of paperwork. Further consideration should be given to administrators having a regular presence on each ward providing information to people and staff. The information gathered through the dashboards could also be more pro-actively used to discuss practice with responsible clinicians again ensuring the focus was outward facing on people using the service.

Feedback from staff working in the Mental Health Act office was that they would welcome further training particularly around the Mental Capacity and Deprivation of Liberty Safeguards.

Acute admission wards

Information about the service

Wards 2, 3 and Jupiter are acute psychiatric units offering mental health care. For example an assessment and treatment service for males and females between the ages of 18 and 75 who suffer from depression, schizophrenia, first presentation psychosis, schizo-affective disorders and other mental disorders. Sleeping arrangements are single sex corridors and communal areas are provided to allow the opportunity for mixed gender interaction. Activities are offered throughout the week including clinical input within the multi-disciplinary team. They have 18, 20 and 23 beds respectively.

Bluebell ward is a 16 bed adult mixed sex, acute mental health ward, for people who are hearing impaired. All referrals are made through Deaf Adults Community Team (DAT).

Summary of findings

The trust used a computerised Electronic Notes System (EPN). Record’s we checked on wards contained evidence of care planning and patients confirmed they were given a copy of their care plans. However, some patients' felt they had not contributed to the care plans and were not always given an updated copy after reviews.

We saw patients' were supported with comprehensive risk management plans and offered a multi-disciplinary assessment at an early stage. Both risks to self and others were assessed.

Staff we spoke with said they would be confident enough to report safeguarding issues. They demonstrated an understanding of the types of behaviors that could trigger an incident and they described effective behavior management approaches to de-escalate and manage potential or presented conflict.

Ward managers told us some staff had additional therapeutic qualifications such as cognitive behavior therapy (CBT) for psychosis and solution focused therapy skills. Staff on some wards attended a ‘reflective practice’ session every week which was facilitated by the ward consultant.

We observed the daily handover meeting attended by the senior nurse, ward doctor, support volunteer and the trainee general practice doctor (GP). They took account of people’s physical health needs as well as mental health.

Staff on all wards told us they felt their managers were knowledgeable, supportive and approachable. We found that most wards managers were aware of the support needs of both staff and patients.

Acute admission wards

Are acute admission wards safe?

Learning from incidents

Staff we spoke with were aware of the trusts incident reporting systems. We were told staff involved would enter the details onto the system and these were then checked by the ward manager. They would then send the information to the trusts incident team. The managers told us, where necessary, immediate plans were put in place to reduce further similar incidents from reoccurring. We were told when serious incidents took place there was an immediate de-briefing with staff involved. Learning from incidents were discussed during team meetings which occurred either weekly or monthly. Records we checked on all wards contained detailed information about incidents.

Safeguarding

All staff we spoke to on the wards told us they had safeguarding training for children and vulnerable adults as part of their annual mandatory training, delivered by the trust. They were able to describe the different forms of abuse and how they would respond to any allegation of abuse and this was consistent with the local policy. Staff were aware of who the safeguarding leads for the wards and the trust were. Training records showed that 95% of staff received mandatory annual training.

All permanent staff that we spoke with said they would be confident enough to report safeguarding issues. They demonstrated an understanding of the types of behaviours that could trigger an incident and they described effective behaviour management approaches to de-escalate and manage potential or presented conflict.

We saw that where serious safeguarding allegations had been made the trust management had taken prompt action to address it.

Safe environment

The design and layout of Wards 2, 3 and Jupiter meant that staff had adequate visibility of people to enable safe practice. Most patients' we spoke with told us they felt safe on the wards. We saw that 'Stop Adult Abuse' posters were visible in ward corridors.

On Bluebell Ward however we noted that female patients had to pass through male areas in order to access other parts of the ward. We were told that a member of staff would be located in the cross over section throughout all shifts.

Restrictive practices

We were told that rapid tranquilisation, physical restraint and seclusion were only used as a last resort. On most wards the level of use of these interventions was low. However on one ward we saw they had been giving rapid tranquilisation following the restraint of a patient daily for the previous five days. Whilst incident reports had been completed for all the incidents we noted that some lacked information as to the amount of people involved in the restraint and the position in which the patient had been restrained.

Risk management

Risk assessments were carried out during patients' initial assessment and reviewed or updated during care plan review meetings or if people's needs had changed. On all wards we saw patients were supported with comprehensive risk management plans. Both risks to self and others were assessed.

All wards used a colour coded zoning rating to identify people's clinical risk.

People who used the service told us they had been consulted in the assessment of risk and were able to contribute during their care plan review meeting.

The ward managers told us they had access to a 'virtual risk team' made up of senior managers. They said they could call them in to help and/or advise on difficult risk situations.

Medication

We saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed, and showed people were getting their medicines when they needed them. On most wards there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. We saw that if people were detained under the mental health act, the appropriate authorities were in place for medicines to be administered to them. This meant people were receiving their medicines as prescribed.

Acute admission wards

We saw that medication was stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We noted that the temperature of the rooms in which medicines were stored was not monitored; therefore we could not be assured that these medicines were being stored at the correct temperature to remain fit for use.

Medicines, including controlled drugs, were stored securely; however, due to an incident with medicines at the trust during our inspection, we requested that the trust review the location of the medicines trolley.Supplies of medicines were obtained promptly. A stock of commonly used medicines was held on the wards to avoid delays in starting treatment.

One person was prescribed lithium, and we saw that a care plan was in place, a lithium information booklet had been supplied to the person, and appropriate blood monitoring had been carried out. Therefore arrangements were in place to administer medicines safely and provide information to people about their medicines.

Whistleblowing

Staff were aware of the trusts whistleblowing policy and they said they felt sufficiently confident to use the policy if they were concerned about people's safety.

Safe staffing levels

Most staff we spoke with on the wards told us they felt the level of staff and skills mix was adequate. However they also said they could always do with more staff. The manager on Wards 2 and 3 told us that on occasions they are able to book extra staff if the needs of the patients required it. For example high numbers of detained patients that required one to one support and observations.

The managers on all wards we visited told us they had two or three vacancies in their wards. They said they were in the process of recruiting for all permanent posts. We saw that these posts were all covered by agency staff.

Patients' we spoke with on all wards said they felt there was never enough staff. However no one we spoke with said they did not feel safe on the wards.

Are acute admission wards effective?
(for example, treatment is effective)

Use of clinical guidance and standards

We were told some staff on Ward 3 had additional therapeutic qualifications such as cognitive behavior therapy (CBT) for psychosis and solution focused therapy skills. Staff on this ward attended a 'reflective practice' session every week which was facilitated by the ward consultant.

We saw on Ward 2 people's physical health care needs were assessed using nationally agreed standards - National Early Warning Scores (NEWS).

Monitoring quality of care

The ward managers told us they completed a monthly monitoring tool called SIREN. They said they reported against staffing levels/mix, safeguarding, complaints, incidents, care plans and risk assessments.

The manager on Bluebell Ward told us the charge nurse was responsible for monthly monitoring and auditing of care plans, risk assessments, progress notes and adherence to the Mental Capacity Act (MCA).

Collaborative multi-disciplinary and multi-agency working for assessments, care planning and access to health services

On Ward 2 we saw good evidence that people were supported through a multi-disciplinary assessment carried out by ward staff. We observed the daily handover meeting attended by the senior nurse, ward doctor, support volunteer and the trainee general practice doctor (GP). They took account of people's physical health needs as well as mental health. The discussion included access to occupational therapy and considerations about people's weight, dental needs, smoking cessation and one patient's seriously high blood pressure. The consultant identified patients' who needed to have bloods taken, patients' on or ready for S17 leave and those fit for discharge. Risk management zones were also reviewed at this meeting.

Patients on Wards 2, 3 and Jupiter were referred to the wards by various Community Mental Health Teams (CMHT's). Patients' on Bluebell were referred through Deaf Adults Community Team (DAT). We saw that there were clear referral notes on all wards indicating patients' care

and support needs as well as identified risks. The managers of all wards told us they met with their relevant CMHT regularly. The managers of the CMHT's we spoke with confirmed this.

Staff on Bluebell Ward told us they felt that patients' physical health needs were not being met. They said there was no general practice doctor attached to the ward and the diabetic nurse had recently left and this post would not be recruited to.

Staff on Wards 3, Jupiter and Bluebell felt that patients' could benefit from dedicated psychological input. They said they could access a psychologist if they needed to, however there was no psychologist in their teams.

Are staff suitably qualified and competent

All staff we spoke with told us they had access to regular mandatory training. The managers told us all staff on the wards were up to date with their mandatory training. We saw evidence on the wards dashboards to confirm most staff were up to date.

On Ward 3 we saw that some staff had had access to specialist training such as personality disorder, CBT, and a health care assistant had been trained to take bloods.

Most staff told us they had regular supervision. However nursing staff on Ward 2 told us supervision did not happen very often. A doctor on the ward said whilst they felt the nurses were quite competent they felt they could be supervised more regularly. Health care assistants on various wards also told us they did not have regular one to ones.

Are acute admission wards caring?

Choice in decisions and participation in reviews

Most of the patients' we spoke with were positive about the staff and the care they had received. Patient comments included “I feel that staff listen to me”, “I have regular one to one sessions” and “The staff are all lovely. They listen to me. I choose want to do”.

There was evidence on all wards that multi-disciplinary meetings about each patient had either taken place regularly or were planned for future dates. We saw that ward rounds occurred weekly on all wards and care plans were reviewed and updated after the meetings. We attended a care plan review meeting on one ward and saw it was attended by the patient, their relative, a social worker, their allocated nurse and the consultant. The clinician explained everything to the people in a language they understood and the needs of family and carers were taken into account. People were encouraged to make contributions to their care plan and treatment.

Record's we checked on wards contained evidence of care planning and patients' confirmed they were given a copy of care plans. However some patients' felt they had not contributed to the care plans and were not always given an updated copy after reviews.

We were told patients' had access to advocacy services and all patients' we spoke with were aware of the advocacy service. We saw that posters were displayed in all wards. In Bluebell Rethink Independent Mental Health Advocate's posters were in an accessible format (pictorial).

Staff we spoke with said they felt that people received good care.

We noted that staff on all wards did not have a good understanding of the Mental Capacity Act. We did not see any evidence that capacity was assessed on Ward 3 even when we saw written in someone's notes that they lacked capacity. Staff were unable to tell us when and how capacity assessments were carried out. Most staff we spoke with did not have an understanding of ‘best interest’ meetings and we did not see any evidence that where people did not have the capacity to consent, the trust had acted in accordance with legal requirements.

Effective communication with staff

Staff on all wards told us team meetings occurred weekly. They said they discussed patients' care packages. We saw notes from some of these meetings and saw they were usually attended by all staff from the multi-disciplinary team.

We were told that community meetings are held weekly on the wards we visited. We saw notes from some of these meetings. The agenda included activities, hygiene on the ward and health and safety of patients'. The meetings were attended by patients' and members of the multi-disciplinary staff team.

We observed good interaction between staff and patients' on all wards.

Acute admission wards

Do people get the support they need

Most staff we spoke with demonstrated good understanding of the needs of the patients' on the wards.

Some staff on Ward 2 and Jupiter told us they did not always have sufficient time to provide people with one to ones. Further, all staff expressed concern that when the shift patterns changed they will not have enough time to carry out one to ones or meet all the patients' accompanied leave commitments. At present there is a two hour overlap of shifts during the day. However this will be changing to 15 minutes overlap in August 2014.

We saw evidence to suggest that on occasions people did not get the support they needed. On one ward there was a patient who was 75 years old. We were told that staff felt they may be suffering from dementia as they were very confused. The manager told us they had one to one support all day. We asked whether they had referred them to the older people's ward and was told the family did not want them to move. We further asked whether any staff on the ward had any training in dementia and was told no.

On another ward we were told a 21 year old patient slept on the older person's ward at night as their ward was over occupied. We also found there was a 17 year old on an adult ward as it was felt their behavior was too challenging for the adolescent ward.

Recovery services

There was a Recovery College on the site at Springfield hospital this is a service for community based individuals to assist them manage their conditions to avoid admission into hospital. This service would be available to inpatients on their discharge.

Staff on some wards told us they loosely followed the 'recovery model' when supporting patients. However we did not see any evidence to confirm this model was being used in care planning.

Privacy and dignity

We observed staff treating patients' with dignity throughout our visit. Patients' we spoke with said staff respected their privacy and dignity. One person said "If I want to discuss something of a private nature, then this is done in a private room." Another said "they will knock on the door before entering."

Care plan review meetings and one to ones were held in designated rooms to ensure people's privacy was maintained.

Restraint

All staff we spoke with told us they had been trained to use restraint. However they said it was only used as a last resource.

We saw on one ward a patient had been restrained on a daily basis. This patients' record indicated they were very unwell and had continually refused medication. As such they were a danger to themselves and other people. The relevant paperwork had been completed after each occurrence. However we noted that a doctor was not present and had not been contacted.

The manager on Bluebell Ward told us they had not had to use restraint in the last three months but that all staff had been trained.

Are acute admission wards responsive to people's needs?

(for example, to feedback?)

Service meeting the needs of the local community

We saw information was displayed on public notice boards on the wards detailing how to make a complaint, including how to contact Patients Advice and Liaison Service (PALS), advocacy and CQC.

All patients' we spoke with told us they were aware of how to make a complaint and most said if they had a complaint they would probably go to their ward manager or allocated nurse in the first instance. People gave us examples of complaints they had made.

Staff on the wards told us they encourage patients', family and friends to give feedback via the 'real time' feedback system. We saw evidence that patients' had used this to make comments. On one ward we were told that following feedback from patients' staff had stopped using keys to bang on doors and windows.

On one ward we were told patients' were sent a questionnaire about what activities they want. Patients' we spoke with told us staff listened to what they said about activities and as a result they were offered more choice.

Acute admission wards

Staff on the wards told us they felt that patients' were not offered enough access to psychological therapies. They said that when people requested it and it was agreed by the multi-disciplinary team, then it could take months before it starts.

Work of the teams reflects equality, diversity and human rights

We saw that patients' had access to interpreters. However we were told on some wards interpreters were only booked for care plan review meetings. We asked staff on these wards how patients' are supported with communication at other times and were told that when there was no staff, who spoke the relevant language, then they would find ways to engage with the patients'. However we were not given any examples.

The trust employed staff with sign language skills to communicate with people with who were hearing impaired.

Some patients' told us some staff did not respect their cultural needs and that no staff reflected their ethnic background. We noted that whilst staff teams on all wards were diverse they did not reflect the ethnic background of some of their patients'. For example there were a number of people from Caribbean backgrounds, however we noted that all staff from an ethnic minority background were of African origin.

Learning from complaints

We were told complaints were recorded by the team managers and forwarded to the trusts' complaints team. They would then investigate and respond directly to the complainant and send a copy to the ward managers.

Staff told us a quarterly report was produced by the trust which analysed complaints. We did not see any evidence to confirm this. However we noted that complaints were discussed at team meetings.

Are acute admission wards well-led?

Engagement with staff

Staff on all wards told us they felt their managers were knowledgeable, supportive and approachable. We found that most ward managers were aware of the support needs of both staff and patients'.

However we found on one ward the manager did not have an in-depth knowledge of the patient's needs. Further, staff stated they did not have enough one to one sessions with them.

Most staff we spoke with felt disconnected from the senior managers at the trust and could not comment as to whether they felt the trust was well-led. One ward manager told us the trust CEO had visited their ward a few times and they felt they were generally leading the trust in the right direction.

Engagement with people who use the service

Some patients' told us they felt the real time feedback was a good way of talking to the senior managers. However most said they had not met any senior managers from the trust. They felt they could always feedback to ward managers.

