# Healthier Communities Select Committee Agenda

Wednesday, 16 January 2019
**7.30 pm**, Committee Room 3
Civic Suite
Catford
SE6 4RU

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**Part 1**


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Members of the public are welcome to attend committee meetings. However, occasionally, committees may have to consider some business in private. Copies of agendas, minutes and reports are available on request in Braille, in large print, on audio tape, on computer disk or in other languages.

# Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Wednesday, 16 January 2019.

Janet Senior, Acting Chief Executive
Tuesday, 8 January 2019

| | |
|---|---|
| Councillor John Muldoon (Chair)<br>Councillor Coral Howard (Vice-Chair)<br>Councillor Peter Bernards<br>Councillor Juliet Campbell<br>Councillor Carl Handley<br>Councillor Octavia Holland<br>Councillor Sue Hordijenko<br>Councillor Sakina Sheikh<br>Councillor Bill Brown (ex-Officio) | |

# MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

**Monday 3 December 2018, 7.00pm**

Present: Councillors John Muldoon (Chair), Coral Howard (Vice Chair), Carl Handley, Octavia Holland, Sue Hordijenko and Sakina Sheikh.

Also Present: Ben Travis (Chief Executive, Lewisham and Greenwich NHS Trust), Lynn Saunders (Director of Strategy, Business and Communications, LGT), Salena Mulhere (SGM Inter Agency Service Development & Integration), Catherine Mbema (Acting Consultant in Public Health), James Lee (Service Group Manager, Prevention, Inclusion and Public Health Commissioning), Catherine Bunten (Service Manager, CYP Joint Commissioning), Tony O'Sullivan (Save Lewisham Hospital Campaign), Aileen Buckton (Executive Director for Community Services), Sarah Wainer (Programme Lead, Whole System Model of Care, Lewisham CCG), Nigel Bowness (Healthwatch), and John Bardens (Scrutiny Manager).

## 1. Minutes of the meeting held on 9 October 2018

*Resolved: the minutes of the last meeting were agreed as a true record.*

## 2. Declarations of interest

The following non-prejudicial interest was declared:

- Cllr John Muldoon is a day patient at Guy's and St Thomas' NHS Foundation Trust (in relation to item 6).

## 3. Responses from Mayor and Cabinet

3.1 The committee received a report explaining the error in the despatch for the November Health and Wellbeing Board (HWB) meeting which meant that it was not possible for the committee’s referral on changes to sexual health services in the borough to be considered by the HWB at its November meeting.

3.2 It was explained that the error was due to an oversight in the relevant team and that all staff have since been reminded of the importance of following due process and utilising systems for the effective management of agendas and reports. Managers will also continue to support staff learning and development.

*Resolved: the committee noted the report.*

## 5. Lewisham hospital (systems resilience)

Ben Travis (Chief Executive, Lewisham and Greenwich NHS Trust) introduced the report. The following key points were noted:

5.1 Lewisham is currently one of the best performing hospitals in London against the four-hour A&E waiting time target.

5.2 While winter does not always lead to increased attendance at the emergency department, there tends to be an increase in people requiring admission.

5.3 Improving patient flow is one of the main aims of this year's winter planning.

5.4 Patient activity and treatment will be monitored more closely to ensure a productive stay in hospital.

5.5 Plans for discharge will begin from the day patients come in, with better coordination among hospital teams and with the local authority.

5.6 The hospital will work with care homes to support them to treat patients without having to bring them into the emergency department.

5.7 The hospital is considering a criteria-led discharge process, which would involve doctors talking to their teams and setting criteria for patients to be discharged, rather than doctors having to be there to sign-off the discharge of every patient on the day of their discharge.

5.8 A "crisis café" will open on the Lewisham hospital site to provide a calmer environment and take referrals from the emergency department for patients with mental health issues. This is being created in conjunction with the local mental health trust and third sector partners with funding from NHS Improvement.

5.9 It was noted that due to the pressure on the London and national mental health system there had been a number of occasions where there had not been any free mental health beds in the country.

5.10 Workforce is the biggest challenge for the hospital, with, for example, a higher number of nurse vacancies than it would want.

The committee asked a number of questions. The following key points were noted:

5.11 The committee queried if any of the 23 patients with mental health issues who had exceeded a 12-hour wait were children. Officers from the hospital said that this would be highly unlikely but agreed to check the figures and provide a response. (The Trust responded post meeting to confirm that all of these patients were adults).

5.12 The committee queried the potential risks of a criteria-led discharge process and what could be done to mitigate these.

5.13 The hospital stressed that the only way that a criteria-led discharge process will work in practice is if doctors are fully behind it. Criteria-led discharge has been put in place in other areas by being clear about what the specific criteria are. The hospital would also closely monitor the impact on readmission rates.

*Resolved: the committee noted the report and agreed to arrange a site visit to the Lewisham Hospital Crisis Cafe.*

**6. Pathology services**

Lynn Saunders (Director of Strategy, Business and Communications, LGT) introduced the report. The following key points were noted:

6.1 There is a national drive to change the way pathology services are provided across the country. All pathology services in England are expected to be joined in networked services. Lewisham and Greenwich NHS Trust (LGT) was advised that is was expected to be part of the southeast London network.

6.2 Pathology services at LGT are provided differently to local partners such as Guy's and St Thomas' (GSTT) and King's College Hospital. The GSTT and King's service is a joint venture with a private sector partner, which has been running for 10 years, but is due to expire towards the end of 2020. The LGT service is run entirely within the NHS.

6.3 The potential value of pathology services in southeast London would be £2.25bn over 15 years. LGT wanted to see an NHS option developed and given equal consideration. However, there were no NHS providers interested in taking on such a large contract.

6.4 LGT decided therefore to explore other NHS networks that it could be part of. LGT is now working with Barts Health and South West London Pathology and is expecting to make a decision by the end of January 2019 to determine which network it will join.

6.5 A key consideration for LGT is the provision of pathology services to GPs. LGT currently provides pathology services to all GPs in Greenwich, Bexley, and Lewisham and for Oxleas Trust. However, Clinical Commissioning Groups (CCGs) and GPs are currently part of the southeast London procurement process. LGT intends to work with their CCG colleagues to find the best solution for the borough and hopes to continue providing services for GPs, which will maintain the important clinical links between GPs and local hospital clinicians.

*Resolved: The committee noted the report, welcomed the decision of the LGT Board to step out of the southeast London private/public partnership in order to maintain a 100% NHS contract, and asked to be informed when a decision about the network partners is made.*

## 4. Public health grant cuts consultation

Catherine Mbema (Acting Consultant in Public Health), James Lee (Service Group Manager, Prevention, Inclusion and Public Health Commissioning), and Catherine Bunten (Service Manager, CYP Joint Commissioning) introduced the report. The following key points were noted:

4.1 The Government will be making a further cut to the Public Health grant to local authorities for 2019/20. In Lewisham, the cut for 2019/20 will be £642,000. This will reduce the grant for 2019/20 to £23,683,000.

4.2 In response to the cuts the Council carried out a range of consultation activity as part of an overall 15-week consultation process. The officer report included in the agenda papers presents the findings of the consultation activity.

4.3 The vacancies within the health visiting workforce are reflective of nationwide vacancy rates. If there were no vacancies officers would explore other areas, such as staffing structure, in order to make the cuts.

4.4 Officers noted that they will need to work closely with Lewisham and Greenwich NHS Trust in order to complete all mandatory health visiting checks and consider in the future carrying out some of the checks in group settings. Officers would always recommend, however, that children within the targeted caseload have such checks in their home.

4.5 A member of the public, representing the Save Lewisham Hospital Campaign, addressed the committee. They noted that the first 100 days of a child’s life are critical to determining health and wellbeing and asked the Council to look at all possible alternatives to the proposed cut to health visiting services.

4.6 The committee expressed concern about long-term vacancies in the health visiting workforce, noting that the population in Lewisham is expected to grow substantially and that health visitors may be the only professionals that see some very young children. The committee noted its concern about any future reduction of the health visiting service.

4.7 The committee expressed concern about the different figures for estimated health visitor caseload ratios being referred to by officers and members of the public and asked officers to seek clarification before presenting its report to Mayor and Cabinet.

*Resolved: the committee agreed to refer its views on the health visiting element of the proposed public health grant cuts in the following terms:*

*The Healthier Communities Select Committee notes the Mayor's manifesto pledge to continue to give the highest priority to our children and family services and to ensure all our young people – no matter what their background or challenges – achieve their potential and thrive. Having heard the responses to the public consultation on public health cuts, specifically health visiting cuts, the committee is concerned about the impact the proposed cuts would have on current and future life experiences of children and young people in Lewisham. The committee therefore asks Mayor & Cabinet to make its decision on the proposed cuts to health visiting services having regard to these points and the evidence produced on health visitor to children ratios in paragraphs 11.21 to 11.33 of the Mayor & Cabinet report on these cuts.*

## 7. Care at Home: integrating health and care services

Aileen Buckton (Executive Director for Community Services) and Sarah Wainer (Programme Lead, Whole System Model of Care, Lewisham CCG) introduced the report. The following key points were noted:

7.1 On 21st November 2018 Mayor & Cabinet approved the proposal to formally integrate a number of social care and health services that support adults in their own homes to improve the quality of service provision.

7.2 This includes the Council entering into a Section 75 (NHS Act 2006) agreement with Lewisham and Greenwich NHS Trust (LGT) and, in the future, South London and Maudsley NHS Foundation Trust (SLaM).

7.3 Although the formal agreement is only between LGT and the Council, there will be close working with other partners, including in the voluntary sector.

7.4 The integration of services is intended to break down the barriers between different professionals working in people's homes and to ensure that people cared for in their homes are central to way in which they work.

7.5 Every local authority in England has to have proposals on how it is going to integrate with its health partners by 2020.

7.6 The full business case for the proposals has been to the Lewisham Health Care Partners and the new arrangements are expected to be in place by 1 April 2019.

The committee made a number of comments. The following key points were noted:

7.7 The committee noted concerns over the stability of the care sector and asked about the plans to mitigate these risks.

7.8 The committee were informed that the proposals seek to work with the care sector to support and develop it further and to look at training opportunities to make it more attractive for staff.

*Resolved: The committee noted the report.*

**8. Information item: partnership commissioning intentions**

*Resolved: the committee noted the report.*

**9. Select Committee work programme**

John Bardens (Scrutiny Manager) introduced the work programme.

9.1 The Scrutiny Manager agreed to arrange the site visit to the Lewisham Hospital Crisis Café and to notify other members who may be interested.

*Resolved: the committee agreed the work programme.*

**10. Referrals**

Resolved: the committee agreed to refer its views on item 4, *Public health grant cuts consultation*, in the following terms:

> *The Healthier Communities Select Committee notes the Mayor's manifesto pledge to continue to give the highest priority to our children and family services and to ensure all our young people – no matter what their background or challenges – achieve their potential and thrive. Having heard the responses to the public consultation on public health cuts, specifically health visiting cuts, the committee is concerned about the impact the proposed cuts would have on current and future life experiences of children and young people in Lewisham. The committee therefore asks Mayor & Cabinet to make its decision on the proposed cuts to health visiting services having regard to these points and the evidence produced on health visitor to children ratios in paragraphs 11.21 to 11.33 of the Mayor & Cabinet report on these cuts.*

The meeting ended at 21.55pm

Chair:

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Date:

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| Healthier Communities Select Committee | | | |
|---|---|---|---|
| Title | Declaration of interests | | |
| Contributor | Chief Executive | | Item 2 |
| Class | Part 1 (open) | 16 January 2019 | |

**Declaration of interests**

Members are asked to declare any personal interest they have in any item on the agenda.

**1. Personal interests**

There are three types of personal interest referred to in the Council's Member Code of Conduct:

(1) Disclosable pecuniary interests
(2) Other registerable interests
(3) Non-registerable interests

**2. Disclosable pecuniary interests** are defined by regulation as:-

(a) Employment, trade, profession or vocation of a relevant person* for profit or gain

(b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).

(c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.

(d) Beneficial interests in land in the borough.

(e) Licence to occupy land in the borough for one month or more.

(f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.

(g) Beneficial interest in securities of a body where:

(a) that body to the member's knowledge has a place of business or land in the borough;

(b) and either

(i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or
(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

**3. Other registerable interests**

The Lewisham Member Code of Conduct requires members also to register the following interests:-

(a) Membership or position of control or management in a body to which you were appointed or nominated by the Council
(b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party
(c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25

**4. Non registerable interests**

Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

**5. Declaration and Impact of interest on members' participation**

(a) Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**

(b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in

consideration of the matter and vote on it unless paragraph (c) below applies.

(c) Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.

(d) If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.

(e) Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

**6. Sensitive information**

There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

**7. Exempt categories**

There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

(a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)
(b) School meals, school transport and travelling expenses; if you are a parent or guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor;
(c) Statutory sick pay; if you are in receipt
(d) Allowances, payment or indemnity for members
(e) Ceremonial honours for members
(f) Setting Council Tax or precept (subject to arrears exception)

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| HEALTHIER COMMUNITIES SELECT COMMITTEE | | | | |
|---|---|---|---|---|
| **Report Title** | Delivery of Lewisham Health and Wellbeing Priorities | | | |
| **Contributors** | Director of Public Health, London Borough of Lewisham | | Item No. | 4 |
| **Class** | Part 1 | Date: 16.01.19 | | |

## 1. Purpose

1.1 This report provides members of the Healthier Communities Select Committee with information on the performance of the agreed Health and Wellbeing Strategy Priorities. Since 2014 the performance in delivering the Health and Wellbeing Strategy is monitored by the Health and Wellbeing Board using a dashboard of outcomes measures in each priority area. This has been used as the basis to update the HCSC on delivery of the Lewisham Health and Wellbeing Strategy Priorities.

## 2. Recommendation/s

2.1 Members of the Healthier Communities Select Committee are recommended to note performance as measured by the health and care indicators set out in the attached dashboard at Appendix A.

## 3. Policy Context

3.1 The Health and Social Care Act 2012 placed a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet needs identified in their joint strategic needs assessments (JSNAs). Lewisham's Health and Wellbeing Strategy was published in 2013. The strategy was refreshed in 2015.

3.2 Nine priorities were identified for the Health and Wellbeing Strategy in 2013, which are monitored through a Performance Dashboard, presented to the Health and Wellbeing Board. In the 2015 strategy refresh the priority outcomes were retained, but three priority actions were identified in order to focus and accelerate effort in delivering the outcomes. To select the most pertinent indicators for the dashboard the Director of Public Health has worked alongside colleagues within Adult Social Care, Children's Services and the Clinical Commissioning Group (CCG) to produce a dashboard which would assist in monitoring health and wellbeing improvements across Lewisham and the effectiveness of the integrated adult care programme.

3.3 The dashboard is based on metrics drawn from the Quality and Outcomes (Primary Care), Public Health, NHS and Better Care Fund Frameworks. These metrics have been selected to assist members in

their assessment of the impact and success of the plans and activities in relation to the Health and Wellbeing Strategy. The dashboard also includes a number of overarching indicators on health and wellbeing.

3.4 The Health and Wellbeing Board agreed in 2018 to focus work on answering key questions. Black and Minority Ethnic (BAME) health inequalities was selected as a focus area, including BAME mental health. Indicators will be selected to understand performance going forward.

## 4. Health and Wellbeing Strategy Priority Updates

4.1 Overarching Indicators of Health and Wellbeing

**Life expectancy at birth** is improving for both men and women, meaning it is now in-line with the national average for both genders. The proportion of babies born at a low weight, measured in the indicator **Low Birth weight of all babies**, has remained stable and continues to be in-line with England.

The latest data for **premature mortality from Cardio-vascular disease** has improved and is now considered similar to the England rate. The number of practitioners attending Making Every Contact Count training is continually monitored by Public Health who co-ordinate the sessions.

Priority Objective 1: Achieving a Healthy Weight

**Excess weight in adults** has remained stable and is in-line with England. Regarding **excess weight in children**, Reception year performance has improved and Lewisham rates for obesity and excess weight are now significantly lower than England and London, and compared to similar boroughs. This is a notable success however it should be qualified that the participation rate was lower than in previous years, 87% in Reception and 89% in Year 6, slightly below the target coverage of 90%. For Year 6 children there was a small increase in obesity rates but an overall reduction in excess weight. As in previous years the proportion of obese children in Year 6 was more than double that of Reception year children, similar to the national results.

In addition the revised GP Personal Medical Services contracts between the CCG and GPs now require practices to record the BMI centile of children who attend for their pre-school booster vaccination (3-5 year olds), offering brief intervention and/or referral to local specialist services as required. This will have a beneficial impact on these indicators in future years.

**Maternal excess weight** increases the risk of poor pregnancy outcomes and is a risk factor for childhood obesity. There has been a slight decrease in the rate over the last two years reflecting the national picture. Overall, around half of women at their booking appointment are overweight or obese. Lewisham **breastfeeding rates at 6-8 weeks** continue to exceed target, with rates amongst the highest in England.

Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

**Uptake of all cancer screening** continues to be an area of concern for Lewisham. Whilst the uptake rates for all (bowel, breast and cervical) cancer screening have remained stable compared to the previous reporting period, they still fall significantly below the national averages and target levels. The revised Personal Medical Services contract between the CCG and GP practices now requires GPs to increase screening rates for cervical cancer and also to directly follow up non-responders to bowel cancer screening invitations.