Psychiatric intensive care units and health-based places of safety

Information about the service

Ward 1 is the psychiatric intensive care unit at Springfield Hospital. It is a 13 bed male only unit.

There is a two bed section 136 suite facility for males and females.

The ward provides intensive care facilities for people compulsorily detained under the Mental Health Act who experience mental illness and present behaviours that need to be managed in a specialist area with staff trained, experienced in management of actual and potential aggression and de-escalation skills.

Summary of findings

The psychiatric intensive care unit (PICU) provided a safe and secure environment for people who needed an intensive and supportive environment during their stay in hospital. The unit is for male patients only.

The section 136 suite is a service for the assessment of people who have been detained by the police using their powers under the Mental Health Act.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units safe?

Learning from incidents

We saw that systems ensured incidents were reported to the trust's risk department, which provided feedback. Completed incident forms indicated actions that had been taken and by whom, and these had been added to the incident reporting system with clear and complete notes about the incident.

Staff told us they had debriefing sessions after each incident in which a person was restrained. These included discussion around whether the restraint was carried out safely and appropriately, whether it could have been done better and how to prevent the incident happening again. There were opportunities to discuss and learn from incidents and medical emergencies in debriefing meetings and at learning events for doctors and nurses. We noted that this support was not necessarily available for people who used the service although we were told this was done informally and recorded in progress notes. We saw evidence that relatives had been informed.

We looked at the notes of one person who had been involved in incidents, but the incidents were not reflected in their risk management plan. Although incidents involving people who used the service were documented in progress notes, the information was not being used to inform risk assessments and risk management plans. Staff said incidents could be indicated in people's notes as risk factors but this was not done consistently and was identified as an area for improvement. This meant it was difficult to see a clear picture of a person's risk history and presented a barrier to learning from incidents as a result.

Keeping people safe

Although most people who used the service told us they felt safe on the ward, one person said they were intimidated by other people and afraid to leave their room. There was no clear strategy in place to facilitate this person participating in activities and social life.

We saw the dashboard system, which showed that staff had been trained in safeguarding adults, infection control and safe use of restraint. There were systems in place to audit and monitor the use of rapid tranquillisation medicines.

Where incidents raised concerns in relation to safeguarding people from abuse, we saw that the ward had taken appropriate action. We saw how the system automatically notified the ward manager of safeguarding information, which meant their attention was drawn to incidents if staff failed to escalate them.

Parts of the ward were not clean or well-maintained. People who used the service said they had to request clean bedding and toilet rolls and one person showed us their bedroom floor was sticky and dirty. This was because outside contractors were responsible for cleaning, which was done on a timetabled basis, rather than as and when it was required to meet people's needs. However, we did see information prompting people to bring any issues to the attention of staff, although people who used the service were not aware of this. A number of repairs had been requested at a recent community meeting and we were told that the person responsible for ensuring these were carried out was on leave. There were no arrangements in place to cover this role at the time of our visit.

Risk management

We heard about one person using the service who had been threatening to harm himself or others. We asked about the person's risk management plan but were told they did not have one. This was confirmed by looking at the person's notes. Another person's risk management plan took one incident into account but did not highlight previous suicide attempts, self harm, absconding and aggression towards others that were documented elsewhere. However, we also saw evidence of good risk assessment and management for one person under the age of 18 who had been admitted to the unit.

We observed discussions at a review meeting around enabling a person to take positive risks by using 'legal highs' instead of illegal drugs.

Safe staffing levels

Staff felt that the staffing levels at times were very good, but could be challenging at other times. This was because of staff absence rather than prescribed staffing levels. The ward covered this by using agency staff, who did not always have the same level of PICU specific skills and experience as permanent staff. This was managed by the use of induction and shadowing. On the whole, staff felt the skill mix was appropriate for the ward.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units effective?

(for example, treatment is effective)

Use of clinical guidelines and standards

Staff told us about evidence based therapies used on the ward. We found several examples of evidence based tools used to assess and monitor people's needs. National guidance such as NICE guidelines on the use of clozapine was used to inform practice.

The nature of the service dictated that it was a short-stay ward and people were discharged quickly in line with national guidance and standards for PICU.

Collaborative and multi-disciplinary working

Staff told us they attended regular reflective practice groups with the multi-disciplinary team and were able to access peer supervision. Some staff recognised that the ward had some work to do in this area but felt there had been a positive cultural shift towards collaborative working. It was evident from the review meeting we attended that medical and nursing staff listened to one another and had the opportunity to share opinions.

We identified some concerns around key information being communicated amongst those responsible for people's care. For example, staff were not aware of whether one person was dependent on alcohol or whether they should observe them for withdrawal symptoms. However, comprehensive progress notes were maintained on the RiO electronic data system and these were updated in real time during review meetings.

Monitoring the quality of care

Staff told us about regular reflective meetings where they discussed as a team what they could improve and how they could learn from things that did not go well. Community meetings were also used in this way to gather feedback from people who used the service. We saw several examples of audits, mostly around safety.

The ward had identified risk management as an area for improvement and had developed handover sheets with areas to be completed focusing on risks and risk management. However, it was not clear how these were linked to individual risk management plans.

Staff qualifications, competence and experience

Some staff had attended care planning training that was led by people who had used services. However, they had not received all the training that they wished to have because of limited resources. This included training in delivering psychosocial interventions. We were told a nurse consultant had been seconded onto the ward to develop a competency framework for nurses. This was positively and enthusiastically received by staff.

Are psychiatric intensive care units caring?

Choices, decisions and participation

Staff explained that people who use the service and their individual needs were the focus of care planning. They ensured this by involving people in care planning meetings and asking for their opinions. Staff, particularly doctors, spoke about people who used the service in a respectful and compassionate way and gave several examples of how they consulted people and checked that they understood what would happen at each stage of their care. However, this was not always reflected in people's notes and care plan sections for people's recovery goals were not always completed or solely contained staff perspectives.

We saw examples of how people had been involved in the running of the ward by being asked what they would like to have or change. For example, people requested specific activities which were then put in place.

Some staff felt there was room for improvement in terms of working with people's relatives and carers although we found evidence in people's notes that family members were involved in their care. We saw information about a local carers' support group promoted on the ward.

Effective communication with staff

Staff told us they met with people weekly to discuss their care and follow up on any issues people identified and had more regular one to one sessions if needed. If they needed to put people in seclusion, staff discussed this with the person afterwards to ensure they understood what had happened and why.

We found there were some difficulties arising from ineffective communication between staff and people who used the service. People said they were unaware of who

Psychiatric intensive care units and health-based places of safety

their care coordinators or the ward manager were and did not know how to access activity equipment that was on the ward. However, there was evidence in people's notes that staff were explaining their rights to them.

Support for people's needs

People had access to physical health assessments and physical examinations on a regular basis. Where assessments indicated the need for specialist input or treatment, this was planned and provided. We saw examples of referrals to urology and forensic services and these took place in a timely manner.

Staff gave examples of how they worked with people by considering their personal situations, backgrounds and reasons for admission when planning care and involving relatives where appropriate.

Privacy and dignity

Staff described how they would maintain people's privacy and dignity when providing intimate personal care. They said they always sought people's consent at each stage of the process and gave them time to reconsider if they declined.

Are psychiatric intensive care units responsive to people's needs?
(for example, to feedback?)

Meeting the needs of the local communities

We saw examples of how the ward worked with the local community to meet people's needs, such as planning to engage Afro-Caribbean hairdressers for people who required the service.

Some concerns were raised by staff about whether bed numbers were sufficient to meet the needs of the local community. PICU beds had recently been reduced in the trust and there were plans to cut further beds.When this was raised with the trust they confirmed that no PICU beds have been reduced and there are no future plans to reduce the bed numbers.

Working together in periods of change

Progress notes were very detailed and clear, giving a lot of information about people's care and progress towards recovery. However, summary information and care plans were often unclear or incomplete, meaning that information could get lost in transition to other services.

There was evidence of collaborative work with adolescent services in preparation for transferring a person under the age of 18 who was using the service.

Learning from concerns and complaints

The ward held regular community meetings for people who used the service to express their views. Minutes from the meetings showed that actions were agreed where people raised concerns. We saw "You Said, We Did" boards that showed how the ward had responded to people's concerns, complaints and requests.

Are psychiatric intensive care units well-led?

Governance, vision and culture

Staff felt there was an open culture on the ward and small problems could easily be raised and resolved. They appreciated this openness and honesty from managers. They said there was a vision for them to work towards and were able to relate this to the vision and values of the wider organisation.

We spoke to senior staff, who had a clear vision of what a good PICU should look like.

Responding to staff concerns

Staff said they were confident in raising any concerns they had and knew how to take issues elsewhere in the organisation if they were not resolved on the ward. However, they had not had to do this and found their managers supportive. Staff said they all got the chance to have their say.

Staff told us they were unsettled by changes to shift patterns but that the changes had been well managed at ward level. Senior staff praised the ward staff for coping very well under difficult circumstances.

Effective leadership

Staff felt that leadership was visible and managers were approachable, including senior managers. Staff were able to access regular supervision. The ward manager gave several examples of changes they had made where problems had been identified.

Records showed that staff had regular supervision, where any performance-related issues were raised as well as allowing staff to focus on short-term performance goals.

Psychiatric intensive care units and health-based places of safety

Staff engagement

Staff said they were able to proactively make positive contributions to the running of the ward, such as producing improved templates for handovers.

Long stay/forensic/secure services

Information about the service

The long stay/forensic/secure services of South West London and St George's Mental Health NHS Trust are based on the site of Springfield Hospital. The Shaftesbury Clinic contains three medium secure wards and one low secure ward. Three of the wards are situated within a designated medium secure unit, whilst the other ward is located within the main hospital buildings. There is a long stay rehabilitation ward within the hospital as well as three low support hostels within the hospital grounds for more independent living.

We inspected all of the three medium secure wards and one low secure ward. The four wards are Ruby, Turner, Halswell Wards which are medium secure and Hume Ward is low secure.

Ruby Ward is a 10 bed ward for female patients only. Turner Ward is an 18 bed assessment and treatment ward for males, which includes five beds designated for the support of long term medium secure patients. Halswell Ward is a 16 bed male only ward providing admissions assessments and rehabilitation to patients'. Hume ward is a 16 bed male only low secure unit. It is located outside of, but is part of, the Shaftesbury Clinic of Springfield Hospital. The ward provides assessment, treatment and rehabilitation to people, with the aim to move people through their care pathway to a less restrictive/secure environment.

We inspected Phoenix Ward which is a long stay rehabilitation ward based within the main hospital buildings. The ward is an 18 bed mixed gender (takes five females) low secure ward. We also inspected the Forensic Outreach Service which supports people living in the community.

Summary of findings

We found a number of positive areas to the service that people received from the long stay/forensic/secure services. People generally felt well respected by the staff and felt staff understood their needs.

People appreciated the wide range of therapies available to them, and felt that they supported their recovery.

There was some good practice that took place in accordance with national guidelines and best practice.

People felt safe on the wards and felt staff listened to them. Complaints were investigated and responded to promptly.

There are a number of areas where the service needs to make improvements. This includes improving security and risks within the environment.

Clear pathways of care need to be implemented, along with a clearly defined purpose for each ward, so that people are in the most appropriate environment for their needs.

People need to be more involved in decisions about their care and treatment, particularly in meetings, such as Care Programme Approach meetings and ward round reviews.

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Summary

We found that whilst some learning from incidents took place, this was not consistent and risks to people remained. Risks within the environment had not always been identified or plans implemented to ensure people were safe. There were appropriate systems in place to minimise the risks to people of abuse. Where people presented a risk to themselves or others, this was planned for and kept under regular review. There was sufficient staffing on the wards, although the levels of therapies staff could be improved to ensure people had sufficient levels of activities, especially on the larger wards.

Learning from incidents

We found that there were systems for the recording and reporting of incidents so that senior managers, within the forensic directorate, were alerted to incidents promptly and could monitor the response to these and the investigation and actions taken to prevent recurrence. For example, in response to one incident, relevant external bodies were informed, such as the Ministry of Justice and commissioners of the service.

There was evidence that learning from incidents, in the forensic services, had taken place. An example of this was improved checks that took place by staff, during the handover between shifts, to ensure the well-being of people who use the service. Another example was that physical health checks of people took place weekly, with an 'early warning system' introduced to enable staff to identify when people's physical health checks required escalation to the medical staff. Staff had also received training in how to respond to a medical emergency.

However, we found that whilst some staff were aware of a recent incident within another part of the trust, robust practices had not been implemented on all of the wards, and people were therefore not protected against potential risks of self-harm. This was in relation to our observation of a plastic bag being brought onto a ward, and not being managed safely to reduce risks to people, as well as the use of plastic bags in the laundry areas. The use of these were not always risk assessed, which put people at risk.

Safeguarding

People who use the service said they generally felt safe on the wards, and knew how to raise an alarm if they felt at risk of harm.

The training records confirmed that staff had received training in safeguarding and that this was regularly updated. The staff we spoke with conveyed an understanding of safeguarding issues and their responsibilities to report concerns. They said they were able to raise any concerns about their work with their line manager and this was acted on. We saw evidence that any safeguarding issues were discussed at weekly ward manager meetings and bed panel meetings to ensure a consistent approach across the service.

We spent time with the safeguarding lead for the hospital, who showed us that safeguarding issues were dealt with in accordance with the PAN London Safeguarding Procedures. They showed how they tracked safeguarding issues to monitor the progress of investigations, through to the outcome to ensure these were managed appropriately and in a timely way.

Safe environment

To enter the Shaftesbury Clinic there was a double door entry and exit system where one door could only be opened once the other door had been secured (known as an 'airlock'). There were lockers for bags and any items that could not be brought into the unit, and visitors were asked to sign a declaration to confirm they would not bring any prohibitive items onto the ward. However, we did observe that although the metal detector alarm sounded as our team and other people progressed through the airlock, we were not challenged about this, or further security measures carried out. These practices could put people at risk where unauthorised items could be brought onto the ward.

The layout of each ward we visited was different, and some wards were more modern than others. Each ward had individual bedrooms for people who use the service, with shared toilets, bathrooms and lounges. People who use the service were able to personalise their rooms to an extent, with personal belongings, televisions and some people chose to buy their own bedding.

During our tour of the wards we found that the windows from a small lounge on Turner Ward (for males) looked out onto the courtyard used by Ruby Ward, which

accommodated females only. Whilst the glass was frosted, we found that when the windows were open, the courtyard could be viewed to an extent, albeit limited by the restricted window. The staff told us that there was a white line in the courtyards that people were not supposed to cross, which was aimed to increase people's privacy and security. We also found that the physical environment of Hume Ward consisted of two long corridors with 'blind spots', meaning there was no direct line of sight for staff to ensure people were safe.

Whilst we looked at the environment of the wards we identified some potential ligature points that could put people at risk. We found that some of these risks had not been identified in the annual ligature audits that took place on each ward, which meant that people could be at risk. We informed the interim operations manager of our findings during the inspection so that prompt action could be taken to assess the risks and to make the environment safe for people.

There were systems in place to minimise infection risks to people who use the service, and there were dedicated domestic staff for the wards. However, we did identify that the material armchairs in people's bedrooms on Turner and Halswell Wards were visibly stained and could be an infection risk. We also saw evidence of 'hand hygiene'audits that took place, where staff were checked to see if there were adhering to the 'bare below the elbow' policy. However, we found that the majority of staff on the wards wore sleeves that reached to their wrists, which could also present as an infection risk to people.

Risk Management and managing risk to the person

The training records showed that staff received annual security awareness training. The staff we spoke with had a good awareness of relational security issues, with regard to professional boundaries, the mix of people who use the service, and external communication, including for people who used the service having access to the internet.