**Early diagnosis** of stage 1-2 cancer has improved slightly and is in-line with England. The **under 75 cancer mortality rate** has decreased slightly, however it remains significantly higher than England. This difference continues to be largely due to male cancer mortality, with lung and bowel cancer deaths increasing. Nationally there has been a general trend of decline over the past 10 years.

Following the publication of a Cancer focused Joint Strategic Needs Assessment in 2017 a number of actions have been taken with the aim of improving cancer outcomes. A task and finish group was set up to develop a NHS Lewisham CCG Cancer Plan (2018-19). Public Health was a member of this group and has undertaken specific action around reducing inequalities which include: Commissioning community based Cancer Research UK (CRUK) training (which reached the Voluntary and Community Sector and others) to provide information and increase confidence around having conversations about cancer including taking up preventative measures such breast and bowel screening. A specific bursary-funded workshop for community members was awarded to Lewisham by CRUK this year. This workshop was held in December 2018 and was well attended, with positive feedback and evaluation. Work is also starting with MacMillan Cancer Support in 2019 to develop a number of community cancer champions from community members that attended the bursary-funded workshop.

Priority Objective 3: Improving Immunisation Uptake

The most recent data on **over 65 flu immunisation uptake** rate has remained stable, but remains below the England average and the national target (75%). Work is in progress with GPs in Lewisham to improve uptake of flu vaccination for all eligible groups by sharing learning from practices with higher levels of vaccination uptake. Promotion of the 65+ flu jab has also been included in key council publications.

The **HPV vaccine** uptake rate has improved but remains below the London and England averages and target level (80.0%). Work is being coordinated between Public Health, Joint Commissioning, the School Health Service and NHS England to ensure continued improvement. Uptake of the **second dose of measles, mumps and rubella vaccine** has also improved and is above the London average but needs to improve to reach to the England average and hit the target (91.1%) and

herd immunisation. Public Health continue to work on the MMR pathway, which includes steps to improve information systems. Public Health is also in dialogue with NHS England to improve promotion of the MMR vaccination to all Lewisham residents. For all childhood vaccinations opportunistic immunisation of children is done whenever they present within the health service.

Priority Objective 4: Reducing Alcohol Harm
**Alcohol related admissions** have fallen again and remain significantly below the England average.

Priority Objective 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
**Smoking prevalence** decreased compared to the previous reporting period and is now in-line with London and England. The self-report rate for **smoking quitters per 100,000 population** is also currently in-line with London and England.

**Smoking status at time of delivery** has increased marginally but remains significantly below the national average.

Priority Objective 6: Improving mental health and wellbeing
**Prevalence of Serious Mental Health Conditions** has remained stable but is significantly higher than the England average. Prevalence is similar to neighbouring boroughs. **Prevalence of depression** has increased slightly, yet remains significantly lower than the national average. Improving Access to Physiological Therapies performance service data continues to improve.

As mentioned above BAME mental health is an area that the Health and Wellbeing Board are focussing on. Furthermore the 2017 Annual Public Health Report focused on Mental Health. The aim of the report was to provide user-friendly information about the levels of mental health and wellbeing in Lewisham, including information about risk and protective factors. The content in summary:

- Providing real-life stories from Lewisham residents across the course of life about living with and through mental ill health.
- Providing information on the strategies, initiatives and interventions being delivered in Lewisham that aim to promote mental wellbeing and prevent mental ill health.
- Providing information about where residents can seek help if concerned about their mental ill health to ensure that mental ill health is identified and treated at the earliest possible opportunity.

Priority Objective 7: Improving Sexual Health
The rate of **chlamydia diagnoses per 100,000 young people aged 15-24 years** has decreased but is above the national average. This performance should be seen in context of the proportion of young people now screened for chlamydia. In 2017, 25% of people aged 15-24 were screened, in 2015 it was 50% of the same population. The **legal abortion** rate has remained stable but is significantly higher than the

London and England average. **Teenage conceptions** have decreased and are in-line with England.

**People presenting with HIV at a late stage of infection** has increased but remains in-line with the national average. Lewisham are currently working with the Elton John Aids Foundation to increase HIV testing both in hospital and primary care. Furthermore the Lambeth, Southwark and Lewisham (LSL) Sexual Health Strategy has identified late diagnosis of HIV as a critical target. In producing the strategy it was found that certain groups had a higher proportion of people with late diagnosis. This insight means that the same groups will be increasingly targeted for screening.

<u>Priority 8 (Delaying and reducing the need for long term care and support) & Priority 9 (Reducing the number of emergency admissions for people with long-term conditions</u>

Within Lewisham's wider integration framework, health and care partners have continued to focus on these priority areas. The Better Care Fund metrics remain the overarching measures by which progress and performance against these priority areas has been measured. The four national metrics are:

- Non elective admissions
- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care (DTOC)

As at December 2018, performance was on track to meet target in all four measures. Full year (2018-19) figures will be available in summer 2019. These metrics continue to be monitored by health and care partners, both by individual organisations and jointly through the BCF.

A wide range of activity across the health and care system has contributed to improving these outcome measures including:

- Identifying patients at risk of emergency admission and holding regular multi-disciplinary meetings
- Commissioning a High Intensity User (HIU) service
- Commissioning an enhanced primary care support service for Care Homes
- Creating a register of patients at risk of diabetes
- For Respiratory illness there has been the development of integrated community hubs to enable better diagnosis and treatment of all respiratory conditions to reduce avoidable admissions. This are expected to open in the near future.
- As urinary tract infections are a key driver of emergency admissions work has been undertaken to promote the Trial without Catheter (TWoC) pathway as well as supporting Care Homes to prevent infections by maintaining good hydration and ensuring that they respond to early warning signs with their residents.

- Mental Health and Acute providers continuing to support high users of Emergency Department care through improved care planning and community based support.
- Reducing attendance of a selected cohort of mental health frequent attenders at UHL A&E by 27%. An additional cohort was selected for 2018/19 and the current trajectory is showing a similar reduction offering self-management programmes.
- Agreeing plans to integrate a number of adult social care services with district nursing and therapies
- Developing further the Health and Social Care Gateway, bringing together Social Care Advice and Information Team and the District Nurse Call Centre. The Gateway will build on the work of the "Face 2 Face" project which supported people to look at the assets available to support their long term health and care needs.
- Providing enablement and rehabilitation services to reduce the need for long term ongoing care. Based on activity during 2018/19 over 89% of people who were discharged with an enablement service remain at home for longer than 91 days post discharge. This is a national indicator for adult social care and Lewisham perform in the top quartile.
- Continuing to work in partnership to reduce the number of Delayed Transfers of Care (DTOC's) and ensure more people return to their own homes and receive the support they need to retain their level of independence.
- To improve and expedite discharges from UHL a Patient Flow Centre has been developed. This is a multi-disciplinary discharge hub operating 7 days per week facilitating safe discharges.

4.2 In addition to the above priorities going forward, the Health and Wellbeing Board is focusing on health inequalities, specifically Black, Asian and Minority Ethnic (BAME) health and wellbeing, including mental health. Indicators to monitor are to be decided.

**5. Financial Implications**

5.1 There are no specific financial implications arising from this report. A range of activity designed to improve performance against these indicators is funded from the Public Health budget using the ring fenced Public Health Grant. This expenditure is reviewed regularly and reallocation to address indicators with poor performance is possible.

**6. Legal implications**

6.1 The statutory requirement to have a Health and Wellbeing Strategy is set out above.

**7. Equalities Implications**

7.1 There are no specific equalities implications arising from this report or its recommendations, but the dashboard highlights those areas where health inequalities exist in Lewisham and can be monitored.

## 8. Further Implications

8.1 At this stage there are no specific environmental or crime and disorder implications to consider.

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# Appendix A - Health and Wellbeing Board Performance Metrics - January 2019

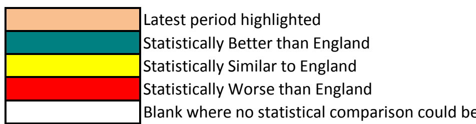
| | Updated indicators are in bold | Frequency | Latest Period of Availability | Previous Available Period (Lewisham) | Latest Available Period (Lewisham) | London | England | England Benchmark | Direction from Previous Period | Data Source |
|---|---|---|---|---|---|---|---|---|---|---|
| **Overarching Indicators** | | | | | | | | | | |
| 1a | **Life Expectancy at Birth (Male)(yrs)** | **Annual** | **2014-2016** | **78.8** | **79.1** | **80.4** | **79.5** | **similar** | | ONS |
| 1b | **Life Expectancy at Birth (Female)(yrs)** | **Annual** | **2014-2016** | **83.1** | **83.3** | **84.2** | **83.1** | **similar** | | ONS |
| 2 | **Under 75 mortality rate from CVD (DSR)** | **Annual** | **2015-2017** | **82.2** | **80.7** | **73.2** | **72.5** | **similar** | | PHOF 4.04i |
| 3 | **Low Birth Weight of all babies (%)** | **Annual** | **2016** | **7.1** | **7.3** | **7.6** | **7.3** | **similar** | | P00455/CHIMAT Profile 2015 |
| 4 | **Number of practitioners trained in Making Every Contact Count (behaviour change training)** | **Quarterly** | **Q1 2018/19** | **90** | **27** | **-** | **-** | - | - | Lewisham Public Health |
| **Priority Objective 1: Achieving a Healthy Weight** | | | | | | | | | | |
| 5 | **Excess weight in Adults (%)** | **Annual** | **2016/17** | **57.9** | **57.8** | **55.2** | **61.3** | **similar** | | PHOF 2.12 |
| 6a | **Excess weight in Children - Reception Year (%)** | **Annual** | **2017/18** | **22.2** | **17.6** | **21.8** | **22.4** | sig lower | | PHOF 2.06i |
| 6b | **Excess Weight in Children - Year 6 (%)** | **Annual** | **2016/17** | **39.0** | **37.9** | **37.7** | **34.3** | sig high | | PHOF 2.06ii |
| 7 | **Maternal Excess Weight at <13 weeks gestation(%)** | **Quarterly** | **Q2 2018/19** | **50.7** | **45.7** | - | - | - | | Lewisham & Greenwich Trust Data |
| 8 | **Breastfeeding Prevalence 6-8 weeks (%)** | **Quarterly** | **Q1 2018/19** | **79.2** | **79.4** | - | **44.4** | sig higher | | NHS ENGLAND |
| **Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years** | | | | | | | | | | |
| 9a | **Cancer screening coverage - breast cancer (%)** | **Annual** | **2017** | **66.0** | **66.7** | **65.9** | **72.1** | sig lower | | PHOF 2.20i |
| 9b | **Cancer screening coverage - cervical cancer(%)** | **Annual** | **2017** | **69.1** | **69.0** | **65.2** | **71.7** | sig lower | | PHOF 2.20ii |
| 9c | **Cancer screening coverage - bowel cancer (%)** | **Annual** | **2017** | **46.6** | **47.0** | **50.3** | **59.6** | sig lower | | PHOF 2.20iii |
| 10 | **Early diagnosis of cancer (%)** | **Annual** | **2016** | **50.2** | **52.4** | **51.9** | **52.6** | similar | | PHOF 2.19 – experimental statistics |
| 11 | Conversion of Two Week Wait Referrals to Cancer Diagnosis (%) | Annual | 2016/17 | 4.2 | 4.3* | 5.3* | 7.6* | sig lower | | PHE Fingertips Cancer Services Portal |
| 12 | **Under 75 mortality from all cancers (DSR)** | **Annual** | **2015-2017** | **149.4** | **146.7** | **123.6** | **134.6** | sig high | | NHSIC - P00381/ PHOF 4.05i |
| **Priority Objective 3: Improving Immunisation Uptake** | | | | | | | | | | |
| 13 | **Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age (%)** | **Quarterly** | **Q2 2018/19** | **83.5** | **85.3** | **74.8** | **86.4** | similar | | COVER Programme |
| 14 | **HPV Vaccine Update (All Doses) %** | **Annual** | **2017/18** | **75.5** | **79.5** | **81.0** | **83.1** | sig lower | | Public Health England - via www.gov.uk |
| 15 | **Uptake of Influenza vaccine in persons 65+ years of age %** | **Annual** | **2017/18** | **67.5** | **67.4** | **66.9** | **72.6** | sig lower | | PHOF 3.03xiv |
| **Priority Objective 4: Reducing Alcohol Harm** | | | | | | | | | | |
| 16 | **Alcohol related admissions (ASR per 100,000 pop)** | **Annual** | **2016/17** | **601** | **522** | **529** | **636** | sig lower | | PHOF 2.18 |
| **Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking** | | | | | | | | | | |
| 17 | **Smoking Prevalence in adults (18+) - current smokers (APS)(%)** | **Annual** | **2017** | **21.2** | **15.5** | **14.6** | **14.9** | similar | | PHOF 2.14 |
| 18 | **4 week smoking quitters (crude rate per 100,000)** | **Annual** | **2017/18** | **2,203** | **2,329** | **2075** | **2,070** | similar | | Smoking Quitters |
| 19 | **Smoking status at time of delivery (%)** | **Annual** | **2017/18** | **4.8** | **5.4** | **5.0** | **10.8** | sig lower | | PHE Tobacco Profiles |
| **Priority Objective 6: Improving Mental Health and Wellbeing** | | | | | | | | | | |
| 20 | **Prevalence of Serious Mental Illness (%)** | **Annual** | **2017/18** | **1.31** | **1.33** | **1.11** | **0.94** | sig high | | Quality Outcomes Framework |
| 21 | **Prevalence of Depression 18+ (%)** | **Annual** | **2017/18** | **7.0** | **8.2** | **7.1** | **9.9** | sig lower | | Quality Outcomes Framework |
| 22 | **Improving Access to Physiological Therapies (IAPT) referrals entering treatment (%)** | **Annual** | **To Nov 2018** | **15.3** | **20.0** | - | - | - | | SLaM |
| 23 | **Proportion of those accessing IAPT who moved to recovery (%)** | **Annual** | **To Nov 2018** | **48.0** | **49.0** | - | - | - | | SLaM |
| **Priority Objective 7: Improving Sexual Health** | | | | | | | | | | |
| 24 | **Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)** | **Annual** | **2017** | **4,735** | **2,573** | **2,199** | **1882** | sig higher | | PHOF 3.02i/3.02ii (NCSP & CTAD) |
| 25 | **People presenting with HIV at a late stage of infection (%)** | **Annual** | **2015-2017** | **37.3** | **39.6** | **35.2** | **41.1** | similar | | PHOF 3.04 |
| 26 | **Legal Abortion rate for all ages (crude rate per 1000 women aged 15-44 yrs)** | **Annual** | **2017** | **23.1** | **23.1** | **19.8** | **16.5** | sig high | | ONS Abortion Stats |

# Appendix A - Health and Wellbeing Board Performance Metrics - January 2019

| | Updated indicators are in bold | Frequency | Latest Period of Availability | Previous Available Period (Lewisham) | Latest Available Period (Lewisham) | London | England | England Benchmark | Direction from Previous Period | Data Source |
|---|---|---|---|---|---|---|---|---|---|---|
| 27 | **Teenage conceptions (Rate per 1,000 15-17 Yr olds)** | **Annual** | **2016** | **23.4** | **22.1** | **17.1** | **18.8** | **similar** | | PHOF 2.04 |
| **Better Care Fund Metrics** | | | | | | | | | | |
| 28 | **The proportion of those aged 65+ who received reablement services after hospital discharge** | **Annual** | **2017/18** | **2.3** | **4.0** | **3.8** | **2.9** | - | | Better Care Fund, NHS England |
| 29 | **Residential Admissions Rate (per 100,000 65+ population)** | **Annual** | **2017/18** | **687.4** | **541.2** | **406.2** | **585.6** | - | | Better Care Fund, NHS England |
| 30 | **Average daily rate of delayed transfers of care (per 100,000 population aged 18+)** | **Annual** | **2017/18** | **7.3** | **5.7** | **-** | **12.4** | - | | Better Care Fund, NHS England |
| 31 | **Non-Elective Admissions (per 100,000 population)** | **Annual** | **2017/18** | **-** | **-** | **-** | - | - | - | Better Care Fund, NHS England |

**Key**

sig high -signficantly higher than England; sig low - significantly lower than England
similar - statistically similar to England
DSR - Directly Standardised Rates
ASR - Age Standardised Rates
ISR - Indirectly standardised Rates
PHOF - Public Health Outcome Framework



Latest period highlighted
Statistically Better than England
Statistically Similar to England
Statistically Worse than England
Blank where no statistical comparison could be made

Arrows Indicate up or down performance of current year /qtr from previous yr/qtr

**Links to Source with their abbreviations**

| | |
|---|---|
| http://www.phoutcomes.info/ | Public Health Outcomes Framework (PHOF) |
| http://www.phoutcomes.info/profile/sexualhealth | Public Health England Sexual Health Profiles |
| https://www.indicators.ic.nhs.uk/webview/ | NHS Indicator Portal (NHSIC) by Health and Social Care Information Centre (HSCIC) |
| http://www.hscic.gov.uk/qof | Quality and Outcomes Framework (QOF) by HSCIC |
| http://ascof.hscic.gov.uk/ | Adult and Social Care Outcomes Framework (ASCOF) |
| http://www.productivity.nhs.uk/ | NHS Better Care Better Value Indicators |
| https://www.nhscomparators.nhs.uk/NHSComparators/HomePage.aspx | NHS Comparators by HSCIC |