Within the care records we saw that risks people presented to themselves and others had been assessed and reviewed regularly to ensure people were supported appropriately. Risk management plans detailed the actions that were required to minimise the risk to the individual. Staff told us that risks were reviewed in the handover between shifts, ward rounds and each person's Care Programme Approach (CPA) meeting, so that the level of support and treatment people received were tailored to changes in the person's condition. If people required one to one support from staff we saw this was arranged. In addition, if people required regular checks to ensure they were safe and well, then this was carried out by staff and recorded. However, we found on Phoenix Ward there had been an incident involving a person who used the service, but the risk overview and risk management plan had not been updated to reflect the change in the person's needs.

The wards used a daily 'zoning' risk management procedure, where people who use the service were categorised into different zones depending on the risk they presented to themselves or others. An example of this on one ward was that people who were in the red zone were a higher risk to themselves or others, and had all visits from friends and relatives suspended, group activities were also suspended and all leave was stopped. People in the green zone posed a low risk and were deemed to be generally stable in presentation and mental state.

The zoning was decided amongst the staff team each morning and recorded on the white board in the staff office area. However, we found that information was wiped away each evening and was not always recorded in the care records, which meant that there was no audit trail of how each person's risks had changed over time. We also found that the zoning across the wards was applied differently and was not standardised. For example, zoning in the forensic outreach service had criteria by which it used an indicator for staff to follow up on people in the community, whereas zoning within the inpatient services did not appear to have any clear criteria attached to how it was being applied, or how it worked within the nature of rehabilitation and recovery of people.

Some people who use the service told us that they had had their leave taken away from them. They said that initially they did not understand why this had happened, but that staff explained this to them, and this helped them understand their own risk behaviours.

Safe staffing levels

The feedback we received from ward based staff, and people who use the service, was that the staffing levels were sufficient to meet people's needs. Some people who use the service said they would like staff to spend more time with them on an individual basis as "they always seem to be so busy".

Long stay/forensic/secure services

Some wards had vacancies for nurses and health care assistants, and we were shown evidence that regular bank and agency staff were used to ensure a consistent level of service whilst recruitment was taking place.

However, within the therapies service the staff did tell us they felt under pressure, with having one occupational therapist to one ward of 18 people, where they said they felt unable to fulfil their role and provide an appropriate level of service to all the people. Some people on the wards did highlight to us that there was not always something to keep them occupied, and at times they felt “bored”.

Are long stay/forensic/secure services effective?

(for example, treatment is effective)

Summary

There was some good practice that took place in accordance with national guidelines, benchmarking and best practice. However, this was not consistent across all the disciplines.

We saw evidence of collaborative multi-agency working and people had access to a range of therapies that they appreciated.

Staff received mandatory training, and told us about more service-specific training they had undertaken. However, the evidence of this was not captured at ward level or by the trust, so it was unclear how they assured themselves that staff were appropriately trained to meet people's needs.

Use of clinical guidance and standards

During our inspection we identified that some clinical guidance and standards were implemented in the work of the service. We saw information to evidence that the medium secure and low secure wards of Springfield Hospital were members of the Quality Network for Forensic Mental Health Services. This enabled the service to measure the quality of the service they offered to people against service specific standards (self-audit). These were then validated by a team of professionals, patient or care representatives. The most recent audit was carried out in November 2013, where the services achieved a score of 75%, and we saw an action plan developed for areas where the service needed to improve.

In the care records we saw evidence of the use of the Health of the Nation Outcome Scales (HoNOS) scales of risk, and that these were reviewed three monthly at each person’s CPA meeting. This meant that people's risks were measured in accordance with recognised standards.

We found evidence that best practice in accordance with National Institute for Health and Care Excellence (NICE) had been implemented in relation to staff being trained to work with families of people who have psychosis. However, the staff said they were unable to implement this in practice due to a lack of protected time to carry this out.

The trust used the commissioning for quality and innovation (CQUIN) targets for 2013/14 to monitor admission and discharges. However, they did not use an integrated total care pathway such as ‘My Shared Pathway’, one of the initiatives developed to reduce lengths of stay in secure mental health settings. Staff said they were aware of this model, but that there was not a specific pathway that they used with people using the service. They said that pathways were discussed in the weekly ward manager meetings and bed management meetings, and we observed evidence of this. However, during our inspection we also found that some people had been in the low and medium secure settings for a significant number of years, and that their pathways and plans to move on from the service were not clearly planned for.

Monitoring quality of care

Within the therapies service we found that the Model of Human Occupation (MOHO) was used to benchmark the service, with evidence of good use of audits to develop the benchmarking standards. The information from this was captured centrally, and evidence from this showed that the occupational health specific care plans were of a good standard. However, within the wards, we found little evidence of any benchmarking across the services to see how they compared nationally across other like for like services. Services appeared to measure themselves only according to what they had in place. We asked staff and managers within the forensic services about any quality improvement programmes in use, such as The Productive Mental Health Ward: Releasing time to care or the Star Wards model. Staff at all levels confirmed that there was no tool in use, but they were hoping to introduce these in the future.

Long stay/forensic/secure services

Collaborative multi-disciplinary and multi-agency working for assessments, care planning and access to health services

Each ward had a dedicated team of professionals which included nurses, a consultant psychiatrist, psychologist, social worker and occupational therapist. In the ward round reviews and CPA meetings we saw that each discipline was represented and had an input into the support people needed, to ensure a multi-disciplinary approach to the support people received.

Are staff suitably qualified and competent

People who use the service said that the staff generally understood their needs and were able to support them in the way they needed.

We saw records to demonstrate that staff received regular individual and group supervision in their work, and an annual appraisal. Staff said they felt well supported in their work and that managers within the service were approachable.

The training records confirmed that most staff were up-to-date in their mandatory training in areas such as basic life support, fire safety, equality and diversity, infection control and managing conflict.

However, the staff we spoke with told us about training they had undertaken in areas such as psychosocial interventions, dual diagnosis and substance misuse, however the records of this training was not captured by the trust, or at service level, so it was not clear how the trust assured itself that the staff were appropriately skilled to meet people's needs.

Are long stay/forensic/secure services caring?

Summary

People generally felt respected by the staff and listened to. People felt they received the support they needed from the therapies services. However, people need to be more involved in decisions about their care and treatment, particularly in meetings, such as Care Programme Approach (CPA) meetings and ward round reviews.

Choice in decisions and participation in reviews

We asked people who use the service if they felt involved in their care and decisions about treatment. Most people who use the service said that they felt listened to in their CPA meetings, and involved in identifying their care needs with their primary nurse. However, the majority of patients we spoke with on Turner Ward, and some on Halswell Ward said they did not feel listened to, particularly where they raised concerns about the medicines they were prescribed and the side effects of these. Some also commented that when they were invited into their CPA meeting, they felt that decisions had already been made about their care and treatment.

We observed some ward rounds and a CPA meeting on Turner Ward. The meetings on Turner Ward were held in a small room, with a projector that displayed the person's care plans on the wall. However, the projector was very noisy and where people had a quiet voice it was difficult to always ascertain what they were saying, which meant that important information could be missed. At one point we did observe that a person clearly stated that they would engage in a risk behaviour if they were to be discharged, and this was not followed up by any of the professionals present, which meant that the person or other people could be at risk.

Similarly, the ward round meeting we observed on Phoenix Ward did not have any involvement of the people who use the service. The staff informed us that if people requested, for example longer leave, this would be raised at the meeting and people will be informed of the outcome of this. This did not promote the involvement of people in their care or provide them with an opportunity to discuss issues relevant to them.

The care plans we viewed were up to date and had been reviewed regularly. We saw that people's needs had been assessed and care plans developed that detailed the individual treatment and support the person required. Care plans had been drawn up in areas such as people's physical health, psychological health, relationships and safety needs. Most of the people we spoke with told us they had a care plan and they were always involved in their care plan review. The care records showed that people had one to one sessions with their primary nurse to discuss their future plans and, where relevant, these were used to update the care plans.

We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and of examples where people's capacity had been assessed. Initially the staff conveyed an understanding of the MCA and capacity tests. However, the examples they showed us in the care records related only

to capacity in accordance with the Mental Health Act 1983. There was no evidence of any formal capacity assessments, best interest meetings or advance statements in relation to people's social, physical and financial needs, which would necessitate the use of the MCA. This did not ensure that people's needs were fully assessed and decisions made in accordance with the requirements of the MCA.

Effective communication with staff

During our inspection we saw that staff communicated with people who use the service in a calm and professional way. The feedback we received from people in most of the areas we visited was that the staff were caring and listened to them. Some people said they would like more interaction from the staff, and for staff to be able to sit and chat with them. However, the feedback from the majority of people we spoke with on Turner Ward was they felt the staff had a 'bad attitude' and were 'inpatient' with them. This did not promote a caring environment for the people who use the service.

Do people get the support they need

We saw that the therapies programme enabled people to get involved in activities that interested them and supported their recovery. Some people who use the service said that they would like to do more exercise.

Recovery services

Within the long term conditions/forensic and secure services we found that there was a comprehensive programme of occupational therapy, psychology and psychotherapy groups that took place both on and off the ward. These were in small groups or on an individual basis with people who use the service. The groups included cooking, community skills, creative activities, health promotion, educational support and allotment groups.

We saw evidence of a friends and family support group that was run by the occupational therapy services, with the involvement of a person who uses the service.

The therapies included Dialectical Behaviour Therapy (DBT) to support people with borderline personality disorder (BPD), and who might have self-harming behaviour or suicidal thoughts. Similarly, people were also able to access Mentalization Based Therapy (MBT) to help them with their recovery. People who use the service told us they valued the occupational and psychology therapies available and said it helped them to develop new skills.

Privacy and dignity

The people we spoke with said that they generally felt their privacy and dignity was respected by staff and the other people who use the service. We saw that each person had their own bedroom, with washing facilities. People were able to make phone calls in private, as the telephones were situated in quiet areas of the ward.

On Ruby Ward (females only), the male staff were aware that they needed to be chaperoned when supporting the people on the ward. On Phoenix Ward, which accommodated males and females, there were segregated areas, such as a female only lounge and the rooms were all en-suite. We saw that the male and female sleeping areas were separated by a partition. However, the window section of this area allowed for male patients' to oversee part of the bedroom area if open, and for female patients' to view the male sleeping area, which did not promote people's privacy and dignity.

We observed in the staff office areas that there was some confidential information about people on display on the walls, such as behaviour care plans or if their leave had been suspended. Whilst this was not always visible from outside the office, the practice did not take into account visitors to the ward who might need to spend time in the staff office.

Are long stay/forensic/secure services responsive to people's needs?

(for example, to feedback?)

Summary

Clear pathways of care need to be implemented, along with a clearly defined purpose for each ward, so that people are in the most appropriate environment for their needs.

People's diversity needs were addressed by the service and care plans implemented to support these, where appropriate.

Complaints were investigated and responded to appropriately.

Service meeting the needs of the people

During our inspection the medium and low secure wards were described to us as accommodating people for up to three years to support them with their recovery and move onto a non-secure environment, or return to prison. We

found that a number of people in the low secure, and the medium secure services had been there for a significant number of years. We also found that the medium secure wards accommodated people who were going through their rehabilitation and recovery, as well as accepting new admissions of acutely unwell people. Staff told us that some newly admitted people could be quite disruptive and required additional support from staff to enable them to settle on the ward. During the inspection we attended a bed management meeting, where it was identified that people had been within the services for a number of years, and the plans in place to support people with their recovery. Within the meeting we observed that new admissions were identified to be accommodated on a ward where there was a vacancy. These arrangements did not promote the recovery of people who were nearing the end of their stay in a secure service, or ensure that acutely unwell people received a consistent level of support.

During our inspection we identified some positive examples where staff responded to people's needs and increased the support for a person where required. We also saw evidence of positive work by the therapies services, with the families of people who use the service, to support people with their recovery.

Work of the trust reflects equality, diversity and human rights

People told us they were supported to practice their religion and that religious representatives could be arranged to visit them on the ward. In the care records we saw that where people did practice a specific religion, there were guidelines for staff to support people's need. People told us that any specific food needs were met, such as if they required Halal or where people were vegetarian or had diabetes.

The staff told us that if people's first language was not English then they were encouraged to bring a relative to meetings to translate for them, or an interpreter could be arranged by the ward. The staff said that on a day-to-day basis they could communicate with people through use of the different languages spoken within the staff team, and through the use of objects of reference. However, we did not observe materials or information available to people in different languages.

We found that the service supported people with learning disabilities through the use of a wide range of easy read documents and posters on display that covered different topics, such as food, activities and occupation therapy information. However, staff were not provided with any training in learning disabilities to ensure that people's needs were fully met.

Providers working together during periods of change

The care records contained evidence of how the service worked with different agencies to support people with their needs. This included the Ministry of Justice, the Multi-Agency Public Protection Authority (MAPPA) and the prison service, as well as the forensic mental health community team. Staff described positive links between the different agencies, and the sharing of relevant information, such as where people were involved in an incident or whether they were progressing well with their recovery.

Learning from complaints

We saw information on display in the wards of how people could make a complaint. Most people we spoke with said that they felt able to raise complaints about their care and these were listened to. Some told us that they used the support of an advocate when they required assistance to raise an issue. The staff we spoke with said they would listen to people if they raised a concern and if they could not address it themselves they would refer the person to the senior member of the staff team. People said that they felt the ward managers were "fair" and did not "take sides" if they raised a complaint about a member of staff or another person who uses the service. One person gave us an example of where they made a complaint, and that in response to this action was taken to make the ward safer.

We looked at the records of some complaints received and the correspondence relating to these. We found that complaints were taken seriously and responded to promptly. The complainant was provided with written information about the outcome of their complaint, and given contact details of other bodies they could raise a complaint with if they were dissatisfied with the outcome of the complaint.

Are long stay/forensic/secure services well-led?

Summary

At service level there was effective leadership and some innovative practice that took place.

Long stay/forensic/secure services

There were systems for the service to capture information and report this to senior managers within the trust. However, a few of the staff we spoke with did not feel that senior managers communicated with them, or cascaded information appropriately about changes that affected them. Staff did not feel supported through periods of change and felt this had a negative impact on the people who used the service.

There was a lack of engagement by senior managers with the people who use the forensic services, and there were limited opportunities where people could provide feedback about the service.

Governance arrangements

The forensic services are members of the Quality Network for Forensic Mental Health Services (QNFMHS), which is a combination of self audit and peer review of services. In November 2013 the Royal College of Psychiatrists carried out a visit in accordance with the standards of the QNFMHS, to the low and medium secure units. By being part of QNFMHS they are able to see how they compare against other similar types of wards nationally. The findings from the recent audit was generally positive with some areas identified for improvement, of which the service had developed an action plan.

Within the forensic services the clinical dashboard system was completed by the senior managers and reported to the trust. This was used to monitor monthly key performance feedback about areas such as recovery goals, care plan reviews, training for staff, CPA meetings taking place and risk assessments. The service also used the SIREN electronic patient care reporting system to share information in relation to any investigations, safeguarding and omitted medicines, which enabled senior managers within the trust to monitor what was happening within the service. The ward managers were clear about the three current areas of risk within the service, and that monitoring of this took place at the monthly business meetings with all levels of staff.

We saw evidence of weekly ward manager meetings taking place, and a monthly performance meeting. Recent minutes showed discussions around issues within the service, key performance indicators, the dashboard, workforce and mandatory training. Similarly, we were shown evidence about directorate and specialist governance meetings, where relevant information from these is cascaded to the forensic staff, such as the outcomes of complaints or safeguarding issues, to prevent recurrence and make improvements to the service.

Engagement with patients

We were informed by senior managers about the service user reference group (SURG) as being a way that people can have their voices heard within the services. However, when we asked people who use the service about this they were not aware of the group. The minutes from the September 2013 SURG meeting did not evidence any input of people from the forensic services or issues that affected them, and they appeared to be more community orientated. We saw that people could raise issues through the community meetings on each ward, and the recovery meeting which was held within the Shaftesbury Clinic, with a representative from each ward attending this. We saw evidence of these meetings and that people were involved in policies and commenting on areas of the service that affected them.

We were also shown the 'Realtime' feedback tablet positioned in the reception area of Shaftesbury Clinic, so that people could answer a short number of questions. However, we found this was only available to people who were able to leave the ward, with no alternative for people who remained on the wards.

The majority of people we spoke with said that their concerns about the food provided were not acknowledged by the trust, and that the food provided was not of a good quality. The staff we spoke with also commented that the food was not always very good, and lacked in choice, and we were shown efforts of each ward to provide more variety to people in the food they received. This included a weekly takeaway of people's choice and communal cooking on some of the wards.

Engagement with staff – ward to board

All the staff we spoke with said they felt well supported at service level by their managers, and had regular team meetings and reflective practice meetings within each ward. However, only half of the staff we spoke with said they felt supported by the trust, understood the future plans, such as in relation to the Foundation Trust application and were kept well informed about any

incidents that had occurred that were relevant to their area of work. However, the remaining staff did not feel that they received timely information, or knew any of the changes planned for the trust, or changes that might affect them.

Supporting staff with change and challenges
In all of the wards staff spoke about their anxieties in relation to proposed changes in their shift and handover timings that were due to take effect in the coming months. Staff said they had received a copy of the consultation document relating to this, but they felt that any feedback they gave was not listened to by senior managers.

The staff felt that the proposals were a 'blanket policy', and that due to the specialist nature of the forensic services, they needed to be viewed differently to the other mental health services. Some staff gave us a recent example of where a trust-wide policy had been introduced regarding the recording of observations, and that they had to adapt these to be more forensic-focused.

The majority of staff we spoke with also highlighted concerns about the reductions to the therapies services, and the impact this could have on the people who use the service. Staff told us they were directed to re-focus their work and prioritise resources to work with people who have been using the service for a number of years. They told us this was done without consultation and has resulted in waiting lists for services and an over-reliance on trainees to provide treatment.

Senior ward staff we spoke with said that the issues identified above were causing low morale within the staff team, and our conversations with staff reflected this feedback.

Effective leadership
We found that at ward and service level there was effective leadership and staff felt supported in their work and part of a team. Staff said that their managers at service level were visible, accessible and approachable, but that they did not always feel connected to more senior managers within the trust. Staff had an awareness of the senior leadership team of the trust, though were not really clear of their role and their scope of responsibility.

We also found that within the forensic community team there was a lack of clear leadership, and the team leader had not received any leadership training since coming into post approximately one year ago. We also found that ward managers within the inpatient services had only just been identified as needing leadership training, and were due to embark on this in the near future.

Within the therapies services we found some positive examples of effective leadership and innovative practice. This included the development of a twice yearly physical health forum, where representatives from each discipline attend this. Each day was devoted to a particular topic that was relevant to the needs of the people who use the service e.g. diabetes or addictions. Also, as highlighted earlier in the report, the therapies services had embedded the use of benchmarking systems and implemented recognised clinical guidance to improve the service people received.

Child and adolescent mental health services

Information about the service

The Child and Adolescent Mental Health Services (CAMHS) include:

The Aquarius Unit and the Adolescent Assertive Outreach Team

The Aquarius unit is a 10 bedded mixed sex general adolescent unit for young people aged 12 – 18 years. The Aquarius unit also offers a day service. Seven of the beds at the Aquarius unit are nationally commissioned by NHS England and referrals are accepted from within the UK. The other three beds are commissioned locally. The Aquarius unit works with the adolescent assertive outreach team (AAOT) in the local community to support young people during a crisis. The service is for young people who have a serious mental illness and are experiencing an acute mental health crisis which requires short term crisis intervention either in hospital or in their own home. The AAOT works with young people within the five London boroughs the trust operates across.

Deaf child, young people and family service and Corner House

The deaf child, young people and family service provides highly specialised mental health care to deaf children and young people aged 0 – 18 years and their families, and to hearing children of deaf adults, in the community. Referrals are accepted from across London.

Corner House is a six bedded national specialist assessment and treatment unit for deaf children and adolescents aged 8 -18 years, with severe complex emotional and psychological problems. Corner House also offers a day programme. The unit is commissioned by NHS England and referrals are accepted from across the UK.

There are four tiers within CAMHS depending on people's needs. Tier 4 services provide specialist day or inpatient services where people with complex mental health needs are assessed and treated. Tier 3 services provide multi-disciplinary assessment and treatment usually in the community. Corner House, the Aquarius Unit and the AAOT are tier 4 services, and the deaf child, young person and family service is a tier 3 service.

Summary of findings

The specialist CAMHS at South West London and St George's supported children and young people with complex health needs and often at times of crisis. The staff spoken with were mindful to maintain a person's safety and were consistently reviewing the risks presented to the young person by themselves, others or the environment. There were processes in place regarding risk management and learning from incidents.

The services were following national guidelines to provide recommended treatment to children and young people. The treatment provided was tailored according to individual needs. The services monitored the quality and effectiveness of their service through the completion of routine outcome measures. The staff at the service were competent and highly skilled, however, there were concerns regarding the quality of agency staff.

Children and young people spoken with felt involved in decisions about their care. They were well informed about their treatment options and were invited to regular review meetings to discuss their progress. The majority of young people told us they were able to speak to staff and received the support they required.

There was a multi-disciplinary and multi-agency approach towards transitions, ensuring that young people's needs were met in a timely manner and there was consistency in the care they received. However, there were some concerns raised regarding the process of referral from deaf CAMHS to deaf adult mental health services.

At a service level, staff felt well engaged and informed about the service and felt the teams were well led. However, there were concerns that staff were not as engaged as they could be regarding the development of the CAMHS directorate and the tier 3 transformation programme. There had been recent changes regarding middle management and there was some confusion regarding people's roles and responsibilities.

Child and adolescent mental health services

Are child and adolescent mental health services safe?

Safe environment

The Aquarius unit was clean and there were hand washing facilities available. There were signs on display promoting good hand hygiene.

There was an air lock at the entrance to the Aquarius unit and Corner House providing a safe environment to young people. This meant unwanted visitors were unable to access the unit and young people were unable to leave the unit without a member of staff supporting them. There were adult services on site and therefore staff accompanied young people when they were off the unit in order to maintain their safety. The garden areas on the Aquarius unit and Corner House were secure and they were not overlooked by adult services.

The Aquarius unit was unable to maintain appropriate gender segregation in line with the recommended guidance. There was one bedroom area and females had to pass through the male corridor to access their rooms. The males had to pass through the female corridor to access the unit's garden area. Staff were used to managing these difficulties and maintain the safety of the young people. The Aquarius unit was due to be refurbished and the plans for the new unit enabled appropriate gender segregation.

Learning from incidents

All incidents were reported through a centralised system and reviewed by the modern matron and the ward manager or team leader. There were monthly reviews of all serious incidents at the monthly CAMHS governance meeting. This included undertaking and reviewing the findings from investigations into serious untoward incidents, and ensuring completion of any actions required.

There were processes in place to learn from incidents that occurred at the service. There had been previous incidents regarding the interface between the Aquarius unit and the children's services provided by the local authority. In response to this, a piece of joint work was undertaken to review the service's roles and means of service delivery. This included reviewing liaison processes between the two services. The aim was to jointly understand people's needs and when and how these needs could be met in the community.

Staff were invited to trust presentations to explore the findings from serious case reviews. Staff were aware of serious untoward incidents that had occurred within CAMHS and learning from this was shared across teams.

Multi-agency discussions took place, when required depending on the nature of the incident, to ensure appropriate action was taken and appropriate risk management strategies were put in place.

Safe staffing levels

There was a multi-disciplinary team (MDT) working on each of the services inspected. The Aquarius unit used the Royal College of Psychiatrists' Quality Improvement Network for Inpatient CAMHS standards to increase the MDT input on the unit and ensure there were appropriate staffing levels in place to support the young people.

On the Aquarius Unit the nursing staff worked on two qualified and two unqualified staff on each early and late shift, and one qualified and two unqualified on the night shift. If young people required one to one observation this was absorbed in the numbers for the first young person and then increased as required depending on the number of young people requiring this level of support. One young person told us, "I feel safe. I've got confidence in staff and you get different levels of observation."

The services for deaf children and young people had experienced a reduction in the staffing levels in their MDT. This meant there was a reduction in the amount of support and treatment available from occupational therapy, speech and language therapy and social work. There had also been a reduction in the nursing establishment and there was a reliance on agency staff.

Young people spoken to on the Aquarius unit felt there were not enough staff. One young person told us, "There are not enough staff to talk to." Another young person told us, "It's always short staffed, especially at night."

Safeguarding

All staff were aware of who the safeguarding lead was for the trust and consulted them when further advice was required. Safeguarding concerns were discussed during handover and governance meetings.

The services were proactive in referring cases to the local authority's safeguarding team if there was a potential that a child or young person was subjected to abuse. For example, there was a concern that a young person was

exhibiting aggressive behaviour and there were concerns as to the safety of their younger siblings. A referral was made to the local authority and joint work was undertaken by the CAMH service, the local authority and the child's school.

The staff team liaised with their social workers to aid communication with the local authority to ensure appropriate safeguards were in place to support children and young people accessing the service. The staff were mindful to monitor the safety of children and young people when using the same facilities as adults. The team's social worker supported staff and other services, such as the child's school, to complete a common assessment framework to identify people's needs prior to family breakdown or potential safeguarding concerns.

Whistleblowing

Staff were aware of the whistleblowing policy and processes.

Managing risk to the person

Risk assessments were undertaken for all young people. This identified the risk they presented to themselves, the environment and to others. Management plans were put in place to address the risks identified. Enhanced observations were used to support young people identified at high risk or requiring additional support.

We saw that it was clearly recorded if a young person had been involved in an incident whilst at the service, and their risk management plans were amended as necessary in response to the nature of the incident.

'Prescribe when required' (PRN) medication was used when required to support young people and maintain their safety. If PRN was used, the rationale and purpose for use was discussed amongst the staff team during shift handover.

Risk management

Incidents and risks on the unit were identified and discussed during handover. There had been an incident with a young person bringing a weapon onto the Aquarius unit and the staff identified how the team approached this with the young person and identified individuals to follow up on required actions. Staff also discussed use of physical restraint and physical interventions that had been used to manage risks on the unit.

A centralised recording tool was used to identify risks to the delivery of effective services, this included information on incidents as well as service pressures and staffing concerns.

Are child and adolescent mental health services effective?

(for example, treatment is effective)

Use of clinical guidance and standards

National best practice guidance was used to establish the models of care used across the specialist CAMH services. A multi-disciplinary approach was used to support children and young people accessing the service and the team followed recommended treatment for the range of diagnoses experienced, for example services used a combination of cognitive behavioural therapy (CBT), solution focused therapy, Dialectical behavioural therapy (DBT), psychodynamic training depending on the young person's needs. One young person told us, "Therapies depend on the person, so I got DBT as I think it's good. On the ward we do mindfulness. We have group work and individual work."

The staff at the adolescent resource centre set up a DBT group for families and a DBT group for young people to support their needs. This was especially for young people who undertook deliberate self-harm. A DBT pathway was established to support young people through the AAOT and the Aquarius unit.

The deaf child, young person and family service had representation on the national care pathway group which discussed use of National Institute of Clinical Excellence (NICE) guidelines. This group communicated and worked with NICE regarding adaptations to existing guidelines to meet the needs of deaf children and young people.

Recommended practice was undertaken for working with deaf children and young people and everyone received a communication profile assessment.

Monitoring quality of care

The specialist deaf CAMH services used the Children's Global Assessment Scale (CGAS) and the Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) to review the effectiveness of their service and monitor the progress children and young people make whilst engaging with the service.

Child and adolescent mental health services

The findings from October 2013 for the deaf child, young person and family service showed people's scores against these scales either improved or remained within their initial range for all disorders. This included mixed conduct and emotional disorder, emotional disorder, developmental disorder, family and communication.

In addition to CGAS and HoNOSCA, Corner House used goal based outcome records to monitor the quality and effectiveness of their service. The findings from December 2013 showed that all but one person had improved on their admission scores, suggesting the young person's functioning had improved. The findings also showed the goals identified on admission had either been met or the young people rated themselves as moving towards meeting their goals.

Corner House had recently been awarded a Quality award and the Signature award. The service was nominated for both awards by the children and young people, and their families.

The Aquarius unit had started to analyse their outcome data and were in the process of registering with the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS to join their routine outcome measurement service and compare performance nationally.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

The adolescent resource centre contains both the Aquarius unit and the AAOT. All referrals were made to the adolescent resource centre and a joint referral meeting took place to identify which service was best to support the young person. The AAOT was set up to support young people in crisis in the community and to reduce the number of out of area inpatient placements. However, the team were experiencing more referrals and the beds on the Aquarius unit were often full which meant more out of area referrals to neighbouring trusts were being made.

The Aquarius unit faced challenges getting multi-disciplinary and multi-agency team input to the young person's initial Care Programme Approach (CPA) meeting. The initial CPA meeting was held usually within the person's first week on Aquarius unit but this could be delayed or not have all agencies represented because of the challenges in getting all the required people to attend.

The deaf child, young person and family service worked closely with the schools in London as that was where most of their referrals came from. As well as supporting and treating the child, the team worked with the teachers to provide them with advice on how to support the child in the classroom. Assessments looked at functional, behavioural and communication needs. The team discussed all new assessments at their weekly care plan review meeting to identify who within the team had the skills to meet the young people's needs and take on the care coordination role. After assessment and discussion with the child and their parents, the team identified an initial care plan which was further developed after input from the multi-disciplinary team.

Corner House received the majority of their referrals from deaf child, young person and family services throughout the UK. However, the current commissioning arrangements at Corner House do not take into account travel costs and the needs of the family in accessing the service, especially as most people accessed a five day service and therefore families need to come to the service every Friday and Monday. This meant the trust was subsidising this cost but it was not sustainable, and it meant there was no equitable access to the service across the UK.

Are staff suitably qualified and competent

The staff were trained to provide the recommended treatments for the children and young people's needs.

CAMHS specific training was available to staff and the service's used training material produced by the Royal College of Psychiatrists to up skill their staff. Additional training had been provided to staff to further meet the needs of people accessing the Aquarius unit. The additional training included; supporting people with Autistic Spectrum Disorder (ASD), supporting people with Emerging Personality Disorder (EPD) and learning techniques such as DBT and mindfulness to support people who self-harm.

The Aquarius unit and Corner House were currently using a number of agency staff on most shifts. There had been concerns raised regarding the quality of the agency staffing. The team had raised their concerns internally through the trust's systems and directly with the agency regarding individual members. One young person told us, "The issue is agency staff … they do things they shouldn't."

There was an overlap of two hours between the morning and evening shift on the Aquarius unit, this enabled staff time to undertake a comprehensive handover and also

attend staff support sessions. This included reflective practice, group supervision and a psychology workshop (a skills learning session). This ensured staff were supported and the team worked together to explore how to best meet the needs of the young people on the unit. All staff received the required managerial and clinical supervision.

Are child and adolescent mental health services caring?

Choice in decisions and participation in reviews

Young people across all services were aware of their care plan, and had either been involved in the development of it or were happy for the staff to develop it for them.

Young people were able to meet with their consultant and their key worker (a member of the nursing team allocated to support them throughout their stay) to discuss their mental illness and the treatment options available. The staff informed us they took the time to discuss with young people what was working well and what was not working so well to tailor the treatment delivered to their needs. As well as one to one sessions with staff, the young people were also invited to take part in their CPA reviews. When appropriate, family members were also invited to these meetings. One young person told us, “We are working together.” Another young person told us, “Reviews depend on your needs. I have my input and I like to talk. Everybody involved in your care is there and my parents. ” A parent told us, “Yes, I do feel involved.”