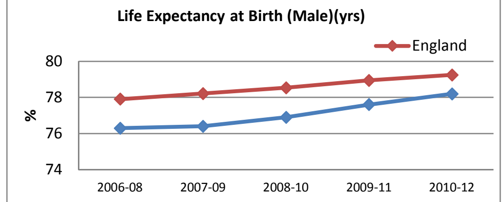
* Data Quality Issue has been reported with this indicator, interpret with caution

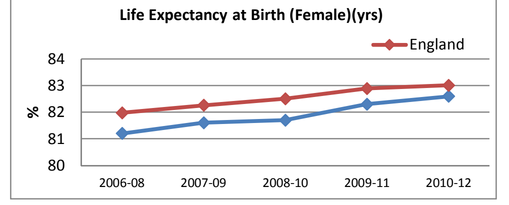
# Overarching Indicator

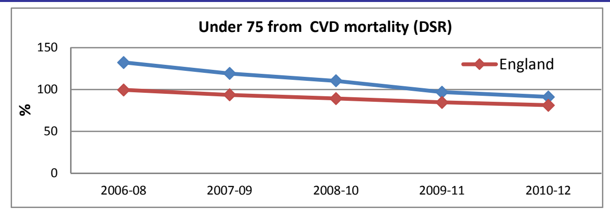
## Health Outcome Indicator Rates

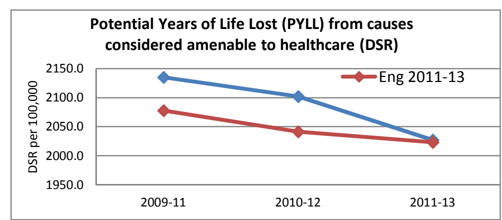
| | Target | 2006-08 | 2007-09 | 2008-10 | 2009-11 | 2010-12 | 2011-2013 | London 2010-12 | England 2010-12 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Life Expectancy at Birth (Male)(yrs) | | 76.3 | 76.4 | 76.9 | 77.6 | 78.2 | 78.7 | 79.7 | 79.2 | |
| Life Expectancy at Birth (Female)(yrs) | | 81.2 | 81.6 | 81.7 | 82.3 | 82.6 | 83.0 | 83.8 | 83 | |
| Under 75 from CVD mortality (DSR) | | 132.3 | 119 | 110.3 | 96.7 | 91 | | 83.1 | 81.1 | |
| Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male) | N/A | | | | 6 | 6.6 | | | | |
| Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female) | N/A | | | | 6.3 | 6.6 | | | | |
| Infant Mortality rates | | | | | 4.8 | 4.9 | | 4.2 | 4.3 | |
| | | | | 2009-11 | 2010-12 | 2011-13 | | Lon 2011-13 | Eng 2011-13 | |
| Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (DSR) | | | | 2134.7 | 2102.0 | 2027.0 | | 1890.2 | 2023.5 | |
| | | 2008 | 2009 | 2010 | 2011 | 2012 | | Lon 2012 | Eng 2012 | |
| Low Birth Weight of all babies | | | | | 8.3 | 8.4 | | 7.9 | 7.3 | ↑ |
| | | | | 2011/12 | 2012/13 | 2013/14 | | | | |
| Proportion of people using social care who receive self-directed support, and those receiving direct payments (Crude rate per 100,000) | | | | | 55.5 | 69.4 | | 67.5 | 62.1 | |
| Delayed transfers of care from hospital (crude rate per 100,000) | | | | 3.0 | 4.9 | | | 6.9 | 9.5 | ↑ |
| Days of Delay (crude rate per 100,000) | | | | | 134 | | | | | ↓ |
| | | | | 2010 | 2011 | | | Lon 2011 | Eng 2011 | |
| Children in poverty (%) | | | | 31.7 | 30.5 | | | 26.5 | 20.6 | |

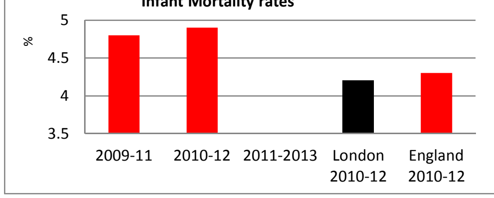
## Trend Charts

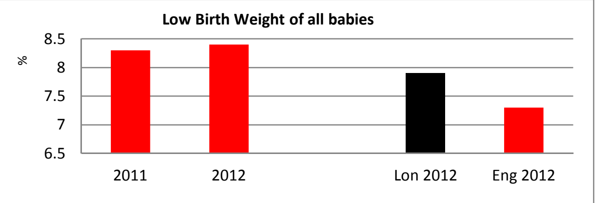


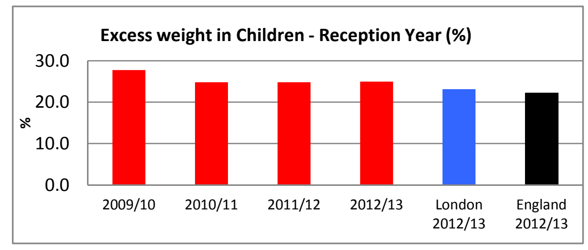



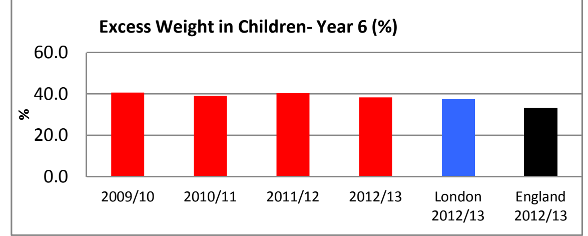



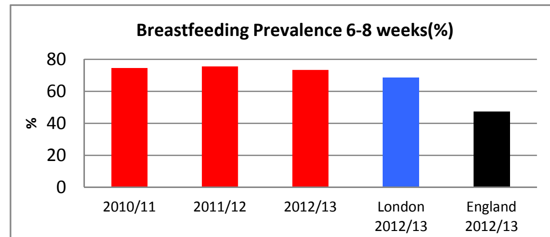
# Priority 1 : Achieving Healthy Weight

| | Target | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | London 2012/13 | England 2012/13 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Excess weight in Adults (%) | | | | | 61.2 | | 57.3 | 63.8 | |
| Excess weight in Children - Reception Year (%) | | 27.8 | 24.8 | 24.8 | 25.0 | | 23.0 | 22.2 | |
| Excess Weight in Children- Year 6 (%) | | 40.6 | 39.1 | 40.4 | 38.3 | | 37.4 | 33.3 | |
| Breastfeeding Prevalence 6-8 weeks(%) | | | 74.6 | 75.7 | 73.5 | | 68.5 | 47.2 | |
| | | | **2010** | **2011** | **2012** | | **London 2012** | **England 2012** | |
| % of physically active and inactive adults - Active adults | | | | | 54.3 | | 57.2 | 56.0 | |
| % of physically active and inactive adults - Inactive adults | | | | | 29.2 | | 27.5 | 28.5 | |

## Trend Charts



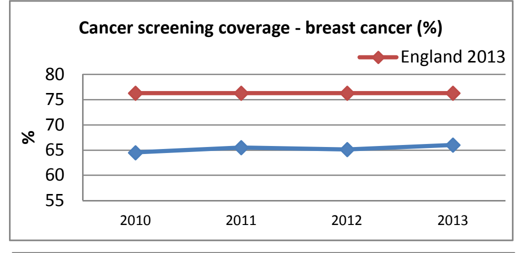



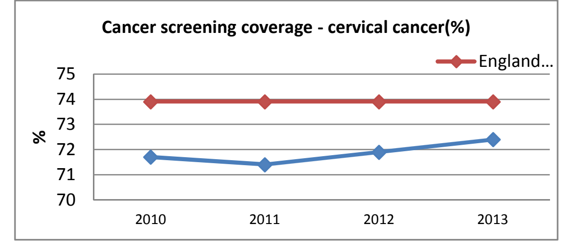



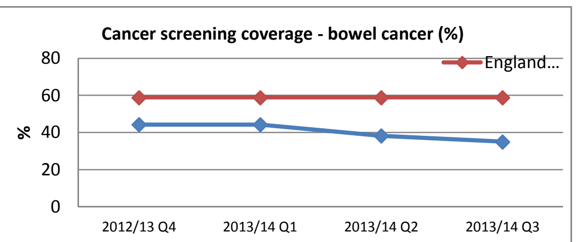
# Priority 2 : Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

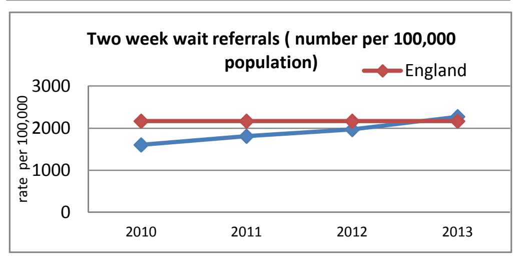
| | Target | 2009 | 2010 | 2011 | 2012 | 2013 | London 2013 | England 2013 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Cancer screening coverage - breast cancer (%) | | | 64.5 | 65.5 | 65.1 | 66 | 68.6 | 76.3 | |
| Cancer screening coverage - cervical cancer(%) | | | 71.7 | 71.4 | 71.9 | 72.4 | 68.6 | 73.9 | |
| Two week wait referrals ( number per 100,000 population) | | | 1601 | 1810 | 1967 | 2273 | | 2166 | |
| | | **2012/13 Q4** | **2013/14 Q1** | **2013/14 Q2** | **2013/14 Q3** | **2013/14 Q4** | **S.E London 2013/14 Q3** | **England 2013/14 Q3** | |
| Cancer screening coverage - bowel cancer (%) | 60.0 | 44.2 | 44.2 | 38.2 | 35 | | 41.4 | 58.8 | |
| | | | **2010** | **2011** | **2012** | | **London 2012** | **England 2012** | |
| Early diagnosis of cancer (%) | | | | | 2273 | | | 2166 | |
| | | **2006-08** | **2007-09** | **2008-10** | **2009-11** | **2010-12** | **London 2010-12** | **England 2010-12** | |
| Under 75 mortality from all cancers ( DSR) | | 172.8 | 173.5 | 168 | 169.4 | 159.9 | 139.1 | 146.5 | |

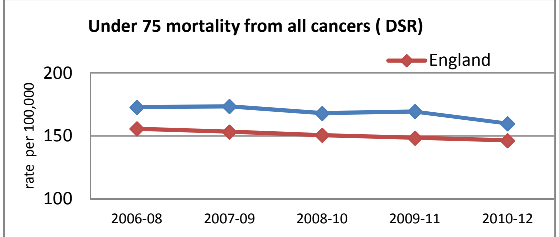
## Trend Charts



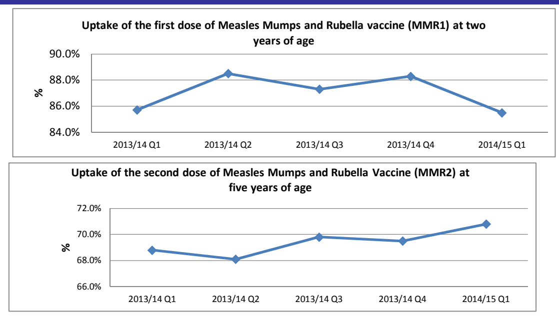
# Priority 3: Improving Immunisation Uptake

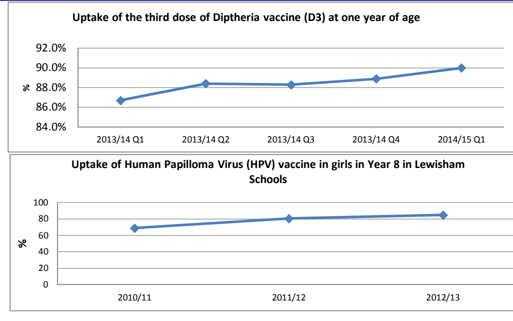
## Percentage Uptake of Key Vaccines

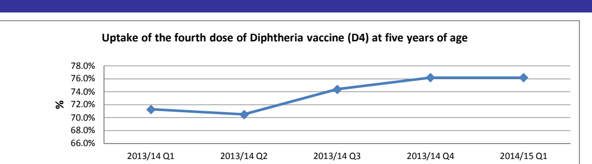
| | Target | 2013/14 Q1 | 2013/14 Q2 | 2013/14 Q3 | 2013/14 Q4 | 2014/15 Q1 | London 2014/15 Q1 | England 2014/15 Q1 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Uptake of the first dose of Measles Mumps and Rubella vaccine (MMR1) at two years of age | 90.8% | 85.7% | 88.5% | 87.3% | 88.3% | 85.5% | 86.8% | 92.4% | ↓ |
| Uptake of the third dose of Diptheria vaccine (D3) at one year of age | 91.9% | 86.7% | 88.4% | 88.3% | 88.9% | 90.0% | 88.6% | 93.9% | ↓ |
| Uptake of the fourth dose of Diphtheria vaccine (D4) at five years of age | 91.1% | 71.3% | 70.5% | 74.4% | 76.2% | 76.2% | 77.3% | 88.6% | ↓ |
| Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age | 91.1% | 68.8% | 68.1% | 69.8% | 69.5% | 70.8% | 79.9% | 88.5% | ↓ |
| | | | 2010/11 | 2011/12 | 2012/13 | 2013/14 | London 2012/13 | England 2012/13 | |
| Uptake of Human Papilloma Virus (HPV) vaccine in girls in Year 8 in Lewisham Schools | | | 68.8 | 80.6 | 84.8 | | 78.9 | 86.1 | ↑ |
| Uptake of Influenza vaccine in those over 65 years of age | | | 69.6% | 70.1% | 68.2% | | 71.2% | 73.4% | ↑ |

Source: HPA Cover Data

## Trend Charts



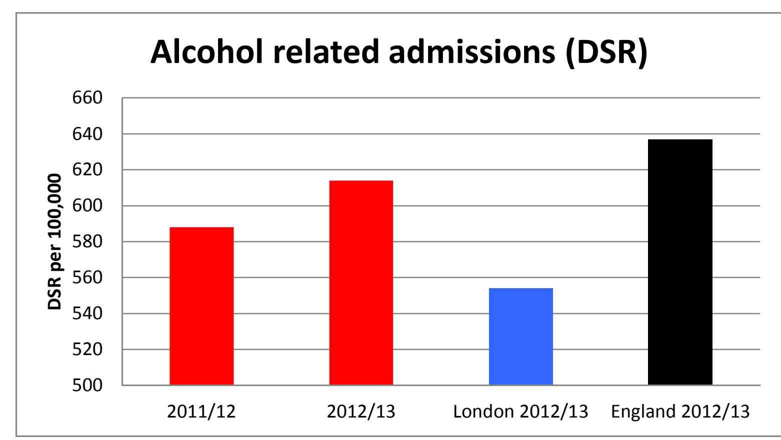



## Priority 4 : Reducing Alcohol Harm

| | Target | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | London 2012/13 | England 2012/13 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Alcohol related admissions (DSR) | - | - | - | 588 | 614 | - | 554 | 637 | |
| Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions (Local source) | - | - | - | - | 120 | - | | | |
| | | | | | | | | | |

## Trend Charts

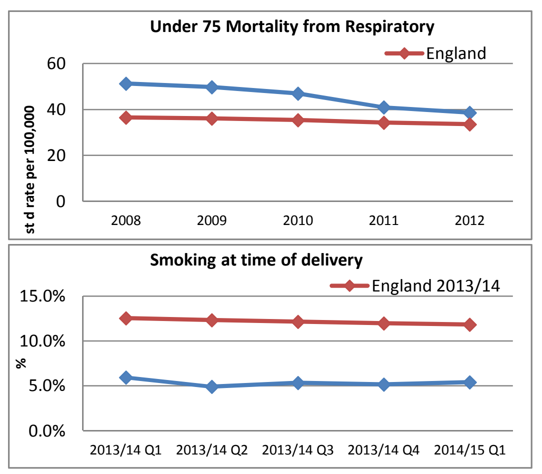


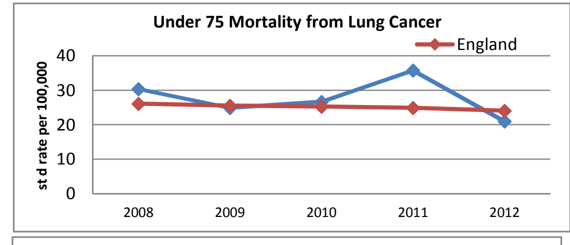
# Priority 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

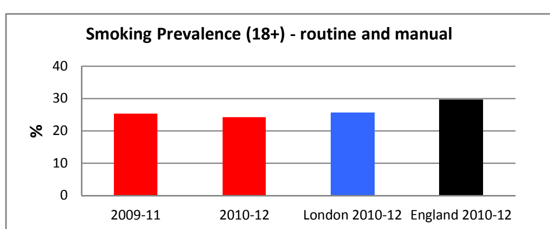
## Tobacco Control

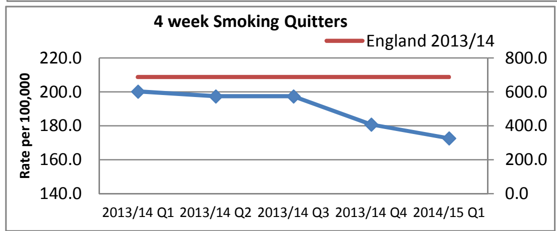
| | Target | 2006-08 | 2007-09 | 2008-10 | 2009-11 | 2010-12 | London 2010-12 | England 2010-12 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Under 75 Mortality from Respiratory | | 51.3 | 49.7 | 47 | 40.9 | 38.6 | 32.6 | 33.5 | |
| | | 2008 | 2009 | 2010 | 2011 | 2012 | London 2012 | England 2012 | |
| Under 75 Mortality from Lung Cancer | | 30.39 | 24.92 | 26.68 | 35.78 | 21.0 | 23.04 | 24.06 | |
| Smoking Prevalence (18+) - routine and manual | | | | | 25.4 | 24.3 | 25.7 | 29.7 | |
| | | 2013/14 Q1 | 2013/14 Q2 | 2013/14 Q3 | 2013/14 Q4 | 2014/15 Q1 | London 2013/14 | England 2013/14 | |
| 4 week smoking quitter (crude rate per 100,000) | | 200.3 | 197.4 | 197.3 | 180.7 | 172.6 | 656 | 688 | |
| Smoking at time of delivery | | 5.9% | 4.9% | 5.3% | 5.2% | 5.4% | | 11.8% | |
| | | | | 2008 | 2010 | | | | |
| Number of 11-15 year-olds who take up smoking (%) | | | | 16.0% | 9.0% | | | | |
| Number of children in smoke free homes (%) | | | | 56.0% | 57.0% | | | | |
| Prevalence of Smoking in 15 year olds (proxy: % Never smoked at all - Yr8 and Yr10 children) | | | | 95.0% | 74.0% | | | | |

## Trend Charts



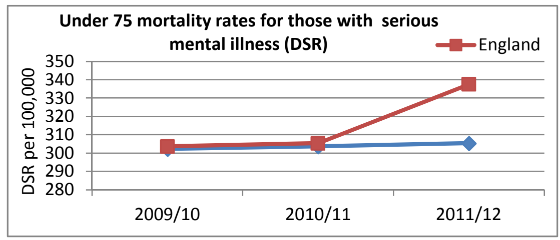



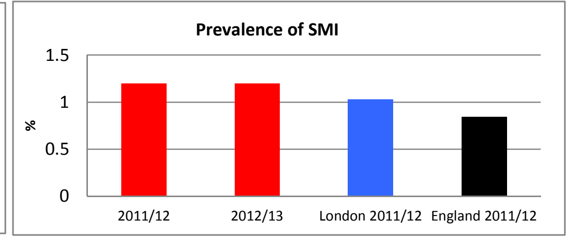



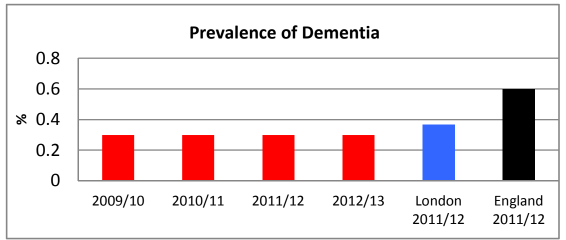
## Priority 6 : Improving mental health and wellbeing

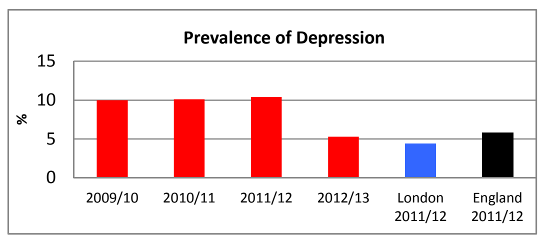
| | Target | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | London 2011/12 | England 2011/12 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Under 75 mortality rates for those with serious mental illness (DSR) | | 302.2 | 303.6 | 305.3 | | | - | 337.4 | |
| Prevalence of SMI | | | | 1.2 | 1.2 | | 1.0 | 0.8 | |
| Prevalence of Dementia | | 0.3 | 0.3 | 0.3 | 0.3 | | 0.4 | 0.6 | |
| Prevalence of Depression | | 10 | 10.1 | 10.4 | 5.3 | | 4.4 | 5.8 | |
| Self-reported well-being - people with a low happiness score | | | | 15 | 10.2 | | 10.3 | 10.4 | |
| | | 2007-09 | 2008-10 | 2009-11 | 2010-12 | | London 2010-12 | England 2010-12 | |
| Suicide rates | | 6.9 | 7 | 7.1 | 7.5 | | 7.5 | 8.5 | |

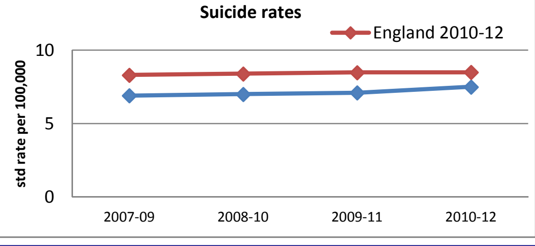
## Trend Charts



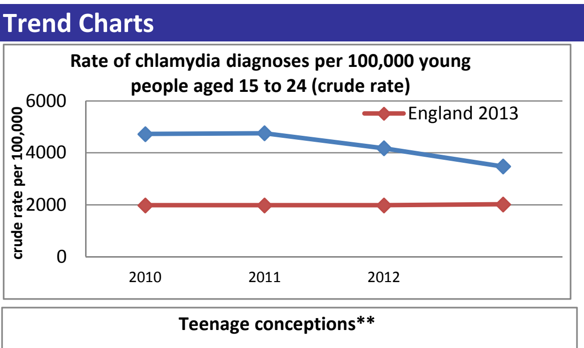



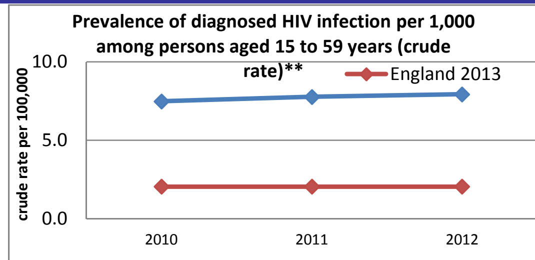



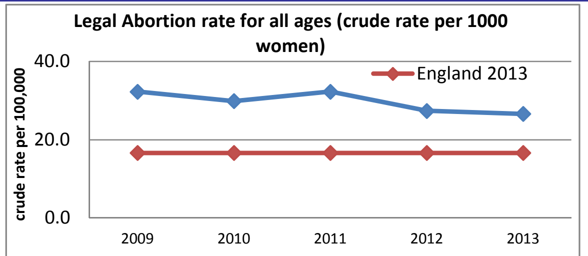
# Priority 7 : Improving sexual health

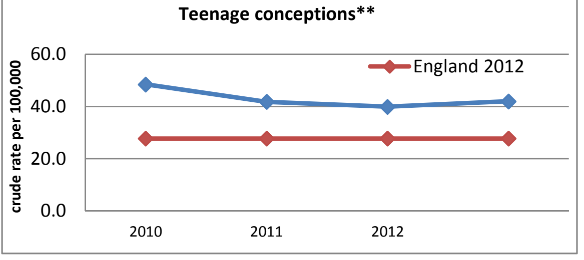
| ** old data - 2012 | Target | 2009 | 2010 | 2011 | 2012 | 2013 | London 2013 | England 2013 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate) | | | 4728 | 4762 | 4179 | 3480 | 2179 | 2016 | |
| Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years (crude rate)** | | | 7.5 | 7.8 | 7.9 | | 5.5 | 2.1 | |
| Legal Abortion rate for all ages (crude rate per 1000 women) | | 32.3 | 29.9 | 32.3 | 27.4 | 26.6 | 21.7 | 16.1 | |
| Teenage conceptions** | | 48.5 | 41.8 | 39.9 | 42.0 | | 25.9 | 27.7 | |
| | | | | 2009-11 | 2010-12 | | London 2010-12 | England 2010-12 | |
| People presenting with HIV at a late stage of infection(%) | | | | 51.8 | 50.9 | | 44.9 | 48.3 | |
| | | | | | | | | | |

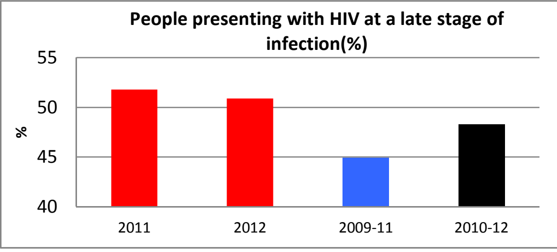
## Trend Charts



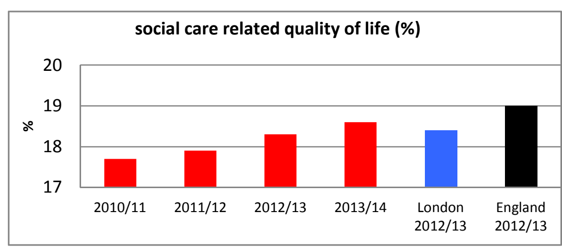



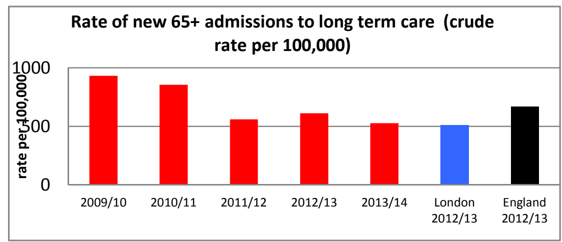



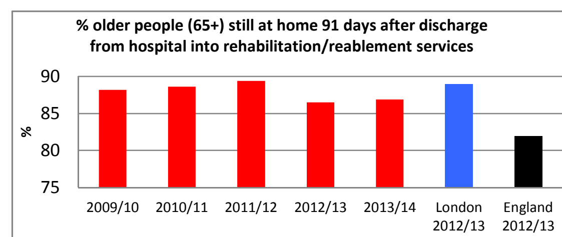
## Priority 8 : Delaying and reducing the need for long term care and support.

| | Target | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | London 2012/13 | England 2012/13 | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| social care related quality of life (%) | 19 | | 17.7 | 17.9 | 18.3 | 18.6 | 18.4 | 19 | |
| Rate of new 65+ admissions to long term care (crude rate per 100,000) | 549.4 | 931.2 | 854.3 | 560.7 | 612.9 | 527 | 509.4 | 668.4 | |
| % older people (65+) still at home 91 days after discharge from hospital into rehabilitation/reablement services | 88.0 | 88.2 | 88.6 | 89.4 | 86.5 | 86.9 | 88.9 | 81.9 | |

## Trend Charts



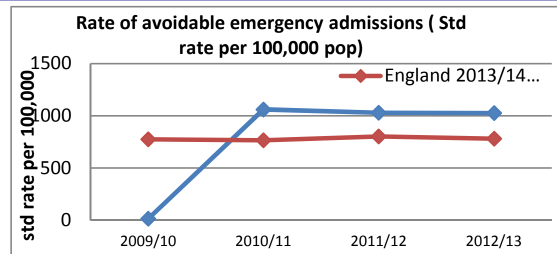



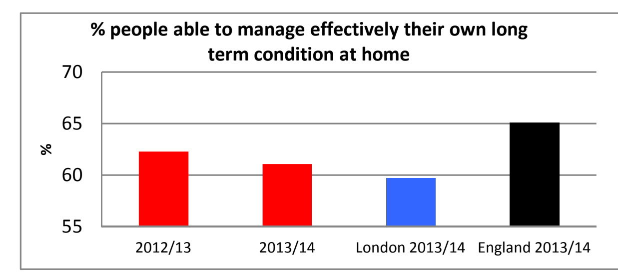
## Priority 9 : Reducing the number of emergency admissions for people with long term conditions

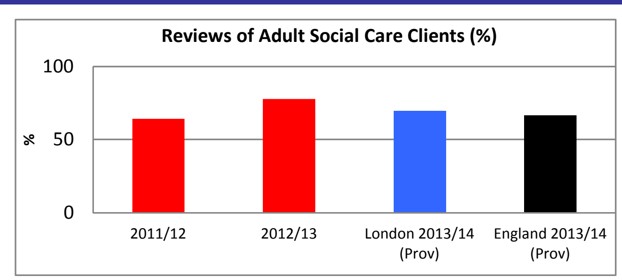
| | Target | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 013/14 (Prov | London 2013/14 (Prov) | England 2013/14 (Prov) | Direction of Travel from Target |
|---|---|---|---|---|---|---|---|---|---|
| Rate of avoidable emergency admissions ( Std rate per 100,000 pop) | | 14.52 | 1061.2 | 1029 | 1027.6 | 940.9 | 734.6 | 780.9 | |
| | | | | | **2012/13** | **2013/14** | **London 2013/14** | **England 2013/14** | |
| % people able to manage effectively their own long term condition at home | | | | 58.1 | 62.3 | 61.1 | 59.7 | 65.1 | |
| | | | | | | | **London 2012/13** | **England 2012/13** | |
| Reviews of Adult Social Care Clients (%) | 70 | 74.7 | 62 | 64.4 | 77.9 | 70.7 | 69.8 | 66.6 | |
| | | | | | | | | **England 2011/12** | |
| Emergency Readmissions within 30 days of discharge from hospital | | 12.11 | 11.96 | 12.73 | | | | 11.78 | |
| | | | | **Jul 2011 - Mar 2012** | **Jul 2012 - Mar 2013** | **Jul 2013 - Mar 2014** | **London Jul 2012 - Mar 2013** | **England Jul 2012 - Mar 2013** | |
| Health-related quality of life for people with long-term conditions | | | | 0.73 | 0.75 | 0.75 | 0.75 | 0.74 | |
| | | | **2010/11** | **2011/12** | **2012/13** | **2013/14 (Prov)** | **London 2013/14** | **England 2013/14** | |
| Emergency admissions for acute conditions that should not usually require hospital admission | | | 1147.8 | 1155.8 | 1324.8 | 1279.4 | 991 | 1164.7 | |

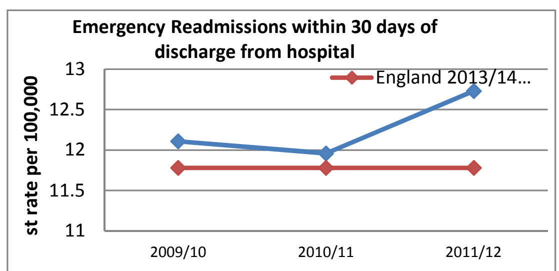
| | | | 2010/11 | 2011/12 | 2012/13 | 2013/14(Prov) | London 2013/14 Prov | England 2013/14 Prov | |
|---|---|---|---|---|---|---|---|---|---|
| Unplanned admission of chronic ambulatory care sensitive conditions | | | 1061.2 | 1029.0 | 1027.6 | 940.9 | 734.6 | 780.9 | |

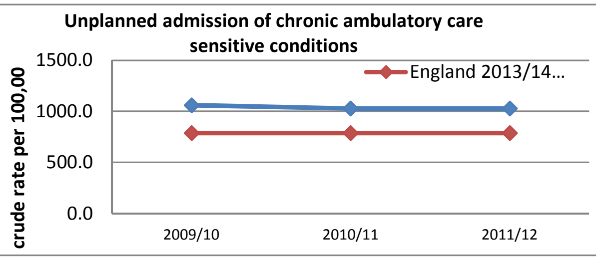
## Trend Charts

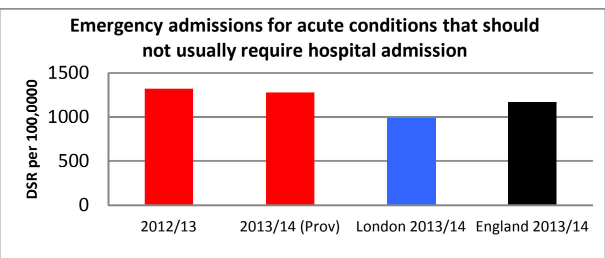


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| Healthier Communities Select Committee | | |
|---|---|---|
| Title | Independent inquiry into bullying and harassment at Lewisham and Greenwich NHS Trust | |
| Contributor | Ben Travis (Chief Executive, Lewisham and Greenwich NHS Trust) | 5 |
| Class | Part 1 (open) | 16 January 2019 |

## 1. Introduction

Attached as appendix A is the final report of an independent inquiry into bullying and harassment at Lewisham and Greenwich NHS Trust.

The Lewisham and Greenwich NHS Trust Chief Executive, Ben Travis, will provide a verbal update and answer questions at the meeting.

Please see relevant press coverage below for further information:

- 'Menacing, threatening and heavy-handed' culture found at trust, *Health Service Journal*, 21 December 2018
- 'Menacing, threatening and heavy-handed' culture of bullying embedded in trust, *National Health Executive*, 21 December 2018

## 2. Recommendations

The Committee is asked to consider and note the update.

## 2. Press articles

'Menacing, threatening and heavy-handed' culture found at trust
*Health Service Journal*
21 December 2018

A damning report commissioned by a trust has exposed the extent of bullying and harassment faced by staff and the "menacing, threatening and heavy-handed" culture.

Lewisham and Greenwich Trust in London commissioned a three-month investigation into the issue in September, which was released this afternoon. It found:

- "Overt bullying" particularly "at the most senior levels" within the south London trust;
- A lack of action to address the issue, which "damaged the reputation and credibility of the executive leadership"; and
- The trust should identify "teams" and staff in problem areas as "a priority".