The staff reviewed a young person’s capacity to understand their illness and treatment, and where appropriate, involved them in decisions regarding their treatment. We saw the young people on the Aquarius unit had been involved in the development of their care plan. This included setting their own goals for their admission and identifying when and where they required support from staff.

The young people were involved in developing the therapeutic timetable on the Aquarius unit. Every half term the programme was reviewed. Young people expressed which activities they enjoyed, for example art sessions with the occupational therapist, and sessions where they thought the focus and delivery of the programme could be amended, for example the coping skills group was adjusted on the back of feedback received from young people. A young person told us, “You can choose what you do in the programme.”

Do people get the support they need?

Young people were encouraged to discuss with staff their expectations and to identify their preferred treatment including if a young person had concerns regarding a treatment option that staff had recommended. Staff took the time to explore why the young person had concerns. They also explained to them why the treatment was recommended and provided them with further information about the specific treatment. Staff worked with the young people to identify a suitable treatment option, whilst always considering the risk to the young person of not complying with treatment.

The Aquarius unit had introduced ‘talk time’ which allocated a staff member to each young person on each shift, in addition to their primary and secondary nurse. Talk time enabled the young person to have time dedicated to them on each shift to talk about whatever they wished. Some young people had used this time to talk about their rights as an informal patient, whilst others had used it to revisit their care plans. This enabled young people to have regular access to staff to ensure they were getting the support they required on each shift. However, one young person told us, “I have a key worker and other staff. But staff are always busy. They don’t have time to talk. There are just a couple of people I could talk to.”

Staff on Corner House worked closely with the children and young people’s parents to ensure they were able to meet people’s needs whilst they were on home leave. This included providing parents with effective communication strategies and encouraging parents to continue to engage their child in activities they enjoyed as part of the occupational therapy they received at Corner House. Crisis and contingency plans were developed before people went home at the weekend so people were aware of how to get additional support when required.

Effective communication with staff

One young person told us, “I have a keyworker who’s my named nurse. We plan when to talk. We can approach staff and we get ‘talk time’ with our shift nurse.” Another young person told us, “The staff are really, really good. They do

everything they say they're going to do." The young person also said, "Definitely I feel listened to. I can pick up the phone and talk to the staff [those involved in their care]. I can call or text and they contact me straightaway."

The staff working within the services for deaf children were required to access British Sign Language (BSL) training in order to effectively communicate and support the children and young people accessing the service. The majority of staff working in the deaf child, young person and family service were at level three showing a high competency in BSL. However, there was no interpreter at night on Corner House which meant there was a risk that children and young people were unable to successfully communicate with staff, especially if the staff were relatively new and hadn't completed their BSL training or they were agency staff.

Privacy and dignity

Each young person at the Aquarius unit and on Corner House had their own bedrooms.

Staff were mindful to maintain a person's privacy and dignity as much as possible. One young person told us, "I feel respected." If a young person used the shower but was considered high risk the staff ensure the door is kept shut but they maintain verbal contact and listen. If the person does not respond they inform them that they will have to open the door to check on their safety.

Restraint and seclusion

Prone restraint was being used at Corner House and the Aquarius unit which was not in line with recommended practice.

The Aquarius unit had a de-escalation room available. This room was used for a variety of purposes. Young people were able to request to use the room if they needed some time away from the group to calm down. It was also used to contain young people and keep them and the rest of the group safe whilst not having to continuously be restrained by staff. There was a policy on the use of this room and the restriction of a person's liberty whilst on the ward.

Restraint techniques at Corner House had been adapted to ensure the deaf staff and young people were able to communicate throughout the restraint. A staff member was nominated as a communicator and ensured eye contact was maintained with the young person throughout the restraint. There was communication to young people upon admission as to the reason why restraint was used and what the process involved.

Are child and adolescent mental health services responsive to people's needs?
(for example, to feedback?)

Service meeting the needs of the local community

The AAOT and the deaf child, young person and family service remained involved during a young person's admission to an inpatient unit and were involved in assessing when the young person could be discharged and suitably supported in the community.

There had been difficulties on the Aquarius unit with delayed discharges because of problems with accessing funding for social care placements. The interaction with social care services varied across the five London boroughs. The Aquarius unit had started to work with the London Borough of Merton to do joint training on the needs of young people and how they can be supported in the community.

Providers working together during periods of change

The consultant from the Aquarius unit was invited to the outreach referral meeting and provided consultation to local community teams to identify young people who may benefit from an admission to the Aquarius unit and also to identify a package of care for young people upon discharge from the Aquarius unit. One young person told us when talking about discharge arrangements, "I will see staff who work in Outreach, who I know already."

The AAOT invited the referring agency, usually a tier 3 community service, to regular CPA meetings so they were kept updated on people's progress and could start discharge planning. The AAOT experienced some difficulties with young people being taken off the waiting list for the tier 3 service during the young person's engagement with the AAOT, which meant there were times when young people had to wait for psychological therapy input upon discharge back to the tier 3 team.

Child and adolescent mental health services

The AAOT worked closely with the early intervention service and the tier 3 drug and alcohol workers to provide joint working or referral to these services to meet people's needs.

The community and inpatient services for deaf children and young people worked closely to meet the needs of people using the service. The community service remained involved in a person's care whilst they accessed inpatient services to keep updated on their progress and provide consistency in care upon discharge back to the community. The community services worked closely with schools, colleges and the child or young person's GP to ensure they had the necessary information to support the young person when they were discharged back to the care of their GP. This ensured all agencies were aware of how to support the young person and how to re-access the service if the need arose.

Corner House had regular teleconferences with the outreach satellite clinics to discuss the needs of children and young people in their local area. This was used to update the local teams on the progress young people from their area were making on the ward and identify referrals and discharge arrangements.

There were challenges when transitioning young people from the deaf child, young people and family service to a deaf adult service. This was because the CAMH service was required to refer the young people to their local community mental health team who then referred onto the deaf adult service. Because of the differences in referral criteria, and at times a lack of understanding of the specific needs of people who used the service due to their deafness, this meant at times there were delays or missed referrals between the local CMHT and the deaf adult service. As such people were not accessing adult services in a timely manner and there were inconsistencies in the care and treatment they received.

Learning from complaints

The trust's complaints process was on display and accessible to children and young people at each of the service's we visited. The trust's complaints process had recently changed and now all complaints (formal and informal) were reported to the trust's complaint's department. Staff were aware to listen to people's complaints and apologise where mistakes had been made.

The teams informed us they tried to resolve complaints in a timely manner and to the satisfaction of the complainant. All complaints were discussed during monthly business meetings.

Are child and adolescent mental health services well-led?

Governance arrangements

Governance arrangements were in place to monitor the quality of service provision within the specialist CAMH services. The Specialist CAMHS governance group met monthly and included representation from the tier 4 and specialist CAMH services, as well as representation from the local community teams and from each professional group. This group fed into the Directorate's governance group, which fed into the trust's integrated governance and quality meeting. The team felt supported to escalate concerns through the governance structure when required. The governance groups reviewed any serious incidents experienced and the findings from root cause analyses, themes from complaints received and the findings from audits and research. The group identified where the service quality was required to improve and disseminated learning throughout the team. The group also monitored the findings from audits to ensure all actions identified were addressed. The governance group reviewed and ratified new policies and procedures.

There were monthly CAMHS consultants meetings across tier 3 and 4 services. These meetings were used to discuss operational and governance issues, review national strategies, disseminate information on trust wide directives and to review findings from audit and research programmes.

There was a programme of audits undertaken in response to identified areas of concern across the trust and also to monitor the care and treatment provided to young people at the Aquarius unit. The audits undertaken included; monitoring consent and capacity arrangements, monitoring completion of physical health assessments including Venous Thromboenbolism (VTE) risk assessments, and adherence to the Care Programme Approach (CPA).

Each week an audit was undertaken ensuring that young people were offered 'talk time' at each shift, and that CPA paperwork was accurately completed. The findings were

analysed weekly and sent to the whole team with action points about what information was missing and what needed to be done. The findings from the February 2014 CPA audit showed that 75% of young people felt there was opportunity for them to speak in the meeting, 75% of young people felt the meeting addressed what was important to them and 83% of young people felt clear about the plans made in the meeting.

An audit had begun to establish how effective the AAOT had been for local people, who used the service, reviewing length of stay and discharge planning arrangements.

Engagement with people who used the service

Weekly business meetings were held for the young people to feedback about the service. These included obtaining their thoughts and opinions on the food, the environment, any concerns regarding the staff supporting them and to get their input into the activities offered on and off the unit. If concerns were raised about the food or the environment the caterers or the facilities department were invited to the meeting to receive the direct feedback and ensure young people had the opportunity to influence change within the service.

Community groups were held twice a week with the young people to discuss and think about the ward dynamics on the Aquarius unit. This allowed young people to have a greater understanding of a range of mental illnesses and the needs of young people with those illnesses. The aim of the group was for young people to understand how their behaviour may affect the needs of others on the unit, and how they could amend their behaviour to support each other.

A parents' support group was set up to provide additional peer support to parents who had children requiring treatment from the Aquarius unit or the AAOT.

Analysis of the experience of service questionnaire in February 2014 showed that the majority of young people were positive about their experience of the AAOT. The comments included, "I got the support that I had wanted for a long time," "Communication was highly respected and my wishes were listened to and followed. Any worries were taken seriously and dealt with quickly." Negative comments included, "I didn't like it when I was discharged from Outreach, it felt like I was being abandoned," "I didn't like the time scheduling because it sometimes interfered with my schoolwork." The deaf child, young person and family service also received mainly positive feedback through completion of the experience of service questionnaire from January – March 2014. Comments included, "It was really good because I could tell them anything and they would listen," "open, honest and helpful. Very professional." Corner House also received mainly positive feedback. Where areas for improvement where identified, actions were undertaken to address the concerns.

Engagement with staff

'Listening into action' was introduced as a means to engage staff throughout the trust. As part of this initiative the staff on Aquarius unit were not using the trust's electronic patient records system and were developing the young people's care plans, crisis and contingency plans in paper format. This was because the care planning template on the electronic records was too complicated and not meaningful to young people and their families. The team also found it easier to engage young people in the care planning process if it was undertaken in paper format and written with them.

'Listening into action' also led to protected car parking spaces for staff that work in the community so they were able to park on site when they had come back from a home visit.

A virtual CAMHS directorate had been established to review the CAMH services across the trust. This included reviewing national services, local services and links with out of area placements. The directorate was going through a transition with a focus on care pathways and referrals. The tier 3 services were also going through a transformation programme. Staff spoken with felt there was a lack of involvement and communication with the staff working in the specialist CAMHS services regarding the tier 3 transformation programme. Therefore they were not able to input into how the potential changes may impact on joint working between tier 3 and 4 services, and how this will impact on the admission and discharge process. Staff felt they were not engaged in the process and were not given the opportunity to comment. It was acknowledged that there could have been more robust and wider staff engagement in meetings regarding the new directorate, the transformation programme impact on tier 3 CAMH services, commissioning arrangements and the applying for foundation trust process.

Child and adolescent mental health services

Effective leadership

The majority of staff were aware of the leadership structure in place for specialist CAMH services within the trust. This included operational management, support through the line management structure, and clinical support from the head of nursing and the CAMHS clinical lead. However, some staff were unclear of the operational leadership structure above the operational manager.

There had recently been a restructuring of the middle manager tiers, including the role of the matron and the operational manager. This included a review of responsibilities between these two levels and the ward manager or team leader. The team felt further work was required to embed the roles and to clarify clinical and operational responsibilities at each level. There was also uncertainty with the remit of the team leader role within the AAOT and it was unclear what their responsibilities were in regards to team management.

There were concerns that AAOT and Aquarius were both part of the adolescent resource centre but that the ward manager for Aquarius reports to the modern matron whereas the team leader for AAOT reports to the operational manager. There were concerns that this was confusing and there needed to be consistency in the management structure for the two services.

The deaf child, young person and family service had recently recruited a team leader. The staff spoken with felt this had helped with communication and the flow of information. The team reported they felt 'they know what's going on more.' Staff morale was high within the deaf child, young person and family service and the staff felt there was strong inter team support and inclusion.

At service level, the teams reported there was good leadership within their teams, and the different disciplines worked well together. Staff felt within the team everyone was kept well informed and "made it their business to understand." Medical staff were clear on their line management structure and reported having good access to their seniors. Staff reported there were supportive teams within each service we visited. The services provided a peer learning environment and skill sharing amongst the team. One staff member told us, "Everyone has a voice – it's not about disciplines."

Staff reported that the chief executive officer was approachable and accessible, and there was clear communication and information from themselves and the medical director.

Services for older people

Information about the service

At Springfield Hospital, there is one ward, Crocus, which is an admission and treatment ward for older people. The ward has 21 beds and accepts people from Merton, Sutton and Wandsworth.

Summary of findings

We found that people who used the service were provided with care which was informed by staff who knew and understood their roles. Staff had a good understanding of safeguarding processes. However, we found that some records relating to falls and pressure ulcer management was not collated consistently and had not necessarily led to ongoing learning and understanding of the causes. This meant that there was a risk that incidents might not be addressed comprehensively.

Staff had a good understanding of relevant clinical guidelines such as NICE guidance which was embedded in practice on the ward. The ward conducted some internal audits of their performance and had benchmarked some areas, such as falls, against other Trust services however it was not clear that this lead to an improvement in practice.

Most of the feedback from people who used service and their family members was positive. We observed kind, thoughtful and respectful care during our visit. We saw that staff knew the people on the ward well and were developing systems, like the personal profile, that ensured people would have a more personalised care. However, we saw that there was little involvement from people in their care plans and information about people's history and biography was not always accessible to staff providing them with care. This meant that there was a risk that care would not be adapted to individuals.

We saw that staff from different disciplines worked together to provide appropriate care and support to people who used the service and that the staff had an understanding of meeting people's needs relating to their culture, language, religion, sexuality and gender.

Most staff on the ward told us they felt supported by their management team and that they were able to raise concerns if they had them. We did not see evidence that supervision was taking place consistently however staff told us they could approach their managers informally if necessary.

Services for older people

Are services for older people safe?

Learning from incidents

Staff told us that when they report incidents, they do not get regular reports back from the team who logs the incidents centrally. One member of staff told us that serious incidents are reported back but otherwise they are not. This meant that there is a risk that learning from incidents did not occur at the ward level unless they were serious incidents.

We saw an audit which had taken place in July 2013 of incidents on the ward. This audit checked that incidents reported via the provider's electronic recording system for incidents matched with RiO records. While the audit reported much good practice, it also identified some anomalies in practice and confirmed that not all incidents were reported in line with the provider's policy. We saw that an action plan had been developed to improve incident recording and to re-audit in December 2013. There had not been a subsequent audit and we saw gaps in the recording of information. This meant that information which was identified in an audit had not been followed up so that learning from incidents could be embedded in practice.

Environment and Equipment

We checked the physical environment of the ward. We found that there were separate male and female areas. We saw that there were signs near the doors of the ward which indicated that people who were not detained under the Mental Health Act (1983) were able to leave the ward and the language of the signs and notices were adapted to those who may have cognitive impairments.

We checked the clinical area of the ward and found that emergency medication and equipment was available and functioning. However, we saw that there were four opthalmoscopes (which is a piece of equipment used to check people's eyes during a physical examination) present, none of which were functioning. We looked at the scales which were used to weigh people and saw that there was a sticker on them which stated that a check was due in June 2013. There was a risk that people using the service would need to use equipment which had not been checked or was not functioning.