Chief executive Ben Travis, who joined the trust in April, told HSJ he commissioned the investigation from Ashfold Consulting after staff raise concerns about bullying and harassment unprompted at a leadership review in May.

Twenty-nine per cent of staff reported bulling or harassment by another staff member over the past year, compared to a national average of 24 per cent

The report said: “Many examples were given of members of the senior leadership team demonstrating a leadership style that at best was described as ‘menacing, threatening and heavy-handed’. [This was] often excused as, ‘Oh well, that’s how they are’”.

The report said this “learned behaviour” filtered down to lower levels, “particularly the general manager” group.

The trust has suffered significant turnover in senior staff since the start of 2017, with the chief executive, finance director and director of nursing all departing. All had been in post for 10 years or more.

The report said: “The presence of overt bullying, both witnessed and reported, particularly at the most senior levels, coupled not only with a lack of visible action to address it, but a laissez faire attitude which appears to condone it, can be interpreted as a lack of willingness to recognise and tackle bullying behaviour.

“This apparent inaction has damaged the reputation and credibility of the executive leadership, as it existed at that time, both at a collective and, in some cases, individual level.”

Recommendations in the report include that “the past failures of the senior team are publicly acknowledged” and that the “employment relations” team continues to be improved.

A new standards policy will be introduced shortly. The report recommended strategies were devised to “[identify] and appropriately tackle those staff subject of or making repeated complaints”, as well as “identify[ing] those teams where behaviour or performance presents as problematic”.

Mr Travis told *HSJ* his staff were depending on him and his team to make sure the report’s findings were taken seriously and acted on.

The report also said bullying and harassment were likely underreported because of “poorly understood reporting channels” and a “significant level of mistrust in the process”.

The report continued: “Whilst I would not describe the bullying in the trust as institutionalised, it is however widespread in that it is evident across all sites, in all divisions, at all levels and perpetrated by managerial, non-managerial and clinical staff.”

*HSJ* understands the trust is considering employing professional investigators to improve the complaints process.

The Ashfold team looked at internal documents and spoke to 75 people. Half of interviewees had been bullied or witnessed bullying and not reported it. The author said this was “concerning [considering] the substantial cohort of senior managers who made up the interview process”.

The report added: “Key to addressing [bullying and harassment] is top level leadership. Although there have been a number of recent changes to board level, there remain questions over their commitment to change, a position influenced by the recent past.

“Additionally, senior clinicians and general managers below the executive must recognise their role in an organisational culture that has left many staff feeling unhappy, anxious and unsupported.

“I believe the current situation presents an opportunity for the trust to take a more enterprising, if not radical, approach to effect sustainable and long-term change.”

The trust’s new workforce strategy, written while the investigation was being carried out, said the organisation hoped to reduce the percentage of staff reporting bullying and harassment by half by 2021.

The employment relations team dealt with 628 cases over the two years from October 2016: 95 disciplinary, 35 bullying and harassment, 36 grievance, 18 capability and 444 sickness. In the same period, there were 11 employment tribunals and “a number of settlements”, the report said.

It added: “The evidence clearly shows the HR function seemingly, if not actually, being inappropriately persuaded or overly influenced by divisional management in relation to many complaints, investigations or outcomes.”

Investigators also quoted one interviewee who said “some managers are really challenged by the whole process especially if it involves race”.

The report said: “The concern is best replayed in a quote ‘I do not want to be accused of racism so I will play this by the book’.

“Such an approach may not have discrimination at its heart but it certainly deprives [black and minority ethnic] staff of the more informal methods of managing behaviour or performance.” It said this might reflect the “disproportionate level of BME staff entering formal proceedings”.

‘Menacing, threatening and heavy-handed’ culture of bullying embedded in trust
*National Health Executive*
21 December 2018

A damning report commissioned by a trust has revealed the extent of “widespread” and “embedded” bullying and a “menacing, threatening and heavy-handed” culture facing its staff.

A three-month inquiry into bullying and harassment at Lewisham and Greenwich NHS Trust (LGT) found widespread bullying in the trust evident “across all sites, in all divisions, at all levels and perpetrated by managerial” and clinical staff.

The employment relations team dealt with 628 cases over the two years from October 2016 with 965 disciplinary, 35 bullying and harassment, 36 grievance, 18 capability, and 444 sickness cases.

“The prevalence of overt bullying, both witnessed and reported, particularly at the most senior levels, coupled not only with a lack of visible action to address it, but a laissez faire attitude which appears to condone it, can be interpreted as a lack of willingness to recognise and tackle bullying behaviour,” the damning report stated.

“This apparent inaction has damaged the reputation and credibility of the executive leadership, as it existed at that time, both at a collective and, in some cases, individual level.”

The inquiry, commissioned by CEO of LGT Ben Travis, involved over 50 mainly one-to-one interviews and concluded that bullying and harassment is “embedded in the culture of the organisation.”

“Many examples were given of members of the senior leadership team demonstrating a leadership style that at best was described as ‘menacing,

threatening and heavy-handed'. [This was] often excused as, 'Oh well, that's how they are,'" the report explained.

The report has recommended that a strategy is devised to identify and appropriately tackle staff who make repeated complaints as a matter of priority and a strategy to identify those teams where behaviour or performance presents a problem.

It added: "Key to addressing bullying and harassment is top level leadership. Although there have been a number of recent changes to board level, there remain questions over their commitment to change, a position influenced by the recent past."

Travis commented: "I want to apologise to anyone in the Trust who has experienced bullying and harassment. This is a watershed moment for the Trust and we need to be clear: bullying and harassment will not be tolerated in any part of the organisation. We recognise that people are working under pressure.

"However, this doesn't excuse bullying, and we need to do more to become an organisation that supports all our staff. The important thing is that we learn so that we can make the changes that are needed to do this."

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

# BULLYING AND HARASSMENT AT THE LEWISHAM AND GREENWICH NHS TRUST

An Independent Inquiry Report

This document contains the report of the Investigating Officer in pursuance of the Terms of Reference set by
Ben Travis, CEO, Lewisham and Greenwich NHS Trust

Andrew Gent
Director



## Preface

Since I joined the Trust, it has been clear that we need to do more to make sure that all staff feel respected, valued and supported. Whilst I've met many staff who have a great experience of working here, I've also spoken to a number of people who have told me about their experiences of bullying and harassment.

Bullying and harassment is recognised as an issue across the NHS as a whole. It's a real concern that our staff survey showed that 29 per cent of staff at this Trust reported problems with bullying and harassment, against a national average of 24 per cent. So I commissioned this independent assessment to find out more from people who have experienced problems and from those involved in handling these issues.

I wanted to give a voice to those who feel that the system has let them down. That's why we have spoken to people who have reported concerns, and I'd like to thank everyone who has shared their experiences for this report. Whilst the report does not represent the views of everyone who works here, it does show the experiences of many members of staff. We need to make this a great place to work for everyone, and understanding the views of those who've not had great experiences is essential for this.

When we commissioned this assessment, we knew that it would make difficult reading. We are sharing this with you as we need to be open and transparent. It's clear that there have been many cases of bullying and harassment in the Trust and, as a leadership team, we've not done enough to tackle this. This includes improving how we investigate cases and supporting anyone who reports concerns.

I want to assure you of my personal commitment to addressing these issues. Our next step is to develop a full action plan to tackle bullying and harassment, in line with the recommendations of this report. We've set up open staff meetings for the next two years to report to you on progress and we will be publicising the dates widely in our Staff Updates and on the intranet. In addition, we will appoint a group to hold us to account on this work. This will be led by an independent chair and will include staff representatives. We will be working closely with our staff-side (the unions in the Trust) and the equality and diversity network on all this.

I want to apologise to anyone in the Trust who has experienced bullying and harassment. This is a watershed moment for the Trust and we need to be clear: bullying and harassment will not be tolerated in any part of the organisation. We recognise that people are working under pressure. However, this doesn't excuse bullying, and we need to do more to become an organisation that supports all our staff. The important thing is that we learn so that we can make the changes that are needed to do this. We need to come together and have the confidence to live our values and challenge others to do so.

**Ben Travis**
**Chief Executive**

## Message from Mike Davey, Staff Side Chair

We have been fully involved throughout the process of the neutral assessment and very much welcome the publication of this report and the recommendations contained within it. For us the subject of bullying and harassment has been a long standing agenda item, both within the Trust and the wider NHS itself, and so again we very much welcome the strong commitment from the CEO and the Trust Executive to tackling these issues here at Lewisham and Greenwich NHS Trust. This includes inviting external scrutiny to hold the organisation to account and to ensure the Trust makes genuine and tangible improvements for staff. As always, we will continue to support our members who are affected by bullying and harassment, while working in close partnership with the Trust to ensure that it delivers on its action plan to address the fundamental problem.

## Message from Manisha Patel, Chair of Equality and Diversity Inclusion Network

The Equality and Diversity Inclusion (EDI) network was set up by the Trust for staff who want to support the organisation in becoming more accessible and inclusive for everyone. We have been fully involved in the neutral assessment into bullying and harassment and it was great to see so many people attending the staff workshops to discuss the recommendations. There is a strong commitment from the very top to addressing the issues in the report, making the Trust a great place to work for everyone. We will be working closely with the Trust and with staff to deliver the recommendations and to support this work.



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## Executive Summary

This report is the outcome of a three-month inquiry into bullying and harassment (B&H) at Lewisham and Greenwich NHS Trust (LGT). It is important to emphasise that this inquiry takes the form of a neutral evaluation, and is not a study or an investigation into any individual allegations. I have no jurisdiction other to report on what I have found, providing advice and identifying necessary actions.

Using a study of key internal documents and data, over 50, mainly one-to-one, interviews involving over 75 people and conducting six workshops, the report provides an assessment of the levels, handling and culture affecting B&H in the Trust. To ensure appropriate context, reference has been made to relevant published studies and reports on the subject. This report is a commissioned inquiry conducted by Andrew Gent of Ashfold Consulting Limited for the Chief Executive Officer (CEO)of LGT.

### Principal Key Findings

- Whilst bullying in the Trust is not described as institutionalised, it is however widespread in that it is evident across all sites, in all divisions, at all levels and perpetrated by managerial, non-managerial and clinical staff. To this extent, it is embedded in the culture of the organisation.
- The prevalence of overt bullying, both witnessed and reported, particularly at the most senior levels, coupled not only with a lack of visible action to address it, but a *laissez faire* attitude which appears to condone it, can be interpreted as a lack of willingness to recognise and tackle bullying behaviour. This apparent inaction has damaged the reputation and credibility of the executive leadership, as it existed at that time, both at a collective and, in some cases, individual level.
- The level of complaints and evidence of poor case timeliness, together with negative descriptions of processes and policies lead me to the conclusion that case management is sub-standard. Whilst the creation of the Employee Relations (ER) team and the introduction of a new case management software are welcome changes, these need to be built upon to drive change and place the ER Team at the centre of a credible, reliable and trusted ER case management process. This is a key priority.
- There are, within the Trust, teams and individuals whose behaviour and performance remain a concern. It is a relatively straight forward exercise to conduct a level of analysis with the current data sets and apply a forensic and justifiable approach to identifying and tackling these problems.  This issue should be addressed as a matter of priority.



### Principal Recommendations

- The past failures of the senior team are publicly acknowledged, and the CEO now develops the senior leadership team in a way that gives confidence to the workforce that change will be effected, and that the team understand the expectations of staff in this regard.
- The Trust builds upon the recent changes to the Employee Relations (ER) Team to enhance its recording, case management, investigative and the decision-making capacity including providing a level of investigative capability and developing case management Key Performance Indicators (KPIs).
- That a Behavioural Standards Policy or Framework is created which clarifies the expected standards of behaviour of all staff and is drawn from the Trust values, professional codes of conduct and bullying and harassment negative behaviours.
- A strategy is devised to identify and appropriately tackle those staff subject of or making repeated complaints and this is acted upon as a matter of priority.
- A strategy is devised to identify those teams where behaviour or performance presents as problematic with a view to making appropriate interventions to address the issues.

### Main Context

- The problems of bullying and harassment in the workplace have been well documented and understood for decades. The health, social care and wider public sector are ‘hotspots’ for bullying and harassment (B&H), which is recognised as a major issue in the NHS.
- Bullying and harassment have unfavourable consequences for effective organisational performance, specifically through increased sickness absence, reduced productivity, higher levels of employee turnover and directly impacting the potential for new entrants into the NHS labour market.
- Negative behaviours, a lack of challenge to such behaviours, organisational change, hierarchy and power, destructive management and leadership styles, and a broad range of stressors around a lack of job autonomy, insufficient resources, ineffective and poor levels of employee and management support are all potential contributory factors for bullying and ill-treatment.

- The culture of an organisation is defined by the role modelling of its leadership as employees closely and carefully monitor leader and manager behaviours.

- The 2017 NHS Staff Survey identified that the Trust had a 5% higher score for 'B&H from other staff' compared to the average score for similar trusts (29% versus 24%).

## Other Key Findings

- The number of reported cases reflects a significant level of under reporting in comparison to the staff survey, exit interviews and other indicative data. A position exacerbated by an unwillingness to report B&H issues due to complex and poorly understood reporting channels, a significant level of mistrust of the process, and a resignation that little will happen in any event.

- Effective data collection and analysis is extremely limited masking the true picture, impacts and costs. The inability to maximise valuable data sources, particularly exit interviews and ER case data, deprives the Trust of an early warning system from which it can take appropriate action. In this regard the Trust is "*data rich but intelligence poor.*"

- The role of Workforce and Education in this context is one of advice, oversight and governance, therefore drawing the ER resources together as one team with a new Head of ER post is a welcome step forward, as is the acquisition of new case management software. However, the strength of feeling and views expressed about the service received and the Workforce role should not be underestimated or disregarded, as they are real and represent a challenge to rebuilding trust in the system. Moreover, there is unlikely to be fundamental change until a full overhaul of the policies and procedures has taken place.

- The foundation to any performance or people management process is a recognition that the role of the supervisor or manager is to provide a level of day to day advice and direction, making interventions when appropriate, challenging negative behaviour or performance where necessary and acknowledging positive performance. However, many managers, particularly those in 'first time' people management roles, do not have the skills or confidence to manage difficult conversations. As a consequence, much behaviour goes unchallenged and escalates to a point where formal procedures are engaged.

- There is a clear deficit of available skilled workplace investigators, the demand for which will depend on the investigation model Trust choses to use. This model needs



to be determined quickly and a training regime implemented to provide quality investigation training.

- The ER suite of policies lack synergy, are too lengthy, too complex and in need of overhaul to streamline processes, bring them up to date and make them more user friendly.

- Key to addressing B&H is top level leadership. Although there have been a number of recent changes at Board level, there remain questions over their commitment to change, a position influenced by the recent past. Additionally, senior clinicians and general managers below the executive must recognise their role in an organisational culture that has left many staff feeling unhappy, anxious and unsupported. Whilst a new CEO has recently been appointed, it is critical that he now develops the senior leadership team in a way that gives confidence to the wider workforce that change will be affected.

- There is no real referencing between the Trust values, B&H behaviours and the professional codes of conduct. The positive reverse of B&H behaviours have much in common with the values of the Trust and those behavioural expectations of the various professional codes and NHS Constitution. There is a real benefit to concentrating the behaviours expected to be demonstrated, and those that are not, into one accessible and recognised behavioural document.

- The use of Performance and Development Reviews (PDRs) as a powerful and appropriate tool for holding individuals to account in relation to values and behaviour is readily accepted by many staff. It is acknowledged that the PDR process is transitioning from paper to an electronic system, none the less the process is regarded by many staff as ineffective and a 'tick box' exercise.

- A holistic suite of KPIs relating to key ER issues is absent. The lack of a published 'balanced score card' deprives the Trust of a tool to hold managers to account. Moreover, managers are unable to determine performance and therefore what needs to be addressed and staff will not have the opportunity to understand and discuss solutions.

- The Workforce and Education Department is regarded as the creator and guardian of the policies, overseer of the accompanying procedures and 'flag bearer' for the principles underpinning those policies. The wider staff have a right to expect those responsibilities will be applied fairly, impartially and, where it is obvious that processes or the principles are not being adhered to, that there is appropriate challenge and intervention. Unfortunately, in too many instances this has not been

the case and the image of the department in this area has, in the eyes of many, been damaged. In pursuing the new Workforce strategy there must be heavy emphasis on meeting the expectations of staff, re-establishing trust and restoring confidence given their critical role in tackling many ER issues including B&H.

- All staff, but particularly managers and consultants, need a heightened awareness of negative behaviours and poor leadership/management behaviours that lead to perceptions of B&H, or are not in keeping with Trust values.

## Key recommendations

It is recommended that:

- The mechanisms for reporting wrong doing are reviewed to produce clear and accessible reporting channels including the introduction of an independent confidential reporting line.

- An Information Management Strategy is devised with a view to the collation, analysis and publication of key data sets to provide for a greater understanding of the issues and target interventions.

- The Trust reviews the structure, training and use of workplace investigators.

- Relevant policies are reviewed and revised to ensure they are fit for the effective management of behavioural issues of all members of staff including; the introduction of a management action file note procedure and publishing all formal disciplinary hearing outcomes.