Safe staffing levels

The staffing levels were at their complement when we visited. We saw that in addition to nursing staff, there was an occupational therapist who was based on the ward from 9am to 5pm during the week. The ward manager was supernumerary.

When we visited there were no substantive health care assistants (HCAs) on duty and staff were provided through NHS Professionals. We spoke with some HCAs who had worked on the ward before and were familiar with the people who were on the ward and able to meet their needs.

There were four consultants who covered the ward and there were four junior doctors (SHOs). They also covered their respective community mental health teams. This meant there was continuity with community services but meant there was a risk of lack of consistency on the ward. We were told that another ward in the trust was piloting a single consultant model which may be used on this ward.

One member of staff told us that sometimes there was only one male HCA on duty and this could be difficult when they needed to respond to emergencies. This meant that while the skill mix was maintained, the gender mix was not always appropriate to meet the needs of patients. We were told that there was one vacant nurse post and there was an intention to recruit a general nurse specifically to this role in order to better meet the physical health needs of people who used the service.

Safeguarding

Staff we spoke with had a good understanding of safeguarding and knew who to contact if they had a concern. We saw that all staff had undertaken safeguarding training. Most staff were able to identify the contact if they had a concern about safeguarding.

Managing Risk

We looked at risk assessments and risk management plans including care plans while we were on the ward. We saw that most risk assessments were up to date and included risk information relevant to providing care to the people who were using the service. We saw that some risks identified in risk assessments were not followed up with risk management plans. For example, we saw in one of the records we checked that a risk of falls was identified but there was no specific risk management plan available.

We saw that people who were admitted to the ward had physical health monitored. We found that the recording and monitoring of physical health ensured that people were provided with care which met their needs.

Medicines Management

We assessed the management of medicines on Crocus ward. We checked prescription charts for 7 of the 18 people on the ward, and we saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear, fully completed, and showed people were getting their medicines when they needed them. There were no gaps on the administration records and any reasons for not giving people their medicines were recorded. We saw that if people were detained under the mental health act, the appropriate authorities were in place for medicines to be administered to them. One person was having their medicines administered covertly, and the appropriate authorisations were in place. This meant people were receiving their medicines as prescribed.We looked at the storage and records for controlled drugs, and we saw that appropriate arrangements were in place to manage controlled drugs.

We saw that supplies of medicines were obtained promptly. A stock of commonly used medicines was held on the ward to avoid delays in starting treatment. Therefore arrangements were in place for people to receive their medicines without delays.We saw that medication and intravenous infusion bags were stored securely. Medicines requiring cool storage were stored in a medicines fridge. Although staff were making a record of the temperature of the medicines fridge, we noted 2 days in March 2014 when the temperature was recorded as 17C and 24C instead of between 2-8C, and there was no record of any action taken. The trust's Medicines Code states that "The temperature must be kept between 2°C and 8°C, checked daily using a maximum/minimum thermometer, and a log of the readings kept. If the reading falls outside of this range, or in the case of refrigerator failure, the pharmacy may be contacted for advice regarding the further use of the medicines stored within". We noted that the temperature of the room in which medicines were stored was 27C on the day we visited. The trust's Medicines Code states that "Medicines must generally be stored at temperatures of 25 degrees C or below". As the room temperature was not monitored or recorded, and staff told us that this room was often warm, we could not be assured that these medicines were being stored at the correct temperatures to remain fit for use.

Medicines were administered from a trolley by qualified staff. We noted, however, that one member of staff dispensed each dose, and a second member of staff administered the dose and signed the administration record, which could introduce the risk of incorrect administration.

We checked the records for two people who had received rapid tranquilisation. We saw that staff had recorded that this was administered to one person because they were "unsettled", although staff told us that they had administered this because the person had been aggressive. There was no evidence of a debrief or mandatory physical health monitoring for these people, which is required by the trusts policy on rapid tranquilisation. We noted that this ward had not submitted any Rapid Tranquilisation reports for the last trust audit.

Are services for older people effective?
(for example, treatment is effective)

Use of clinical guidance and standards

We spoke with nursing and medical staff who displayed a good understanding of clinical guidelines, for example, NICE guidelines regarding the use of psychotropic medication for people with dementia. One member of staff explained to us that this guidance is fundamental to the care which was provided. Medical staff told us they have access to continuous professional development to ensure that their knowledge base was up to date and that it could be transferred into practice. Medical staff told us the trust was piloting a single consultant model on another ward and that this ward would be moving to that model in the future.

Monitoring the quality of care

Staff told us about the systems they use to report incidents which occur on the ward. The information was reported on RiO which was the trust's database which logged daily records and relevant information. There was also a specific system, Ulysses, which specifically recorded incidents. We looked at records to see how incidents, such as falls which resulted in harm, were recorded. We found that incidents were not consistently recorded, for example, we saw

records where a person had had a fall which was discussed by their doctor in a ward round but it had not been logged in RiO by nursing staff. We also saw that after this fall, a multifactorial assessment had not taken place as was recommended in NICE guidance (NICE clinical guideline 161 “Falls: assessment and prevention of falls in older people”).

Collaborative and multidisciplinary working

Medical staff on the ward also worked in community mental health teams and provided medical input to the respective specialist home treatment teams, teams which worked with those who had behaviours which challenged the services providing care to them and memory services. There was an occupational therapist who was based on the ward. Staff told us they had access to staff in community teams and that the ward and community teams worked together to ensure that best outcomes for people who used the service.

We observed a ward round where community staff were present and contributed to the meeting. One member of staff told us about a situation where staff from the community based ‘challenging behaviour’ team had been involved in providing in-reach support to someone who used the service to facilitate their discharge. This meant that services worked together to provide the best outcomes for people who used the services.

We saw records which indicated that information was shared between community and inpatient teams.

Skill, experience and competence of staff

We checked the training records of staff who were based on the ward and saw that most staff had completed their mandatory training. Staff told us they felt their managers were supportive and approachable however we saw there had not been consistent supervision provided in the past. We spoke with the ward manager who told us that this was being addressed. Staff told us they had not received specific training related to dementia externally and if they wanted to source specific training in this area, they had to look for it themselves. This means there was a risk that staff may not have access to specific training related to the user group that they work with.

We were told that two nurses on the ward had undertaken family therapy training and this would be used to facilitate support for family carers. We were told that another nurse on the ward was working on research related to people with dementia which would enhance their practice. We saw that an issue had been raised by one of the local CCGs (Clinical Commissioning Groups) related to staff attitude and that this had been addressed by staff customer service training. This meant the training needs of staff were tailored to issues which had been identified in practice.

Are services for older people caring?

Choice, decisions and participation

We spent two days on Crocus ward and we spoke with people who used the service, family members and carers and we observed care being delivered at different times of the day. We saw that the interaction between people who used the service and staff members was positive and that staff responded to people with patience, kindness and ensured that they were treated with dignity.

We observed a community meeting which was led by the ward occupational therapist. We saw that people gave feedback and suggestions and that they had been responded to. We saw this from previous minutes of community meetings as well as by observation. For example, we saw that when issues had been raised about menu options, these had been changed as a result of the feedback given. We saw that people were asked about their preferences regarding activities and that when people did not wish to engage in activities or were not able to, they were offered 1:1 time with staff.

We observed a ward round. However, on the day we attended, people who used the service were not involved in the ward round and did not join the meeting about their care. We saw that discussions during the ward round included conversations with professionals about capacity and consent. The staff team showed good understanding of the people who were on the ward and consideration was given to people’s preferences. We saw that people did not participate in the ward round which we observed. It was not clear whether this was their choice or because they had not been invited. This meant that there was a risk that people were not offered the opportunity to participate in meetings about their care and needs.

We looked at care plans and saw that they lacked personal detail and information, particularly biographical information. We spoke with the ward manager who showed us that the ward had begun to develop ‘patient profiles’. These were one page summaries of information

about things which were important to people who were on the ward, including photos and summary information about their preferences. This meant that the ward staff were providing personalised care however this was not reflected in the care planning documentation.

We saw that there was a “You said, We did” board on the ward which indicated areas where the staff on the ward had taken action to change the care on the basis of feedback. This shows that people were involved in their care and had an input into the way the ward was run.

Effective communication with staff

People we spoke with told us they were informed about their care by staff on the ward. One person told us “I feel informed” and another person told us, “I find them [nursing and medical staff] good”. We saw that progress notes did not indicate involvement and discussion with people who used the service however we observed people being involved in discussions and having information about choices and decisions shared with them.

Provision of necessary support

As well as the nursing and medical staff on the ward, there was an occupational therapist who was based on the ward. We saw that there was access to a clinical psychologist but this was through a referral in the community teams. On one of the days we visited, we saw that someone had been admitted to the ward from one of the acute adult wards. We were told that sometimes the ward takes people from one of the acute adult wards when there are not enough beds on the adult wards. This meant that sometimes there were younger adults on the ward. We were told that when this happened, the person returned to their ‘home’ ward during the day and that people were moved to a more suitable ward quickly. However, there was a risk that some people were not having their needs met on the ward if they were of working age and were nursed on a ward for older adults, which included people who had dementia.

Privacy and Dignity

Most people told us they were treated with dignity and respect by staff on the ward. We saw that staff ensured that people’s privacy was respected when providing personal care to people by ensuring they knocked on people’s doors before entering rooms and kept the doors closed when delivering personal care.

Restraint and seclusion

We asked for incidents when restraint was used on the ward. We were told that the ward did not have access to this but that the use of restraint on the ward was ‘minimal’. The lack of clearly identifiable information about the use of restraint meant that there was a risk that information to learn from incidents when restraint was used may be lost.

Are services for older people responsive to people’s needs?
(for example, to feedback?)

Meeting the needs of the local community

We asked staff how they ensured that people’s cultural and religious needs were met on the ward. We also asked people who used the service if they felt their needs were met in terms of culture, language, religion and sexuality. Most people told us they were treated with respect by the ward staff.

Staff told us the ward had a chaplain available to meet the spiritual needs of people who used the service. Staff told us that they could book interpreters when people who did not speak English were on the ward and we saw that the staff had booked an interpreter for a ward round meeting.

Staff told us that they tried to meet people’s needs and preferences regarding food which met their cultural needs. We saw that the ward was developing the use of ‘patient profiles’ which evidenced that issues regarding culture were addressed so staff understood the needs of different groups of people and were able to respond to them.

Providers working together through periods of change

We saw that discussions regarding discharges took place with other providers and with the relevant community teams. Appropriate information was shared to facilitate safe discharges. We saw that other professionals were present at review meetings and ward rounds to ensure that people’s treatment, care and discharge arrangements were discussed.

Learning from complaints and feedback

The service had not received recent complaints however we saw that the ward had reached a target of 77% of people who used the service having provided feedback on the service. Feedback was primarily received through paper comment cards however we were told that there would be

a move to use tablets to get more real time feedback. This would allow people to feedback in different ways. We saw that there was information about access to advocacy and complaints in the ward.

Are services for older people well-led?

Governance

The ward manager told us they attended a monthly ward manager meeting where broader governance issues were discussed. They told us that their clinical director was accessible and they frequently met to ensure that issues which needed to be discussed could be raised.Staff told us that they felt supported by their managers and able to raise concerns.

Engagement with people who use services

The ward had regular community meetings where issues which were raised by people who use the service could be addressed. People were consulted about the service and their feedback was sought and this was used to improve and develop the service. For example, we were told that people had made suggestions about different menu options which had been put into practice by offering cooked breakfasts at weekends.

Engagement with staff

Staff told us they felt that engagement with the senior management had improved with the new CEO and the change in the executive level leadership. They told us the modern matron and nurse consultant were visible and approachable.

Effective leadership

Most staff told us they felt supported at the local level and felt proud to work for the provider. However, some staff told us they did not feel older people's services were a priority to the organisation as a whole and sometimes they did not feel that the services in this area had a strong voice within the organisation as a whole.

Specialist eating disorder services

Information about the service

Avalon Ward is a national, specialist service providing care and treatment for male and female patients over the age of 18, experiencing severe eating disorders. There are currently 18 inpatient beds on the ward.

Wisteria Ward is a specialist eating disorders service for male and female young people between the ages of 11 and 18 years who have anorexia nervosa and require specialist inpatient treatment. The ward provides intensive treatment programmes and takes both local and national referrals.

We spoke with staff, including doctors, nurses, managers, health care assistants and therapists. We spoke with people who used the service and carers. We observed a ward round, team meeting and handover between shifts as well as interactions between staff and people who use the service. We looked at care and treatment records.

Summary of findings

Staff on both wards had a good understanding of safeguarding processes and were able to protect people at risk of abuse. Wisteria Ward was a safe and secure unit where individual and environmental risks to the young people were managed effectively. There were sufficient staff to care for young people on the ward. On Avalon Ward, however, although most environmental risks were being managed we found one area where ligature risks, although identified, were not being managed. We noted from analysis of staffing rotas on Avalon Ward that although the numbers of staff on duty were consistent with the trust's assessment of staffing needs there were many occasions when there were fewer than the required three qualified staff on duty.

The care and treatment of people with eating disorders reflected relevant research and guidance. There was a good pathway of care for the most physically unwell people using the service which involved liaison and partnership working with the local acute hospital and staff followed nationally agreed guidance. Wisteria Ward was accredited nationally through the Royal College of Psychiatrists Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC). A recent detailed evaluation of the service showed that there were overall improvements between assessment and discharge in a range of measures indicating the effectiveness of the service. A self-assessment of Avalon Ward against the Royal College of Psychiatrists Quality Network for Eating Disorders pilot standards in November 2013 identified a high degree of compliance with expected standards. Permanent staff were skilled in and knowledgeable about eating disorders and received support and supervision which enabled the delivery of safe and effective care. However, both staff and people who use the service recognised that many bank and agency staff lacked knowledge and experience of eating disorders.

The majority of feedback from people who use the service, about the care and treatment provided, was positive. People were involved in developing their care plans and were well informed about their treatment. They felt able to ask questions about their care and information was provided in a way they understood. The

Specialist eating disorder services

service used a recovery approach to working with people and recovery goals were clearly stated in people's care plans. We observed caring and compassionate interactions between staff and people who use the service. Staff were non-judgemental in their approach and treated people respectfully. However, the occasional use of inappropriate rooms for nasogastric feeding failed to maintain young people's privacy and dignity on Wisteria Ward. The provision of meals, although meeting people's nutritional needs, failed to take account of the specific needs of people, for whom eating sufficient amounts of nutritious food was already particularly difficult.

The wards provided a national service to people with eating disorders and often admitted people whose needs could not be met in their own area. Many people had complex needs with additional mental health needs. There was an effective system in place to manage and learn from complaints. People knew how they could make complaints and raise concerns and said they were listened to by staff. However, staff on the wards had raised concerns about the quality of food and lack of a treatment room of an appropriate size on Wisteria ward and these concerns had yet to be addressed by the trust.

We found that Wisteria Ward in particular was well-led. The ward manager worked proactively within trust governance systems to influence and bring about changes that benefitted young people with eating disorders. People who use the service were encouraged to give feedback about their care and treatment and had ways of influencing how it was provided. The culture on the wards was open and encouraged staff to reflect upon their practice. However, staff from all disciplines told us they considered the trust senior management did not fully understand the needs and complexity of the eating disorders service. Clinicians in particular did not feel listened to by senior trust managers and experienced a disconnection from the trust board.

Are specialist eating disorders services safe?

Safe environment

We found that Wisteria Ward was a safe and secure unit. It ensured appropriate levels of security while caring for children and young people in the least restrictive way. A recent audit of ligature points on Wisteria Ward showed that improvements had been made to the safety of the environment. Potential ligature points were managed as part of both ward and individual risk assessments.

Male and female sleeping areas were separate. People on Avalon had single rooms. On Wisteria most rooms were shared but were always same-sex. There was a separate lounge for males on Avalon Ward.