- The content, use and training of PDRs is reviewed to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus and a positive emphasis on individual development needs.

- An appropriate KPI regime is introduced which recognises the key indices upon which to measure B&H performance and hold managers to account at a Trust, Divisional and Team level.

- An education programme should be put in place for all staff to heighten awareness of B&H negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how staff should respond when they are recipients of such behaviour.

- All managers, particularly those in foundation management role or new to post should receive appropriate training for managers to provide the skills and confidence to challenge poor behaviour by managing difficult conversions or difficult people.



Underpinning all the recommendations in this report is the need for broad cultural change and the need to restore the trust and confidence of the staff in the leadership, processes and systems through which poor behaviour is managed. Delivering such change will require a genuine and demonstrable commitment on the part of the Board and senior leadership, including recognition that it will be difficult to build confidence that there will be fundamental change, particularly if some of those expected to be the levers of change are regarded as part of the change that is needed.

There is now a responsibility to act and I am confident that the new CEO will ensure a swift and appropriate response to this inquiry. The findings in this report and the recommendations made will, I hope, be of real assistance in that task. I recognise that some recommendations, and the actions required to make them effective, may challenge thinking around workforce policies and practices that have been shaped by years of NHS HR tradition or culture. Such is the scale of the bullying and harassment problem, both within the Trust and wider NHS, I believe the current situation presents an opportunity for the Trust to take a more enterprising, if not radical, approach to effect sustainable and long-term change.

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# Introduction

## Investigator Qualifications

I am an Investigator with over 40 years investigative experience, ten years of which as Head of Investigations in the Professional Standards Department of two police forces. I am nationally accredited across a broad range of investigative disciplines including serious incidents, public complaints, counter corruption, workplace grievances and misconduct matters. I am an ILM Qualified Workplace Investigator, a member of the Association of Workplace Investigators and an OCN Accredited Mediator. I have 20 years senior management experience in a number of public sector organisations and have conducted a number of inquiries with a wide-ranging organisational scope.

I bring to this inquiry what I regard as valuable experience, an extensive background in investigating and managing difficult employee relations issues and many years' experience of representing, advising and training both employers and employees on bullying and harassment in the workplace. I also have a clear understanding of the policies, procedures and skills required to address these issues effectively. I have drawn on this experience in considering all the information provided to this inquiry and in making recommendations about what needs to be done.

## Background

This inquiry arose as a result of concerns raised with the CEO regarding a number of responses received from staff during the Leadership Capacity Review, conducted by the Trust in late spring of this year. Whilst these concerns related to potential bullying behaviour at the highest levels in the Trust, the CEO was aware of underlying concerns of wider spread bullying and harassment throughout the organisation, which appeared to be reflected in the Staff Surveys, Exit Interviews and emails sent to him personally.

A decision was made to appoint an external, independent investigator to conduct an inquiry into the extent of bullying and harassment within Lewisham and Greenwich NHS Trust (LGT). The Terms of Reference (ToR) were constructed accordingly and on 1st August I was formally commissioned to conduct the inquiry on a 'neutral evaluation' basis and to report by 1st November 2018.

## Confidentiality Caveat

This report has been written to fulfil the Terms of Reference (ToR) and as such contains information and observations designed to openly inform both the Trust Board and wider staff of the findings of the inquiry. However, given the nature of the inquiry, the ToR and the methodology adopted, it is inevitable that details of cases, allegations of bullying, potential perpetrators and targets would be disclosed or discovered.



Clearly the open publication of such confidential information is both inappropriate and unnecessary. As mentioned below, any details received, which in my view, pointed to a significant and immediate intervention being required would be passed to senior Workforce personnel to facilitate an intervention.

## Terms of Reference

**1.** *Carry out a neutral evaluation of the levels, handling and cultural issues affecting instances of bullying and harassment across the Trust over the last 3 years*

*The Consultant will be provided with a bundle of documents in order to be able to carry out this evaluation, including but not restricted to:*

1. *Trust policies on disciplinary, grievance, bullying & harassment, performance and mediation*
2. *Staff Surveys for last 3 years*
3. *Medical Engagement Scale Reports for 3 years*
4. *CQC Reports*
5. *Grievance, conduct, performance statistics and analysis for last 3 years*
6. *Numbers of ER cases relating to harassment and bullying which have resulted in ET, dismissal for SOSR or settlement agreement*
7. *The recent consultant's report on the "Leadership Capacity Review"*
8. *Summary of exit interviews for the last three years*
9. *Trusts vision and values statement or program*
10. *Outline of Leadership Training or other training provided to managers relating to B&H and / or managing difficult situations or people*

*The consultant may also conduct interviews with:*

1. *Staff Associations*
2. *Freedom to Speak Up Guardians*
3. *HR ER team*
4. *Operational Teams*
5. *Other Internal or external stakeholders as directed*

**2.** *Report to the CEO on the findings of the above enquiries including any recommendations for action as part of a plan to improve the Trusts approach to harassment and bullying issues.*

### Inquiry Scope, Caveats and Terminology

The Inquiry has invited Trust staff and others with relevant perspectives (including staff representatives) to offer in person or in writing their experiences of perceived bullying and harassment. All contributions will be treated in strict confidence and will not be published or liable to release. Any references to such information in this or any report arising from the Inquiry will be anonymised and quotes will not be attributable.

It is not the purpose of the inquiry to reopen past complaints of bullying or harassment or to investigate new ones against particular individuals. It is hoped that the opportunity offered to Trust staff to present their experiences to an independent third party, in confidence, may help them to achieve closure, where appropriate.



Neither was there any intention of inquiring into the specific workings of any department or division. That said, like most inquiries of this nature, it will touch on the construct, application and effect of relevant policies and procedures. In this context it is inevitable that a light will be shone on parts of Workforce and Education (WED), not only as organisational owners of the key policies and procedures but as stewards of the entire system and guardians of the standards and principles underpinning them. In this context I use the word 'system' to mean the entirety of the policy, procedure and related processes.

Throughout the report I reference levels of management and leadership, and in a similar vein clinical and operational functional teams. Given the wide range of roles and bandings, together with a complex and changing organisational structure, I have made some assumptions or interpretations based on my understanding and I apologise if this understanding or nomenclature is not wholly correct.

**Board** – means the executive directors and non-executive directors of the Trust
**Executive** or **Executive Team** - means the executives
**Senior Team / Senior Leadership Team** – means the executives and senior management strata directly below the executives, the Trust Management Executive. (TME)
**Senior Managers** – means those fulfilling a management role mainly at band eight or nine
**Leadership –** means those fulfilling any role managing people or any other role that has influence or power, including in a clinical context e.g. doctors, particularly consultants
**Divisions** -means Clinical and Corporate Divisions
**Teams** – means clinical specialties and wards in a clinical setting or other operational teams in a corporate context
**Workforce** – means Workforce and Education Department (WED)
**HR** – means Human Resources and has been used in different contexts. It has been used to mean the wider accepted Human Resources functions and is how WED has been described by many staff.

The inquiry aimed to present preliminary findings to the CEO before the end of October, depending on the numbers of people who come forward, and a Final Report as soon as reasonably practicable thereafter.

However, the large number of people who wished to contribute to the inquiry, the sheer volume of information they provided including workshop feedback was such that the information gathering phase of the inquiry continued until the beginning of December. It was therefore not possible to present the findings in the timescales originally agreed.

## Inquiry Methodology

The basic methodology of all inquiries is the examination of key documents, data sets and the obtaining of witness accounts. Although this inquiry is not a study, as many of the recently published reports on bullying and harassment have been, I felt it appropriate to consider the findings of those reports. This has been particularly so given their relevance to the subject, the nature of the recommendations and their applicability to this inquiry. Accordingly, I have referenced key reports and, where appropriate, relevant research that underpins or explains my findings and conclusions. Below I outline the key documents upon which I relied, a full list is contained in Appendix A.

### Data

- Staff Survey 2017;
- Sickness Absence;
- Vacancy Rates;
- Temporary and Agency Staffing Levels;
- Exit Interviews Summaries;
- Complaints and PALs data; and
- ER Case Data

### Documents

- Exit Interview Reports and Summaries;
- PDR content and the Online Appraisal manual; and
- Various emails and documented submissions.

### Policies

- Grievance and Disciplinary;
- Capability;
- Dignity at Work -Bullying and Harassment;
- Sickness absence;
- Speak Up – Whistleblowing; and
- MHPS Policy

### Other Key Reports and Research

- The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings – A study by University of Bradford (2010);
- Bullying & Harassment at the South East Coast Ambulance NHS Foundation Trust: An Independent Report (2017);
- Bullying and harassment: how to address it and create a supportive and inclusive culture -BMA (2018);



- The Bullying and Harassment of House Of Commons Staff: An Independent Inquiry Report (2018);
- Workplace Culture at Whittington Health NHS Trust: An Independent Report (2018); and
- The price of fear: estimating the financial cost of bullying and harassment to the NHS in England (2018)

### Interviews

The interviews carried out fell into three discrete sets:

- Staff who, by virtue of job role, would provide key evidence;
- Staff who were suggested to me by Workforce or other interviewees or those identified by myself; and
- Staff who came forward wishing to contribute.

The fact that the inquiry was being conducted was publicised to the wider workforce, together with an invitation to contribute to the interviews. The selection of other staff to be interviewed was contained in the terms of reference (ToR) or directed by the senior leadership of Workforce, whose administrative support organised the interview schedule. The reason for an interviewee being scheduled was, in most cases, was unknown to me until I began the interview. I did identify some candidates for interview based on their role or having been named by other interviewee's, but these were minimal. Towards the end of the interviewing process it was evident I was seeing people who had elected to speak with me as the level of confidence in the inquiry grew.

As this was not a in depth study, the range of interviews was restricted, in the main, to those identified by the Trust and volunteers. The contributors involved staff from all sites, representing most divisions, occupational groups, managerial and non-managerial roles. I am satisfied that I have seen more than sufficient to fulfil my terms of reference. Whilst retaining confidentiality, and to provide a broad overview of the range of interviewees included, I highlight the following:

- Board members;
- WED staff;
- TME members (clinical and corporate);
- Other senior managers (clinical and corporate);
- Chairs of a number of representative groups;
- Individuals involved in past or current cases;
- Staff Side, EDI and Freedom to Speak Up Guardians; and
- Other volunteers

In order to provide a consistent and structured interview, I utilised a guide at the outset of the interview process and has been attached at Appendix A. However, this approach became less critical when interviewing a number of interviewees who wished to provide accounts of their own experiences.

There has been significant engagement with this inquiry from both current and former members of staff and I have received information from over 75 people. The reliving of traumatic experiences can be painful and distressing, and I am extremely grateful to everyone who came forward and provided such helpful information and observations.

The contributions therefore contained information from across the Trust, from staff working at all levels, as to the prevailing culture in the Trust, incidents of alleged bullying and harassment, the level of support for those subjected to such treatment, the adequacy of procedures and views about necessary changes.

The accounts describe behaviour of managers, colleagues and include medical staff. None of those descriptions were based on hearsay. The accounts given related to incidents in which the interviewees had themselves been directly involved, or that they had witnessed happening to others. The number and breadth of the contributions have provided a deal of information and some invaluable insights. They also revealed some clear patterns and themes. In accordance with the assurance as to confidentiality, there is nothing in this report which could lead directly or indirectly to the identification of any contributor.

The giving of information in confidence in this way can be criticised as providing a platform for disgruntled employees. The compelling counter argument however, as is now well understood, is that people who have been bullied or harassed, or who have seen this happen to others, are generally reluctant to come forward and report it. Less than 15% of the people contributing by way of interviews and submissions referred to formal cases in which they were either alleged perpetrators or targets. In addition to these, nearly 50% been subject to or witnessed bullying behaviour and either did not report it or act formally upon it. As an aside, this in itself is a little concerning given the substantial cohort of senior managers and senior leadership who made up the interview process and may be an issue that needs attention from the Board. Therefore, the interviews are far from being the observations of a discontented few, but rather they provide, in my view, a sound basis for the findings and recommendations set out in this report.

Throughout this report, I have included a number of direct quotes from interviewees, which are italicised. These put into words the depth of feeling and the genuine concerns of Trust staff. Each quote is generally representative of views that many others also expressed.



Overall, the information given to the inquiry has been detailed, thoughtful and measured. In my view, there was a general lack of exaggeration and a willingness to acknowledge personal failings, which indicated some careful reflection. Everyone who attended meetings spoke freely and frankly. People welcomed the opportunity to speak about matters and were fully cooperative. Much of what they had to say reflected the pride that members of staff have in working for the NHS, but that generally served to emphasise the level of resentment and unhappiness about their experience of working in the Trust.

## Staff Workshops

As the Inquiry developed it was felt appropriate to expose some key findings and associated recommendations to workshops, with a view to validating some of my findings and testing the practicality of the emerging recommendations. The workshops were made up of staff expressing an interest in assisting the process following advertising of the workshops to all staff.

The workshops were held over two days and were attended by 115 people, two thirds of whom I had not previously met. The range of attendees was fairly broad in relation to ethnicity, managerial, non-managerial, clinical and medical staff. These workshops were extremely useful and reflected a significant level of support for the findings and recommendations together with some practical considerations which, where appropriate, have been included in this report. A copy of the recommendations placed before the workshops is included in Appendix B.

During and post these workshop events there remained a desire by staff to come forward and add their experiences to my inquiry. The general tenor of the wider discussions underlined my assessment of the cultural and leadership dimensions to the B&H problems in the Trust and reinforced the expectation that positive action will be taken following the completion of this report.

# Context

## Workplace Bullying and Harassment

The problems of bullying and harassment in the workplace have been well documented and understood for decades, as observed by Lewis (2018):

*Workplace bullying and harassment (B&H) has been recognised as a contemporary workplace issue that affects organisations of all sizes and in all continents (Einarsen et al., 2011; Fevre et al., 2011; Lewis et al., 2016). Bullying (and harassment) is complex with multiple causes at individual, group and organisational levels. Individual, social/group and organisational experiences illustrate how negative behaviours, a lack of challenge to such behaviours, organisational change, hierarchy and power, destructive management and leadership styles, and a broad range of stressors around a lack of job autonomy, insufficient resources, ineffective and poor levels of employee and management support are all potential contributory factors for bullying and ill-treatment (Baillien et al., 2011; Fevre et al., 2012; Lewis et al., 2016).*

*Research shows that larger, complex organizations, which are equipped with policies and practices designed to tackle bullying, were more likely to experience the phenomenon (Fevre et al., 2012). That research demonstrated that managers and supervisors are often cited as the perpetrators of the behaviours many employees label as 'bullying', but that co-workers, clients/patients and families of patients can also be perpetrators (Fevre et al., 2011).*

*Research evidence shows that effective leadership and management, along with a range of employee support such as occupational health and counselling services, buffers the effects of bullying whilst their absence exacerbates it (Lewis et al., 2016).*

## Workplace Bullying and Harassment in the NHS

The 2013 Francis Report into the Mid Staffordshire NHS Foundation Trust reported how a culture of bullying can harm an NHS organization. Bullying can affect the ability of staff to undertake everyday tasks, which ultimately impacts patients. It should therefore come as no surprise that bullying and harassment have unfavourable consequences for effective organisational performance, specifically through increased sickness absence, reduced productivity, higher levels of employee turnover, directly impacting the potential for new entrants into the NHS labour market, excessive litigation costs, damaged organisational reputation and of course patient experiences (Francis, 2013).

It has been reported how health and social care, and the public sector more generally in Britain were hotspots for bullying and mistreatment.

Within a British health and social care context, Fevre et al., (2012) reported that negative behaviours associated with incivility and disrespect were the most prevalent, but also that



behaviours associated with unreasonable management in the form of demands and expectations also helped explain how employees feel ill-treated at work.

Recent data for the NHS in England (2017) showed 13% reporting bullying by managers, 18% by co-workers and 28% by patients/relatives. Only 48% of incidents of bullying were reported, suggesting the scale of the problem is much greater.

## The Meaning of Bullying and Harassment

The terms "bullying" and "harassment" can mean different things to different people and it is important to understand what they mean in this context, and what I mean in using these terms. I have not sought to deal with the legalities or the legal liabilities of individuals or the Trust other than to say that harassment on the basis of a protected characteristic may be considered discriminatory under the Equality Act 2010. Also relevant is the employer's duty under the Health and Safety at Work Act 1974 to protect employees from work related violence, which includes acts of bullying and harassment.

ACAS have described bullying and harassment together as "*offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious, or it may be insidious. It may be persistent or an isolated incident. It can also occur in written communications, by phone or through email, not just face to face. Whatever form it takes, it is unwarranted and unwelcome to the individual.*"

The important question is whether the actions or words are viewed as detrimental and unacceptable to the target. It is the deed itself and its impact on the target that matters, not the intention of the perpetrator.

Such behaviour can take the form of easily noticed, physically threatening or intimidating conduct with immediate impact, or it can take place behind closed doors, or be much more subtle or camouflaged and difficult to identify.

Some bullies lack insight into their behaviour and are unaware of how others perceive it. Others know exactly what they are doing and will continue to bully if they feel they are unlikely to be challenged. Bullying and harassment can sometimes be overlooked, as a result of common euphemisms being used by way of explanation or justification, referring to someone as "that's the way they are" for example. The information provided to this inquiry has demonstrated all these different features.