Avalon Ward was situated on the second floor and was accessible only by stairs. The trust had plans to install a lift as part of a refurbishment of the ward in general. This would enable easier access to the ward.

Risks in the environment were generally well managed on Avalon Ward. However, we found an unlocked small dining room which had a number of ligature points and three items of equipment including a toaster and fan, with long flexes. Although the risks had been identified in an audit of ligature points in July 2013 the audit report did not identify how the specific risks in the environment would be safely managed. Staff told us that the room was not generally kept locked. Without a clear risk management plan in place people were not protected against potential risks of self-harm.

Learning from incidents

Staff knew the types of events, near misses and incidents they needed to report and how to report them. Ward managers reviewed all incidents and identified potential learning and improvements. There was evidence that learning from incidents was shared with staff in both individual supervision sessions and within team meetings. Appropriate changes were implemented to minimise the risk of incidents reoccurring.

Safeguarding

Staff had undertaken training in safeguarding children and vulnerable adults and knew how to respond appropriately to any allegation of abuse. There were detailed policies and procedures in place in respect of safeguarding to support

staff to respond appropriately to concerns. Staff knew where to refer safeguarding concerns and to obtain safeguarding advice. The social worker on Avalon Ward was the safeguarding lead. They had good interagency links and provided training sessions for staff on safeguarding. People who use the service told us they felt safe on the wards.

We saw that when people refused certain aspects of their care this was respected by staff. For example, when a person refused to be weighed. When people were treated without their consent this was done lawfully. Staff showed good understanding of relevant legislation in relation to consent and capacity.

Whistleblowing

All staff we spoke with were aware of the whistleblowing process. Staff felt confident in raising concerns and how to escalate these if necessary.

Managing risk to the person

There were procedures in place to identify and manage risks to people who use the service. We observed that staff discussed risks related to people at the handover between shifts and in the multi-disciplinary ward round. Patient safety was taken into account in the way care and treatment was planned.

The wards had good links with the local acute hospital and were able to obtain the results of blood tests promptly. This enabled them to identify concerns and respond to changes in people's physical health in a timely manner. People we spoke with confirmed they had regular blood tests and understood the reason for this. Staff assessed people's physical health regularly. A system of recognition of early warning signs enabled nurses and health care assistants to identify when people's clinical observations required escalation to medical staff.

We reviewed the electronic records of four people who used the service, including their care plans and risk assessments. We saw there were individual risk assessments in place related to people's assessed needs. There were clear risk management plans for areas such as self-harm. People told us they were able to take part in the risk assessment process and staff explained clearly to them when restrictions were put in place.

The service had systems in place to deal with foreseeable emergencies. All staff were trained in basic life support techniques. Training records confirmed this and staff told us they felt confident in dealing with medical emergencies.

We saw the emergency equipment on both wards was easily accessible. Records showed that emergency equipment was checked weekly to ensure it was fit for purpose.

Risk management

Regular meetings were held to review risks to overall service delivery. Key performance data was analysed and reported to the monthly directorate performance review. Reports were used to identify early warning signs and risks that could affect the quality of care and treatment provided, including staff sickness levels, relationships within the staff team and mandatory training compliance. Action plans were put in place to address shortfalls.

All admissions to the service were reviewed by a bed panel, including senior clinicians, which ensured that the needs of the ward and all people using the service were considered before a new admission was accepted. On Avalon Ward there was a limit to the number of people with serious physical health needs that could be cared for safely at any one time and this was reflected in decisions about admissions. This ensured people were not put at risk of poor care and treatment.

Medicines management

Appropriate arrangements were in place in relation to the management of medicines. A Care Quality Commission pharmacist inspector reviewed medicine administration records for several people on Avalon Ward and found these were completed appropriately and accurately. There were fridges for medicines requiring cold storage at the right temperature. Records showed that the fridge temperatures were checked on a daily basis to ensure they were within the required range. Medicines were stored safely in locked cupboards and the drugs fridge.

Safe staffing levels

We found that there were enough members of staff to care for young people safely on Wisteria Ward. Staffing levels were adapted when changes in needs were identified. For example, if a young person required one to one support or close monitoring, additional staff would be obtained. Regular bank staff, with a good understanding of eating disorders, were usually available to provide additional cover on Wisteria Ward when needed. Sickness rates on the ward were low.

Specialist eating disorder services

Levels of consultant psychiatrist cover for the service were in line with Royal College of Psychiatrists recommendations.

On Avalon Ward staffing levels had recently been increased to seven staff on each day shift and five at night. Additionally, the skill mix of staff had been changed to ensure there were three qualified staff on duty on each day shift. Staff told us the ward had "felt safer" since the introduction of more staff. However, when we visited the ward on 18 March 2014 we found there were six staff on duty as a nurse had called in sick at short notice. On 20 March 2014 we found there were six staff on duty in the morning only one of whom was a qualified nurse, rather than the required three. This was reported to be due to unexpected staff sickness. The modern matron came to the ward to provide additional cover. On the afternoon of 20 March 2014 we observed that staff only became aware of a shortfall in staffing levels for the afternoon shift ten minutes before it began. Attempts were then made to obtain a replacement. When we reviewed the staffing rotas for the first three weeks of March 2014 we found that, while there were seven or more staff on duty on the majority of shifts, there were fewer than three qualified nurses on duty on 16 occasions which was 40% of shifts. This meant the trust was not meeting the staffing requirements for the ward that they had determined were necessary to provide safe and effective care.

Most people who use the service told us there were not enough staff on Avalon Ward. They said therapeutic groups and activities were sometimes cancelled because of insufficient staff available to facilitate them. Real-time feedback comments made by a person using the service in March 2014, using an electronic device, described the ward as "short staffed and chaotic."

Are specialist eating disorders services effective?

(for example, treatment is effective)

Use of evidence-based clinical guidance and standards

Peoples' care and treatment reflected relevant research and guidance. Goals around weight restoration were individually planned and agreed with the person following the National Institute for Health and Care Excellence (NICE) guidelines.

There was a good pathway of care for the most physically unwell people using the service which involved liaison and partnership working with the local acute hospital. Staff followed 'Management of really sick patients with anorexia nervosa' (MARSIPAN) and 'Management of really sick patients with anorexia nervosa under 18' (junior MARSIPAN) national guidance to ensure high standards of physical health care.

Wisteria Ward used a mainly systemic approach to caring for young people. The manager told us they were open to using other models of care and were reviewing other approaches in light of the changing needs of young people who were referred to and used the service. The service was accredited nationally through the Royal College of Psychiatrists Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC). Avalon ward was preparing for accreditation with the Royal College of Psychiatrists Quality Network for Eating Disorders.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

There was evidence of effective multi-disciplinary team (MDT) working. People who use the service had access to nursing and medical staff as well as psychologists, psychotherapists, occupational therapists, social workers, a dietitian and a family therapist. We saw that care plans included advice and input from different professionals involved in people`s care. People who used the service and carers told us that they were supported by a number of different professionals on the wards.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment. The consultant and managers told us that the unit had a good working relationship with the local acute hospital and was able to obtain prompt test results and transfer people to acute care when needed. Care programme approach (CPA) meetings took place and were attended by other health care providers. For example, the person`s community care coordinator, when this was possible. Video and teleconferencing facilities were sometimes used to facilitate participation. If professionals were unable to attend, the wards ensured professionals were kept up to date about people's care.

People who were close to discharge told us there were clear plans in place to manage their care and treatment in

the community. Key health professionals were identified in their discharge plan and one person's comment was typical of others when they said they knew "exactly what is going to happen when I leave here."

Monitoring the quality of care

The manager of Avalon Ward showed us the clinical dashboard system that was used to monitor clinical and workforce performance measures, including current staff compliance with statutory and mandatory training requirements. Staff told us that audits were used to monitor risks and the quality of the service. However, when we asked the ward manager, who was very new in post, and nurses on Avalon Ward for evidence of audits they were unable to provide any. The manager was not sure how audits of care records and medicines were being recorded but said they took place and action was taken in response to learning from the audits. For example, staff were reminded to review and update care plans where shortfalls were identified.

Wisteria Ward had conducted a detailed evaluation of the service, examining the progress of a sample of young people discharged from the service between March 2013 and February 2014. Measures of progress included weight and body mass index (BMI) and a range of recognised assessment and evaluation tools, such as, Health of the Nations Outcomes Scales for Children (HONOSCA). Results showed that despite the complexity of the young people's needs there were overall improvements in every measure, with significant positive differences between assessment and discharge in weight, BMI and HONSCA.

Avalon Ward had conducted a self-assessment of the ward against the Royal College of Psychiatrists Quality Network for Eating Disorders pilot standards in November 2013. The assessment showed an overall compliance with expected standards of 97% and highlighted where improvements could and were being made.

Trust board members had visited Wisteria Ward in January 2014 to conduct a '15-step Challenge.' This process was used as a way of enabling staff and managers to see a ward through the eyes of a patient or visitor and understand how improvements could be made. A report and action plan was produced in response to the visit.

Most people we spoke with were positive about overall standards of care and treatment even though they did not always want to be in hospital.

Suitably qualified and competent staff

Staff received appropriate training, supervision and professional development. Staff told us they had undertaken recent training pertinent to their role including in safeguarding children and adults, fire safety, and how to restrain a person safely. Records showed that most staff were up to date with statutory and mandatory training requirements. New staff undertook a period of induction and shadowed other staff for several days before being included in the staff numbers. This helped ensure staff were able to deliver care to the people safely and to an appropriate standard.

Nurses were trained how to provide nasogastric feeding safely and the competence of nurses was tested to ensure they were able to place nasogastric feeding tubes correctly prior to feeding. Additional specialist training and discussion of complex cases was provided during the overlap period between shifts. This meant there were suitable arrangements in place to ensure that staff received appropriate professional development and provided high quality care and treatment to people with eating disorders.

Staff were supported and supervised to provide care and therapy to people. Staff told us that they received regular individual and group supervision and had completed an annual performance appraisal. A debrief was offered to staff following serious incidents.

Staff were concerned that a proposed trust-wide reduction in the overlap between shifts would affect the capacity of the wards to continue to provide staff support groups and specialist training, essential for professional development. These usually ran during the early afternoon overlap of shifts allowing for maximum staff attendance.

People who use the service told us that permanent staff members and regular bank staff on the wards were well trained and met their care needs. However, most people told us that many bank and agency staff were "not appropriately trained" and were not aware of the needs of people with eating disorders and how best to support them. All agency staff underwent an induction before working on the unit. Detailed written information was provided on how to care for a person with an eating disorder, which new staff were expected to read on their arrival at the service before beginning their shift. Senior staff on Avalon acknowledged the quality of bank and agency used on the ward was "not what it should be" and shortfalls in knowledge and skills in relation to eating

disorders and at times the level of spoken English had been identified. Senior staff told us that five additional permanent nurses were in the process of being recruited in order to ensure the quality and competence of staff working on the unit and decrease the reliance on bank and agency staff. Attempts were made to use regular bank staff where possible to ensure they understood the needs of the people who use the service. This had been more successful on Wisteria Ward.

Are specialist eating disorders services caring?

Choice in decisions and participation in care

People told us they felt respected and involved in making decisions about their care. Assessments were made in respect of a person`s capacity to make specific decisions. We saw that care plans reflected individuals' needs and choices as far as possible. Due to the health needs of the people, some elements of choice and care were limited for therapeutic reasons. People told us that staff explained treatment options and why there were sometimes restrictions on choices. We observed that any restrictions were discussed in the staff handover and multi-disciplinary ward round. This meant that any restrictions were agreed by the care team on an individual basis and reviewed regularly.

People who used the service and their relatives understood the care and treatment choices available to them. A parent we spoke with said they felt very well informed about their child's care and treatment and felt they could influence the way treatment was provided in order to better reflect their child's needs. A person using the service on Avalon Ward said, "I feel involved in my care planning most of the time." Another person told us "I feel as though my opinions are taken seriously."

We observed in the ward round on Avalon Ward that people using the service were treated with consideration and respect. They were included in a review of their care plans and their views were recorded. Good explanations of the treatment plan and rationale were provided and people's concerns were addressed.

Effective communication with staff

People who used the service told us they felt well informed about their treatment. They felt able to ask questions about their care and information was provided in a way they understood. Independent advocacy services were available to people. A carer told us communication with staff was "excellent."

There was a named nurse system which ensured that people had weekly one to one meetings with their named nurse or associate staff member, who stepped in when the named nurse was on leave. This was in addition to their individual therapy programme. Records showed that named nurse meetings took place on a regular basis. There were community meetings where people could raise any concerns they had about the service, including practical and maintenance issues, so that they could be addressed.

People receive the support they need

People's needs were assessed and care was delivered in line with their individual care plans. Records showed that risks to physical health were identified and managed effectively. Observation levels, physical monitoring and weight restoration goals were determined according to individual needs. We reviewed several care plans on both wards and these showed that individual person-centred plans were in place which addressed people's assessed needs. Care plans were detailed and included the views and comments of people who use the service. People told us they were involved in developing their care plans and they were reviewed and updated regularly. People gave examples of how their religious and other individual needs were met.

People were offered a range of treatment options on the wards including group and individual therapy, family therapy, psychotherapy and occupational therapy activities. Staff told us that they supported peoples' recovery by accompanying them outside the hospital, for example, by going shopping and on longer journeys to their homes. Young people on Wisteria ward told us it could be "a bit boring" on the unit and said they would like more fun groups.

There was a school on site and teaching staff kept in regular touch with young people's schools. Support over the telephone was offered to young people during periods of leave. A carer told us this had been "invaluable."

On Wisteria ward there was space for families to stay when visiting the unit and a family area with a kitchen where

families could prepare a meal together. This was particularly important for parents and carers who travelled long distances to visit and enabled the practising of skills with the support of staff.

People who use the service had mixed views about the staff caring for them. Some staff were described as "very supportive" whilst others were described more negatively. People said most staff were "kind and supportive" and "compassionate." Most people were positive about the attitude of staff and described the ethos of the wards as non-judgemental. We observed staff interacting with people in caring and compassionate ways. Negative comments concerned agency and bank staff's lack of knowledge of eating disorders which meant they did not always know how to respond effectively to people's needs.

All staff we spoke with reported that the quality of food was poor and unappetising. People on both wards were required to eat one and half standard sized hospital meals at each meal time in order to obtain sufficient nutrition. For an eating disorders service the quality of food and appearance of meals was essential to meeting the needs of people effectively. However, the provision of meals, although meeting people's basic nutritional needs, failed to take account of the specific needs of people, for whom eating sufficient amounts of nutritious food was already particularly difficult.

Recovery

The service used a recovery approach to working with people. Recovery goals were clearly stated in people's care plans. Staff worked with people collaboratively. People we spoke with agreed the service was recovery oriented. For example, one person on Avalon Ward said, "I feel in control of my recovery" and several others agreed with this.

Privacy and dignity

People's privacy and dignity were respected most of the time. People who use the service told us staff treated them with respect, even when restrictions in relation to their care and treatment were in place. Individual sexual orientation was respected and people told us they had not experienced any prejudice or discrimination from staff or others.

The treatment room on Wisteria Ward was too small to be used to safely provide nasogastric feeding to young people who required it. As an alternative staff told us they sometimes used young people's bedrooms, the lounge or the occupational therapy (OT) kitchen, when a young person required nasogastric feeding under restraint. This ensured the procedure could be carried out safely. Staff demonstrated how they maintained privacy by lowering blinds on the OT kitchen window. However, the use of any of these rooms for nasogastric feeding was inappropriate as it failed to wholly maintain young people's privacy and dignity.

Use of restraint

Staff were sometimes required to restrain people who used the service. Training records showed that staff were up to date in training in the use of safe physical interventions. There was detailed guidance for staff on nasogastric feeding using restraint. This ensured the practice was lawful, carried out safely and was not excessive.