It is also important to recognise that the key differential for a good proportionate of bullying situations is that a power or authority differential between individuals. This may normally be

seen as a supervisor / manager and subordinate; however, this can frequently include professional standing such as exists in the medical or academic professions. It can also be a perceived power differential borne of cliques, friendships or knowledge, all of which cannot be overlooked. In the context of this report the managers and medical staff, especially consultants, have very much the same emphasis in that they have, in my view, an absolute leadership responsibility insofar as their behaviour is concerned.

## Types of Bullying and Harassment

Understanding bullying in the NHS limited to the NHS employee survey, which, by design, does not ask the level of questions to understand the problem in more depth. There is a growing argument that these need to be expanded to reflect exposure to the 21 negative behaviours, as described by Ferve, *et al* (2011), which form the cornerstone of the British Workplace Behaviour Survey (BWBS) and the frequency to which that occurs. This approach has been adopted in recent studies into B&H in the NHS by Lewis (2018). An example of the behaviours is contained in Appendix C.

These questions break the behaviours into three clusters:

- Violence and Injury as a result of Violence;
- Unreasonable Management Behaviours; and
- Incivility and Disrespect Behaviours

These more granular questions, including frequency of exposure, provide a much more informative data set upon which to understand the issues and identify root causes.

## Costs of Bullying and Harassment

Whilst not a specific part of the ToR, the recently published paper by Kline and Lewis (2018) on the financial cost of bullying and harassment to the NHS in England provided a timely opportunity to contextualise the Trusts' position in this regard. This is particularly pertinent as in considering a business case for any recommendation and actions required and it provides a process from which the cost effectiveness of such actions can be measured.

The paper conservatively estimates the costs to the NHS in England as £2.281 billion per annum. Whilst it is accepted that these costs are both real and opportunity costs, they none the less amount to a significant amount, which on a pro rata basis will apply to the Trust. There is clearly much overlap with other key workforce indicators such as turnover, vacancies, sickness and the use of agency and bank staff and therefore concerted attention to bullying will inevitably impact on those indicators.

However, as Kline and Lewis (2018) observe;



"*Bullying and harassment are everyday features of many UK workplaces, with health and social care being the most prominent employment sector bedevilled by workplace ill-treatment…….. With the massive budgetary pressures facing the NHS, it is more relevant than ever to address the real costs of bullying, both moral and financial.*"

## Levels of Bullying and Harassment

### Findings

#### Employee Engagement Overall

Data obtained from the 2016 and 2017 NHS Staff Survey was examined to establish some baseline indicators. Staff engagement scores were compared with other combined acute and community NHS trusts and were classified as 'below average', with an average but decreased score for staff ability to contribute towards improvements at work. This is consistent with a general overall and noticeable decline in performance across the survey since 2015. Of greater concern however is the significant decline in the responses for the Friends and Family questions *"I would recommend my organisation as a place to work"* from 60% to 52% compared to an NHS average of 59% and *"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"* from 62% to 54% with an NHS average of 69%. Such a decline is a real cause for concern, which the Trust has recognised. It almost amounts to a collapse in trust and confidence of the staff over a short period, which I cannot attribute to any operational or organisational event. The Trust has indicated that the 2017 responses have changed significantly, returning to previous or better levels, the 2018 Staff Survey will provide more clarity in that regard.

In terms of bullying and harassment and attendant issues, the Trust had a 5% higher score for B&H from other staff compared to the 2017 average for similar trusts (29% versus 24%) with above average scores for work-related stress (43% versus 38%). LGT also reported higher than average experiences of discrimination (18% versus 10%) up from 14% in 2016. 17% of racial minorities reporting discrimination from a manager/team leader compared to only 8% of white respondents. Survey evidence from 2017 also showed that racial minorities reported higher levels of bullying and harassment in LGT from other staff compared to white colleagues (30% versus 29%) with a margin that has closed since the 2016 survey.

The 2017 NHS survey also provided insights into the occupational groups most likely to report bullying. Given that the more problematic bullying is that perpetrated by other staff, the focus here is on interpersonal relations between staff at LGT. The 2017 NHS data for LGT showed general management (44%) and maintenance (42%) reported the highest levels of bullying and harassment from other staff with nursing, nursing/healthcare assistants and medical the next highest levels. Reporting the most recent experiences of bullying/harassment/abuse amongst these occupational groups was 56% or less, with medical reporting at 35%, thus suggesting a potential for under-reporting. That said, the 2017 survey showed an improved but slightly below average score for reporting B&H at LGT compared to other similarly structured trusts.

The 2017 results were slightly surprising in relation to general management and maintenance occupational groups were concerned. A comparison with the 2016 results reveal an increase



from 31% to 44% for general management and 8% to 42% for maintenance. This was accompanied by a drop in reporting from 56% to 44% for general management and a 0% reporting for maintenance. This tends to indicate a significant uplift in bullying in the general management occupational group and a decline in willingness to report. This data supports the general level of incidents and unrest in the managerial roles in relation to the poor behaviour exhibited at higher levels, raised during interviews and covered later in this report.

I am surprised that this issue does not appear to have been identified and givens me some concern regarding the level of analysis of the survey results, particularly in the light of other emerging information relevant to this issue.

#### Staff Survey

As mentioned above 29% of staff completing the survey reported bullying from managers or colleagues with 46% reporting those events. Based on a 32% completion rate for the staff survey this would indicate that 265 events of bullying were reported by staff during 2017. Accepting that the reporting question also covers bullying events from the public which staff may be more willing to report, this still leaves a significant difference from the formal cases per year recorded by the Employee Relations Team (ER). Accepting that some cases will be dealt with without referral to ER, this is still indicating a potentially significant level of under reporting.

The frequency of this survey, its lack of detail and the low levels of completion make it a poor source of really understanding the nature of bullying and the impact of any change or progress in tacking it. A focused but expanded survey, run on a more frequent basis, say quarterly, is a much-needed tool.

#### Exit Interviews

Towards the end of 2017 and in response to a 6% take up rate and the need to reduce staff turnover levels, an initiative was launched in Workforce to drive up the number of completed exit interviews. This was principally conducted by personal interviews with a project manager from Workforce, following a reach out to leavers who had not been previously interviewed.

For the period December 2017 to May 2018 the interview rate was driven up to 48%. Although the subsequent report indicates that main reasons for departure or moving was promotion prospects, work life balance and health and well-being, it did report a significant level of discontent encapsulated in the conclusions:

***"This project has produced some very rich anecdotal evidence that the culture within the Trust is not as it should be. People are not very nice to each other and staff that have been in the same posts for a long time are resistant to change and are bullying peers and managers in some areas. This is apparent in many areas around the Trust, in all divisions"***

A more detailed examination of some of the feedback reveals a significant level of comments relating to treatment in the workplace which would be considered as bullying and harassment, below are a few examples:

***"I've witnessed a lot of bullying in the Trust. Matrons scream in the faces of ward managers and others"***

***"A year ago, there was lots of bullying – it nearly broke me, but one of the instigators went on long term sick and left and the other went on maternity leave so it was ok afterwards. I did inform managers of the problems, but nothing happened."***

*"**Very bullying culture in this Trust – finger pointing at meetings, GM shouting at people**"*

The interviews were able to identify individuals and teams where, for whatever reason, bullying was prevalent and problematic and the same perpetrator names were raised on many occasions. This included most divisions and at all levels up to and including senior leadership. In my view there were instances that demanded an intervention and some undoubtedly, if investigated, could have led to disciplinary proceedings. It is of no surprise that many of the names and locations were subsequently raised during my later interviews with existing staff.

So concerning were the emerging findings, several examples were raised immediately with the leadership in Workforce and although summary reports of the findings were sent to the respective divisions it is not clear what has happened to them. Furthermore, there were instances where a number of staff left two different teams in a short space of time. They were subject of further interview which provided detailed and quite graphical accounts of extremely poor treatment leading directly to their departure. These interviews were reported, but again, there is no clear indication of what interventions followed. During my interviews it was evident there was a feeling of ***"so what, what's going to happen about them"*** and the overwhelming view was nothing tangible has occurred. This needs to change. There should be a strong expectation that the exit interviews are properly collated, analysed and used to inform managers as to issues that may require attention and hold them to account for doing so.

The exit interviews are, and remain, a rich source of information as to the underlying 'health' of the workforce and organisation. The reliance on managers to conduct this process is all well and good but when, in many instances, they are part of the problem appropriate alternative avenues to provide feedback are necessary. The completion of a form either in writing or via a download is not using technology to best effect to encourage completion.



There is little incentive for managers to encourage departing staff to complete the process and they are not held accountable in this regard. It feels that these interviews have been overlooked by managers and not pursued by Workforce until the commendable initiative in December 2017. Accepting that reports may have been placed before Board or Committees it is difficult to identify what meaningful activity or actions have arisen which impact on the collation, analysis and use of exit interviews, which seems a relaxed approach by the Trust considering the workforce issues being faced in relation to retention and turnover.

The exit interview form itself does not reflect that bullying and harassment may be a feature of someone's exit and so, even if completed, does not provide for proper feedback. It would be useful if the form reflected more the 21 bullying negative behaviours and sought to explore answers to the key issues facing the workforce and engagement dilemma's in the Trust.

It appears to me that the whole process needs to be revisited, revised and re energised to provide reliable exit data, capable of analysis with other data sets to identify emerging issues or problems and inform the Workforce Strategy.

### ER Data

Accepting that the ER function has recently been consolidated and new case management software introduced, the regular production of data relating to ER cases is inadequate and could be significantly improved. The fact that this function operated previously in divisional silo's demanded that at least the same record keeping process and standards should have been enforced. This was not the case and a as consequence the data appertaining to these independent operations could not be effectively collated, analysed or published. Consequently, no meaningful data around case management was published on a Trust wide basis. It is difficult to understand why the absence of this key information seems not to have been pursued by the senior leadership of Workforce until recently and, equally, up to that point, its absence accepted by the Board.

Whilst the new case management software is having current open cases and all cases from April uploaded onto it, in my view this hinders proper year on year analysis, the identification of repeat perpetrators and targets, and comparative investigation performance data. It should not be that onerous to take existing data from spreadsheets, clean and import key datasets from the last few years into the software by way of file transfer. Many managers, particularly those in clinical settings, also observed that they would like a greater amount of performance data particularly complaints data, so the issue appears to be one of relevant information not just ER data.

The data provided shows ER cases from October 2016 to October 2018 as follows:

| **ER Cases** | **Number of Cases** |
|---|---|
| Disciplinary | 95 |
| Bullying & Harassment | 35 |
| Grievance | 36 |
| Capability | 18 |
| Sickness | 444 |
| **Total Number of ER cases** | 628 |

I am unable to comment on comparative data with similar trusts as I do not have that information and it is an area of bench marking for the ER team. Although I do not have accurate year on year data, my feeling is that the levels may be high, and this observation has been made to me by the ER team. I add to this that in the same period there have been 11 Employment Tribunals (ET) and a number of settlements. Whilst accepting there may be various different reasons for those ET claims, not necessarily B&H, they would still relate to how an employee feels they have been treated by or in the Trust. Indeed, the observation was made that a number of the claims had featured opportunities for early intervention which may have prevented as escalation to formal proceedings and the subsequent ET.

However, it is the inability to readily produce and publish key data which is of concern. This lack of information raises questions in some minds as to the commitment of Trust to understand and tackle this issue in a transparent way, as the below observation indicates.
***"If you're not collecting or publishing data it raises a suspicion as to why and questions the Trusts' commitment to deliver against its ambition"***

## Other Workforce Data

Other workforce data is readily available including sickness, vacancy, turnover, temporary staffing and PDRs. Whilst this data is published, like most organisations it is difficult to digest, and frequently is produced in demand to other drivers. The need to 'overlay' such information with other key dataset to provide for the identification of trends, hotspots and target specific interventions is very clear and greatly desired by managers.

Whilst some steps are being taken to tackle this, these need real impetus and a clear understanding of what the managers need to effect change. The view of many managers is that they receive little useful combined data and analysis which they can easily understand and share with their teams to start addressing a range of workforce issues.

***"I only get staff survey results. Nothing else is there to engage with, it would be really useful to have greater information to allow me to raise issues with my team"***



## Other Data Sets

The Trust, like most other NHS bodies collects significant levels of data which are subject to examination in their own right and primary for the purpose collected. For example, public complaints, Datix, Serious Incidents, Maintaining High Professional Standards, Speak Up, Student feedback and Health Education England but to name a few. Whilst it is outside my brief to examine these, it is evident that many of these deal with the performance of staff in different arenas.

Many of the causes of poor or adverse performance across these indices lay in attitudes and behaviours of the staff. This is supported by national complaints data which identifies highest causation of complaint being communications and behavioural issues. Indeed, this was a significant matter for the Trust in the CQC inspection of 2017 where the levels and handing of public complaints was criticised and required immediate attention.

There are examples elsewhere in the NHS and certainly in other industries where such data is overlaid with core workforce data to provide a more holistic picture, not only of the emerging problems, teams and people but where there appears to be few problems and good practice. This approach would help to resolve many workforce and operational problems not just bullying and harassment, and requires a clear strategy for Management Information and Information Management.

## Reporting Channels

It is evident that what constitutes bullying and harassment is not well understood by many staff. Equally, it is also important to distinguish between bullying behaviour and reasonable management responses to actual or perceived misconduct, or to poor performance by an employee. A few interviewees described instances when managers who had instigated appropriate conduct or performance management proceedings found themselves on the receiving end of a grievance accusing them of bullying. This is an issue I address later in the report; however, such a lack of understanding limits the challenging and reporting of poor behaviour.

The complex issues of concerns as to what will happen, trust in the system and reprisals arose frequently during the interviews and are addressed in more detail later. However, there is a significant loss of trust by the staff and in these circumstances the use of overt reporting channels diminishes and the need for other reporting avenues grow

There is also confusion with as to the roles of the EDI Network and Freedom to Speak Up Guardians (FSUG), neither body having clear terms of reference at the time of being interviewed. This needs to be addressed particularly as the Network is not intended as a reporting line.

The Freedom to Speak Up Guardians do have reporting in their remit although their role and how it operates is not fully understood by staff and is not contained in the Whistleblowing Policy. Observations and concerns were made regarding the FSUG which related to their original purpose, make up and selection. In essence, the view that they were created to allow confidential reporting of clinical practice and patient safety and not B&H is noticeable, albeit it is recognised that many models exist in the NHS, and they could be used for B&H issues. However, the FSUG were made up of ex members of the trust and that the EDI profile of the team does not reflect the workforce was felt by many to undermine their position as a reporting mechanism for reporting behavioural or conduct wrongdoing. The Trust may need to review this going forward.

The report into the refresh of Trust values also noted staff views pertinent to this area:
***"Staff would like to see a mechanism put in place where they can raise any concerns about other staff behaviour in a safe and confidential way. Where their concerns will be acted on appropriately and where they receive feedback on what has been done about it."***

The need for a clearly independent reporting line, particularly in the short term, was recognised and is considered an appropriate step to allow confidential reporting including anonymous reporting. The development of anonymous complaints mechanisms for harassment, regarding it as a valuable tool in addressing harassment in larger organisations and in the regulated professions. Such mechanisms enable employers both to facilitate safe reporting and to develop a picture of a person's pattern of behaviour. Anonymous complainants can be informed in cases where there have been multiple complaints and asked whether they wish to make a formal complaint alongside others. There are many organisations that provide an experienced and efficient service for reporting wrongdoing for many public sector industries.

The Whistleblowing policy describes a plethora of avenues for reporting wrongdoing of all kinds. The most efficient and effective systems are those that are limited, simple and well understood, this is not the case in either the NHS or Trust and this needs urgent attention.

### Support for Staff

The support networks for staff from the seeking of advice, right through any process are not as clear as they could be. The referral to the Employee Assistance Programme (EAP) and Occupational Health are well understood by managers, less so by staff and the experience of EAP is variable.

More importantly the availability of trusted sources of advice and guidance is limited. Whilst approaching colleagues, Workforce or staff side are recognised avenues, the level of trust in those avenues is very low for a variety of reasons. There is the need for a network of suitable volunteers, selected and training to act as trusted sources of advice and support on how to



deal with many concerns, particularly bullying and harassment. This approach has been used in many other organisations and does much to provide confidential and neutral advice, prevent unnecessary escalation of minor issues and is another source of identifying emerging trends.

## Conclusions

Understanding the true levels of B&H in the Trust is difficult as the main tool for this the annual staff survey and this has its limitations. But even so the reported levels are high by comparison to other similar Trusts and may potentially be higher. The number of reported cases reflects a significant level of under reporting in comparison to the staff survey, exit interviews and other indicative data.

The current position is exacerbated by a real level of unwillingness to report B&H issues due to complex and poorly understood reporting channels, both overt and confidential, a significant level of mistrust of the process and a resignation that little will happen in any event.

Even given recent change, the inability to maximise valuable data sources particularly exit interviews and ER case data deprives the Trust of an early warning system from which it can take appropriate action.

Effective data collection and analysis is extremely limited masking the true picture, impacts and costs. The Trust has many workforce and other pertinent data sets, which if appropriately collected, collated and analysed would provide the basis for a real understanding of the problems, proper comparisons between teams or even other trusts and allow for appropriate interventions. This would be true of a number of areas of the Trust's business not just ER issues. In essence the Trust is *data rich but intelligence poor*.