Many people we spoke with had experience of being restrained by staff. Sometimes this was in order to prevent them harming themselves or when treatment was being provided. Most people told us this had been carried out safely and in a way that maintained their respect and dignity. People who had been restrained told us that staff usually talked to them afterwards about what had happened.

Are specialist eating disorders services responsive to people's needs?

(for example, to feedback?)

Meeting the needs of the local community

The wards provided a national service to people with eating disorders and often admitted people whose needs could not be met in their own local area. Most people had undergone treatment in their local areas before being considered for admission to the service. Many people had complex needs with additional mental health needs.

Providers working together during periods of change

Staff on Wisteria Ward, which was a national service, identified some difficulties in the care pathway and in ensuring a smooth discharge for young people. They told us that many intensive outpatient services had closed recently which made it difficult to ensure young people received the services they needed when discharged. However, community teams were invited to care programme approach meetings and were closely involved

in the discharge of young people back to their local area to ensure sufficient support. The social worker on Avalon Ward had close links with people's local teams and was fully involved in discharge and after care planning.

There were good links with local adult eating disorders outpatient and day hospital services. A nurse on Avalon Ward acted as the main liaison between the services and people were able to move effectively between services in a gradual manner. People who were to be discharged to the day unit usually attended the service during the day and slept on the ward at night to ensure a smooth transition prior to their final discharge from the inpatient service.

Learning from complaints

There was a system in place to learn from any complaints made. People who used the service told us that they knew how to raise concerns and make a complaint. They could raise concerns in community meetings and this was usually effective. However, records of community meetings on Avalon Ward in February and March 2014 showed that some maintenance issues had been raised several times by people before being addressed.

The trust had not responded promptly to concerns raised by staff about the quality of food provided to people who used the eating disorders service and the lack of an appropriately sized treatment room in which to provide nasogastric feeding under restraint. All staff we spoke with reported that the quality of food was poor and unappetising. People on both wards were required to eat one and half standard hospital meals at each meal time in order to obtain sufficient nutrition. For a service of this nature the quality of food and the appearance of meals was an essential part of meeting the needs of people effectively. Despite raising this with senior management on numerous occasions staff told us the trust had failed to respond to the specific needs of people using the service.

Staff had raised concerns with senior managers in the trust about the lack of appropriate space in which to nasogastric feed young people on Wisteria Ward, when this was necessary. Staff were unsure whether refurbishment plans, which included a larger treatment room, would go ahead. The concerns of staff had not been responded to promptly by the trust. Young people continued to be receive nasogastric feeding in their bedrooms, the ward lounge or the occupational therapy kitchen, which did not ensure their privacy and dignity was respected. In addition, it was not therapeutic for young people to be restrained and treated in environments which were also used for therapeutic groups and relaxation.

Are specialist eating disorders services well-led?

Governance arrangements

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Wisteria Ward incidents were reviewed at monthly child and adolescent mental health service (CAMHS) clinical governance meetings. Managers told us that the trust board had an overview of incidents reported in the service and had requested more information about the management of one young person about whom there were frequent incident reports. This ensured the trust maintained oversight of the service.

Staff and therapists in the service were concerned that the modern matron, who had many years of experience in eating disorders, was the matron for the adult inpatient eating disorder service only. The management of the care pathway was split between different modern matrons and staff considered this a lost opportunity in terms of best use of the expertise available. Wisteria Ward was part of the CAMHS team which was thought to be effective but there was an acknowledgement that there was a loss of expertise and access to specialist support. Both CAMHS and the eating disorders service were part of the same service directorate which meant they had the same management at a senior level.

Engagement with staff

Staff from all disciplines told us they considered the trust senior management did not fully understand the needs and complexity of the eating disorders service. They said the trust wanted the service to fit into standard trust systems some of which failed to acknowledge the complex needs of people with eating disorders. Clinicians in particular did not feel listened to by senior trust managers. This view was not recognised by a senior manager we spoke with who described occasions when staff views had

led to changes in decisions and highlighted the involvement of senior clinicians in the review of eating disorders services underway. However, they said they planned greater engagement with staff to ensure better communication with staff at all levels.

Engagement with people who use the service

The service regularly asked people, carers and staff for their opinions about the service provided. Several people told us they were encouraged to give feedback either via written surveys or a real time feedback device, located on the wards, which allowed people to give their feedback electronically. Real time feedback results were shared with people using the service and staff. Concerns were fed back via local governance structures. Where action had been taken to address people's concerns this was displayed on the wards.

Carers described good communication with staff on Wisteria Ward. A parents/carers group was held on a Sunday evening on the ward, which enabled carers to give feedback about how weekend leave had gone and engage with staff more generally.

Effective leadership

We found that Wisteria Ward was well-led and there was evidence of clear leadership. The ward manager worked proactively within trust governance systems to influence and bring about changes that benefitted young people who use the service. For example, there were plans to invite representatives from catering to attend the ward community meeting to discuss young people's nutritional needs and issues related to the provision of meals.

The manager of Avalon Ward had been in post for only a few weeks at the time of the inspection but was already considered to have made significant improvements to the ward and quality of care provided. However, it was clear that the ward had been without effective leadership for many months prior to this when there had not been a permanent manager in place.

The culture on the wards was open and encouraged staff to reflect upon their practice. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by the multi-disciplinary team and line managers.

Other specialist services

Information about the service

Seacole Ward is a national, specialist service providing care and treatment for male and female patients over the age of 18, experiencing severe Obsessional Compulsive Disorders.

The ward provides a national service to people with Obsessive Compulsive Disorders and often admits people whose needs could not be met in their own local area.

Summary of findings

We spoke with staff, including doctors, nurses, managers, health care assistants and therapists. We spoke with people who used the service. We observed a handover between shifts as well as interactions between staff and people who use the service. We looked at care and treatment records.

On our initial visit we spoke to 10 patients in a group setting, who all felt that the ward did not offer them the treatment and care that they needed, felt it was not following national guidelines and that they were not involved in their care. On this occasion we were unable to speak to enough staff to triangulate this information and it was therefore decided to make a further unannounced visit as part of the comprehensive inspection.

We found that Seacole Ward was an open ward and all patients were informal. We were informed that there was sufficient staff to care for the patients on the ward. We noted from analysis of staffing rotas on Seacole the numbers of staff on duty were consistent with the trust's assessment of staffing needs.

The care and treatment of people with Obsessive Compulsive Disorders does reflect relevant research and guidance and this was confirmed by the consultant psychiatrist, nursing team and also by the inspection team

The trust used a computerised database system called 'RiO'. Record's we checked on wards contained evidence of care planning and patients confirmed they were given a copy of care plans.

We saw patients were supported with comprehensive multi-disciplinary risk management plan. Risks to self and others were assessed, updated at regular intervals and formulations were undertaken by the CBT therapist and were available in patients' notes.

Feedback from people who use the service about the care and treatment provided was mixed. People were aware of their care plans however felt less included in their production and reviewing of these. They were all aware of their daily regime and their anxiety ratings plan. People did not feel included in their ward rounds

Other specialist services

and felt this was a process they were rarely involved in and when speaking to staff they confirmed that patients are not always present or invited to be present when discussions were taking place about their care.

Staff felt that people understood their care plans and were involved in them however there was acknowledgement that due to the nature of their illness this information is not always absorbed by them.

The staff informed us that they had the opportunity to receive supervision and peer support run by external parties.

Are other specialist services safe?

Risk and care planning

The trust used a computerised database system called 'RiO'. Record's we checked on wards contained evidence of care planning and patients confirmed they were given a copy of care plans. However they felt less included in their production and reviewing of these.

We saw patients' were supported with comprehensive risk management plans and offered a multi-disciplinary assessment at an early stage. Both risks to self and others were assessed.

Staff training

Some people told us that they felt some of the staff didn't understand their disorder and on occasions made things worse when they did or said the wrong thing. Staff told us some that some staff had additional training however it was acknowledged that further indepth training would be of benefit to patients and staff.

Handover

We observed the daily handover meeting attended by the nurse in charge and the nursing team coming on duty. This handover was thorough and covered all areas of risk, care plan and other therapeutic activities.

The care and treatment of people with Obsessive Compulsive Disorders does reflect relevant research and guidance and this was confirmed by the consultant psychiatrist, nursing team and also by the inspection team. Some patients we spoke to felt that the therapy sessions that were offered were not enough stating that one hour a week was insufficent, but they did not feel able to discuss this with their care team. We were informed that whilst they may only have had one hour of therapy a week they have an intensive daily programme that has to be followed and completed.

There was a good pathway of care for the patients, which included ongoing therapy as well as follow up treatment at one, three, six and 12 months

Staffing levels

Most staff we spoke with on the wards told us they felt the level of staff and skills mix was adequate. However they

also said they could always do with more staff. The manager on the ward was an acting position due to a secondment of the substantive manager and this was until August 2014.

The manager on Seacole told us that they had two or three vacancies in their wards. They said they were in the process of recruiting for all permanent posts. These vacant shifts are covered by bank or agency staff.

Patients' we spoke with on all wards said they felt there was never enough staff on the ward.

Are other specialist services effective? (for example, treatment is effective)

Use of clinical guidance and standards

We were told that some staff had additional qualifications in training such as Cognitive Behavioural Therapy (CBT) and psychosocial interventions. They also had a peer supervision session most weeks run by an external facilitator.

The care and treatment of people with Obsessive Compulsive Disorders does reflect relevant research and guidance and this was confirmed by the consultant psychiatrist, nursing team and also by the inspection team. Patients' however said they were unable to access therapy as per national guidance and staff were unable to give examples of evidence-based interventions. Patients' also said that therapists were good but they only saw them once a week. Patients' alleged outcome data was not a true reflection of their progress. Patients' said they rarely saw consultants, therapists, nursing or occupational therapy staff with sufficient knowledge of Obsessive Compulsive Disorders to care for them appropriately.

Collaborative multi-disciplinary and multi-agency working for assessments, care planning and access to health services

Staff on Seacole were clear that all treatment is inclusive for the patients' and they are actively engaged in their plan of care. Some patients' however did not agree with this and felt that the approach on the ward was not inclusive and decisions were quite often made in ward round which directly impact on their care, without their knowledge. This included changes to medication. The two cognitive behavioural therapists who work on the ward were interviewed and they were clearly able to articulate their role on the ward and also describe in detail the therapeutic approach they followed when working with patients'. In addition to this they were involved in the MDT meetings, staff handover and reflective practice meetings. All formulations that they worked on were shared with the wider team and were updated as necessary within the ward round. It was felt that some further group sessions may enhance the treatment already offered.

Are staff suitably qualified and competent

All staff we spoke with told us they had access to regular mandatory training. The manager told us all staff on the wards were up to date with their mandatory training.

On Seacole we saw that some staff had had access to specialist training such as, CBT and psychosocial interventions, but most felt that there was no formal training offered to everyone and this should be considered. People who use the service told us that permanent staff members and regular bank staff on the wards were well trained and met their care needs. However, most people told us that many bank and agency staff were “not appropriately trained” and were not aware of the needs of people with Obssessive Complusive Disorders and did not know how best to support them.

Most staff told us they had regular supervision.

There is currently an overlap of two hours between the morning and afternoon shift which the staff felt was usefully used for reflective practice and supervision; however there are plans to change this shift system which would shorten the available time for such supervision sessions

Are other specialist services caring?

Choice in decisions and participation in care

People told us they did not feel involved in making decisions about their care, but were aware of their care plans. We saw that care plans reflected individuals’ needs however at times were not patient focused and didn’t contain evidence of their views being sought. Due to the complexity of the Obsessive Compulsive Disorder and the needs of the people, some elements of choice and care were limited for very clear therapeutic reasons; however we found that these reasons were being poorly communicated to patients' and were not being understood or completely absorbed by the patient group.

Other specialist services

Four patients' told us that there medication had been changed without their knowledge.

Effective communication with staff

Staff told us they met with people weekly to discuss their care and follow up on any issues people identified and had more regular one-to-one sessions if needed.

There was an effective named nurse system in place which ensured that patients' had a one to one meeting with their named nurse on a weekly basis. They also had a daily nurse system so that if required they had a point of contact during each shift.

Support for people's needs

People had access to physical health assessments and physical examinations on a regular basis. This was carefully monitored as at times patients' exhibited behaviours that manifested themselves as physical ailments, when were actually part of their Obsessive Compulsive Disorder. However all physical ailments, including fluid and diet charts, were discussed fully in the handover period.

People were also offered lots of occupational therapy activities as well as opportunities to leave the ward and attend the gym. We were informed that these sessions are all mandatory on the ward as it is part of their therapy. Some patients felt that this was unreasonable and at times felt that if they chose not to attend these sessions this would be seen negatively in their treatment reviews.

People's needs were assessed and care was delivered in line with their individual care plans and national guidelines. Risk and observation levels were reviewed daily

People who used the service had mixed views about the staff caring for them. Some staff were described as “good “ and “very knowledgeable” whilst others were described more negatively. People said most staff were supportive but sometimes due to lack of training they could be quite dismissive.

Are other specialist services responsive to people’s needs?
(for example, to feedback?)

Meeting the needs of the local community

The wards provided a national service to people with obsessive compulsive disorders and all people admitted were people whose needs could not be met in their own local area. Most people had undergone treatment in their local areas before being considered for admission to the service. Many people had complex needs with additional mental health needs.

Providers working together in times of change

Seacole Ward, which is a national service, identified a care pathway which assisted with discharge planning. This was not without difficulty at times due to geography.

Patients' were encouraged to attend their follow up appointments but if this was difficult due to geography they conducted telephone interviews.

People were allowed leave to their home following ward rounds and if for some reason the patient did not return when they were supposed to consideration was given to conduct a home visit to try and encourage them to return.

Learning from complaints and concerns

The ward held regular community meetings for people who used the service to express their views. Minutes from the meetings which were clearly displayed on the ward notice board showed that actions were agreed where people raised concerns..

Patients didn’t know how to access advocacy and at the follow up inspection this still seemed to be the case. We asked the ward manager and nursing staff to show how patients' could access advocacy, but were told that there was no advocacy provision for this ward as it was a national service and this had been decommissioned.

Staff were aware of how to inform patients' to make complaints and they felt that there was a system in place to allow learning from complaints.

Are other specialist services well-led?

Governance arrangements

Staff felt there were clear governance structures and an open culture on the ward and problems were seen to be resolved easily.

We spoke to the consultant psychiatrist, Cognitive Behavioural Therapy (CBT) therapists and nursing staff who all felt that the ward was well run, which enabled and supported them to provide this national service.

Other specialist services

Engagement with people who use the service

Staff felt that patients' were engaged with on a regular basis; however patients' said the nursing staff had to do what consultants said even though they didn't really understand it and the consultant was controlling. Staff didn't feed this back: they said consultants were helpful but the trust's senior management was at times problematic

Patients' had a regular community meeting which they chaired and these minutes were accessible and clearly showed actions that came out of the meetings.

Effective leadership

We found that Seacole Ward was well-led and there was evidence of clear leadership. The Acting ward manager was a seconded post however this was to be for a significant period which will allow stability.

The ward manager operated an open culture on the ward and she encouraged staff to discuss any issues.

Some patients' had the view that the ward nursing staff did not get a say in the care and treament on the ward and this was becuase the consultant psychiatrist made all of the decisions, this did not however seem to be the case when we spoke to the nursing staff as they felt included in all discussions and care plans. The ward staff were clear that the ward was well led and that they very much worked as a multi-disciplinary team and this included the therapists, consultant psychiatrist, occupational therapy as well as nursing staff.

The handover was multi-disciplinary and the therapist often joined these meetings. Nurses, with the patients permission, sat in the CBT sessions to allow for greater sharing of the therapeutic work.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

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

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