## Recommendations

1. The mechanisms for reporting wrong doing are reviewed to produce clear and accessible reporting channels including:
    a. Clarification of the roles of the EDI network and Freedom to Speak Up Guardians;
    b. The introduction of an independent confidential reporting line; and
    c. An overhaul of the Whistleblowing Policy

2. The Trust considers the introduction of a network of Resolution Advisors;

3. The exit interview process is urgently reviewed, revised and re energised; and

4. An Information Management Strategy is developed with a view to the collation, analysis and publication of key data sets to provide for a greater understanding of the issues and target interventions.



## Handling of B&H Cases

### Findings

#### Context

In considering my findings in this area recent changes in the Employee Relations function of Workforce and Education must be acknowledged. I should also acknowledge that much of the performance around the handling of any ER case rests with the managers responsible for the investigation or similar and not with the ER team. The difficulties with skills, experience and availability of those managers are highlighted on later in this report. The previous structure had the ER and some other HR functions working within Divisional silos with a HRBP lead for each. This approach has been recognised in the NHS as not being the most efficient and effective use of resources but also the "silo" nature of the functioning of different divisions, each team / division being "sovereign to itself" was likely to conceal some of what is happening. The signs are usually there to be discovered and there needed to be a much higher level of awareness and monitoring which may not have existed.

The system as it stood previously and to a larger extent, in procedural terms, still exists is that when a B&H issue arises the local manager determines whether a matter should be investigated, who investigates, and at the end of the process, what happens or whether a case proceeds to disciplinary hearing. If it does, this will normally be heard by other managers in the division as will any appeal. It does not take much to see how this can be problematic in a number of area's particularly in B&H cases where the alleged perpetrator is a manager in that division. As one complainant observed:

***" when the investigation was complete and I had returned to work, I was called to see xxxx about my grievances. We spoke about the outcome and he told me there was no point appealing as he would hear it anyway. A member of HR was present during this discussion…"***

The evidence provided to me clearly shows this to have been the case with the HR function seemingly, if not actually, being inappropriately persuaded or overly influenced by divisional management in relation to many complaints, investigations or outcomes. As one manager observed;

***"…. They are supposed to be neutral and not protect the managers, which is what I saw in my case. I was the one complained about and I didn't need protecting!"***

The role of WED in the existing system is one of advice, oversight and governance, therefore drawing the ER resources together as one team with a new Head of ER post is a welcome step forward, as is the acquisition of new case management software. My findings almost exclusively detail what has occurred prior to these changes and as such many of the observations should be seen in this context. That said the strength of feeling and views

expressed about the service received and the role WED play in the system should not be underestimated or disregarded as they are real and represent a challenge to rebuilding trust in the system. More over there is unlikely to be fundamental change until a full overhaul of the system has taken place. In this context I use the word 'system' to mean the entirety of the policy, procedure and related processes. The below observation of the system from a senior and experienced member of staff is typical in this regard;
***"…in respect of Employee Relations here, it is one of the worst I have seen. If you take the handling of grievances; the time it takes, the way we treat people raising grievances and the feedback they get, in particular…"***

I was struck by the willingness of the ER Team to recognise the ills of the system and take advantage of the potential for change, including having a more central role in the recording and handling of all ER cases. This represents a real opportunity to improve key areas of the ER process which are subject of real concern and criticism.

### Use of Informal Procedures

The foundation to any performance or people management process is a recognition that the role of the supervisor or manager is to provide a level of day to day advice and direction, making interventions when appropriate, challenging negative behaviour or performance where necessary and acknowledging positive performance.
***"Managers should really be attending courses on managing difficult conversations and bullying and harassment, it is part of their daily job and its 'nipping some of these things in the bud' before it escalates"***

***" … for me what is more important, if we can, we should 'nip it in the bud' before it becomes anything more formal"***

These sentiments were expressed all too frequently and represents the overwhelming view that many managers, particularly those in 'first time' people management roles, do not have the skills or confidence to manage difficult conversations. As a consequence, much behaviour goes unchallenged and escalates to a point where formal procedures are engaged. I address this issue in more detail later in the report.

The observation ***"…some managers are really challenged by the whole process especially if it involves race"*** reflects the research by Archibong and Daar (2010) which shows that in the NHS and a number of other public sector industries, part of this reluctance to engaged is the fear of being accused of bullying, particularly if the member of staff is BME. The concern is best replayed in a quote ***"I do not want to be accused of racism, so I will play this by the book"***. Such an approach may not have discrimination at its heart but certainly deprives BME staff of the more informal methods of managing behaviour or performance. I do not suggest there are not instances of discriminatory behaviour as there probably are in some cases.



However, this issue is important in understand the Workforce Race Equality Standard (WRES) data which reflects a disproportionate level of BME staff entering formal proceedings.

There is also a willingness in policy and practice to allow those raising the issue to dictate how it should be resolved. Whilst a complainant's views are relevant the process cannot be dictated on that basis. Most early B&H matters can be resolved by managed discussion without entering a formal investigation. All ER policies that have behavioural or grievance issues at their heart should be able to mandate an informal or mediated approach before investigation, where this is appropriate.

It is also accepted by many managers, and recognised in other organisations, that from time to time the day to day guidance does not bring about the change required but the situation does not demand entering formal procedures. Experienced managers point to having conversations with staff and recording such, by way of a file note, to evidence intervention if there is no improvement or a further occurrence. This is a good practice and the use of those management action / advice notes in subsequent proceedings has been supported in recent employment tribunals decisions.

However, the Trust, like many others, does not have a policy or process which describes when and how these notes are made, how they are kept or any other governance around this common management practice. This exposes the managers, staff and organisation to real risk in my view. The practise should be acknowledged and enshrined in policy as a part of the processes for managing all ER processes as it would provide for a consistent, legitimate tool for behavioural change. In other organisations it is also used following investigations where there may not be the justification for formal proceedings, but suitable advice or direction needs to be given and documented. Whilst there were questions as to the storage, consistency and governance of the notes, there was overwhelming support of the principle from contributors, particularly at the workshops. ER would have a key role in the governance of this process, although the introduction such a policy will place a spotlight policy and procedure governing the use and maintenance of staff personal files.

Whilst the Trust has a mediation scheme and supports mediated solutions, these are all too frequently late and used in quite difficult circumstances. To facilitate a dialogue at an early stage is a preferred approach and does not require a full mediation session or highly trained mediator. This should be made clearer in policy and practice terms.

### Initial Reporting and Recording

In general terms, accusing someone of bullying is a serious matter and such an accusation should not be made lightly. It is always right to consider whether the "perpetrator" was under acute pressure and just having a bad day, for example, and whether this was just an isolated outburst with no lasting effects and the behaviour was out of character, or whether such

incidents had happened before. Patterns of behaviour are extremely important in effectively tackling this and, I would argue, all ER issues. It is therefore important to maintain reliable records and to log reported incidents and their outcomes accurately, and to have processes in place to enable patterns to be picked up and their historical and systemic significance understood.

Many people were highly critical of poor record keeping and poor follow up in respect of such incidents, and of the consequent inability of those responsible for dealing with such allegations to do so fairly or effectively. While recognising the abilities, professionalism and the dedication of most individuals working in WED, the department was the subject of concerns and criticism in a number of respects. This in the main related to the maintaining of records, perceived breaches of confidentiality, conflicting advice being given by different WED personnel, and a general lack of follow up of reported incidents. The below was typical in this regard;
***"The complaint was investigated and ultimately upheld but the way this was handled was appalling; It was 15 weeks before the official investigation began, there was no transparency and those that had complained were not kept informed. I sent repeated emails asking for updates with no response."***

***"I wanted to raise a grievance but was told by the XXXX that I would be wasting my time and would be better off leaving."***

The system that exists at the moment relies very much on a manager 'notifying' ER but there is little mandatory requirement to do so, especially in a timely fashion. Neither is there a common referral form which allows standard information about any relevant matter to be passed on. What tends to happen is emails or telephone referrals are made to a variety of WED personnel and this gives rise to delays and inconsistency. It also does not provide for WED proper oversight of managerial activity in relation to ER issues. As described earlier, many contributors felt that WED were not sufficiently neutral and allowed commissioning managers to 'plough their own furrows'.

There will obviously be occasions when an allegation of bullying is wrongly or unfairly made, as a response to legitimate conduct or performance management. I identified a few instances amongst all the information provided where I considered that this was the most likely scenario. And I recognise that a manager on the receiving end of such an allegation will be justifiably upset and angry.

On the other side of the coin, however, is that grievance, performance management or disciplinary proceedings can sometimes be misused as a means of controlling or humiliating someone, or even in extreme circumstances to terminate their employment or cause them



to leave. There were a number of examples of referred to in the accounts provided to me where this was a possibility.

***"I was investigated for a discipline matter, it took 16 months and at the end nothing was found against me. This was just the manager picking on me. I'm not the only one who has suffered from her behaviour"***

The whole procedure for reporting ER cases, not just B&H cases, needs to reflect compulsory and timely referral to ER for assessment and recording. This will permit ER to ensure consistent and appropriate action is being proposed and provides an opportunity for appropriate advice to be given and this should be in a timely fashion. A greater mandatory role for ER at the initial and final stages will help reduce such instances and go some way to restoring trust in the process.

### Investigation Procedures

Before considering my findings in detail it is worth commenting on the data relating to the timeliness of cases provided to me. It should be noted that these relate only to cases classified as bullying and harassment, but it is highly likely this will be common to other case types including disciplinary.

- Average time taken to complete B&H cases – four months;
- Number of B&H cases over 28 days old – 33; and
- Number of B&H cases open currently – eight

Of the cases closed in the last two years, 33 were over 28 days old with an average time to complete of four months. These included cases completed by external investigators, which were themselves over six months.

These figures lend support to the numerous complaints made regarding timescales, which some have experienced as over 12 months, 16 months in one discipline case. These timescales are unacceptable and are the major source of concern and discontent of those involved both alleged perpetrators and targets alike. Given that most lengthy cases feature staff become absent through sickness for long periods, the costs to them, their teams and the Trust is significant, and this position cannot be allowed to continue.

The process seems to be that the commissioning manager selects an Investigator, normally from their Divisional resources based on availability, workload, previous experience and perceived managerial skill, in that order. Whilst there is no doubt that there are a number of managers who have been trained and have experience in conducting work place investigations, there is no collective awareness as to exactly who is and to what level. Whether they have received appropriate training does not seem to feature in the considerations when appointing to an investigation. There is certainly no central Investigating

Officer list or pool. Indeed, by admission a number of managers have conducted investigations having not been trained, or trained some time previous and not had recent experience.

Those that have been trained reveal how variable in quality training can be with some trained in other trusts or the Local Authorities appearing better versed in the necessary understanding, skills and techniques. Such a lack of quality training and experience, coupled with the pressure of conducting investigation without protected time to do so, will inevitably impact on timeliness and quality. Many complaints and examples of unwarranted delay were accompanied with a lack of being kept informed and transparency around the process and outcomes. This is unacceptable, every person involved in an investigation particularly the principals, have the right to be provided with regular updates and most, if not all reports should be written in a way that permit disclosure to both parties at the conclusion of the inquiry.

There is a tension in the current model that centres on the use of resource's as described above or seeking an external investigator, which should be reserved for cases where internal investigation is not appropriate. The could, in part, be relieved by the ER team having a deployable, skilled investigative capability to take on cases that are more complex or involve line managers.

The Trust may need to consider what its model should be in relation to workplace investigations and the investigator resources needed. This will determine the training requirements in this regard. If it intends to retain a corpus of investigators amongst the wider staff, then an assessment should be made as to how many and at what level they sit. The view of staff is that there should be at least 30 at a variety of levels who are given particular training but that all managers should have at least half a day foundation training.

On a similar vein I note the CQC criticism of the complaints which, on the surface of it have some similarities with the issues I am finding. The Trust may wish to consider a wider review of all its case handling and investigation processes to identify if there are opportunities to establish common approaches.

The seriousness of any allegations and whether they involve the line manager of the complainant need to be taken into account when considering an appropriate investigator and a process for allocating independent investigators needs due consideration. These could be drawn from another division, ER or, in the most serious circumstances, externally. This may happen at the moment, but it is not structured, and a more defined investigation continuum should be devised where appropriately skilled investigators are appointed commensurate to the case seriousness and complexity. If external investigators are engaged then the Trust should be sure they are properly trained, preferably qualified, experienced and have the



capacity to deliver in a timescale commensurate with the seriousness and complexity of the case.

The management of all live cases, irrelevant of the investigator, is a responsibility of the ER team. The need to ensure timeliness and standards is, in my view, a part of the teams remit, and this should be expressed in policy and procedure. Disproportionate or incomplete investigations featured in some accounts provided to me and this process will go some way to managing this issue.

Policy gives licence to the movement of staff during investigations. This is a difficult issue to manage whilst being fair to all, particularly if one of the parties is a manager. The amount of times it has been referred to and criticised gives me concern as to how it may be used and may be a default to appropriate if somewhat difficult management. It should not be seen or expressed as a right, and only reserved for the most serious occasions. Policy may need to be reviewed in this regard.

### Suspension

Suspension was raised by some contributors. Of concern was a validated example which appeared totally inappropriate and unnecessary, the consequence of which was the individual leaving the Trust. This arose due to the rather bullish approach of a senior manager and the inability of a member of Workforce to provide robust and appropriate advice or challenge the matter. Whilst I have not sought precise data, I am assured that numbers are low. That said this is another issue, which in my view requires central and high-level approval. The policy permits a level of managerial autonomy, which has no operational imperative and should be tightened up. Suggestions as to suspension should be included as part of the referral process and only approved when agreed by the Deputy Director or Director of Workforce and Education. Policy should reflect this and include an appropriate review regime whilst suspension is in operation.

### Outcomes and Transparency

At the completion of the investigation the report should be forwarded to ER before any decision as to outcome are made or transmitted. The ER Manager can then consider, with advice if need be - particularly in disciplinary cases, whether the investigation has been thorough and fair, the report is of the correct quality, and the recommendations justified.

ER may also take a view, if the matter is to go to hearing, who may be best place to deal with it, and should oversee the disciplinary or hearing process.

Many complaints were made that the whole of the process lack transparency, with many citing that the outcomes were not known, no copy reports or redacted reports were provided.

Therefore, explanation for actions or inaction were missing, leaving participants feeling frustrated and aggrieved. As the below expresses:
***"…there were a lot of witnesses and complaints, yet the investigation didn't uphold anything. Even someone in HR said that this was unusual…."***

These issues arose on at a number of interviews and included very detailed explanations or documentation in support. Whilst not privy to the whole case I cannot help but feel that some investigations may have been weak, and others had questionable conclusions and outcomes.

It is important that through its processes and procedures the Trust can demonstrate that it will uphold its standards or undertaking, and that staff can see this is the case. The below observation was one frequently made:
***"…people do not see any consequences to their behaviours, I've never heard of anybody being disciplined for bullying. You can have a policy but if you don't act on it then there is no deterrent"***

I consider that suitably sanitised outcomes for all disciplinary cases, irrelevant of finding or 'offence' / breach should be published on the intranet. Given that many NHS professional regulating bodies make full disclosures in professional misconduct proceedings, the approach is already familiar. It should be noted that this approach was welcomed by most workshop attendees.

### Role of ER Team

Much of the potential role of the ER team has been touched on in the above narrative but I feel it is worthwhile emphasising some points. The conduct of an investigation and the preparation of the subsequent report is the responsibility of the investigator. The practice of writing, completing or editing such reports in the ER team, is not appropriate. Accepting that this was to lend assistance to the investigator or correcting a substandard report, such activity not only is outside their remit but leaves ER open to legal challenge. However, the opportunity for ER to have an independent and properly skilled investigative capability is a consideration as part of the Trusts' approach to managing these issues.

The team should become the centre of excellence and knowledge for all parts of every ER process providing sound consistent advice, quality assuring referrals, investigations and outcomes. As overseers of the investigations processes, the team has a role to ensure timely and appropriate investigations take place. This requires them to have been trained to do so, which, as a team they have not.

ER should provide consistent and recognised check points for reporting, recording and investigations. This should include being a proper and considered gateway to disciplinary proceedings without causing undue delay or having bureaucratic processes.



However, they need to raise staff awareness of who they are and their role to engender staff confidence and trust. They should also be considerate of their role in the 24/7/365 operating environment of their customers and be responsive to that.

Most case management systems have some case reviewing process designed to dip check the standards of handling, investigations and outcomes. This would normally be from outside the organisation. In this case arrangements with a partner Trust would be a useful start. It should be a process which will enhance learning and validate quality.

Finally, the team will need to create and maintain a suitable suite of Key performance Indicators (KPIs) and Team Performance indicators to establish and monitor the performance of the processes and their contributions to it.

### Existing Policy and Procedure

I have not forensically dissected the existing policies but make general observations given the amount of recommendations likely to affect them in any event. There is a lack of synergy between the relevant ER policies specifically Discipline, Grievance, Capability, Sickness and Whistleblowing and Bullying and Harassment. For example, naming and activities of stage one and informal stages, which should all be informal and expectations as to file notes mentioned in one but not others. More importantly, the opportunity to have one investigative process, common escalation stages and standard documents for all ER process is a feature I have seen within the best ER policies and procedures.

In general terms the policies, in common with other NHS policies, are unnecessarily lengthy, and complex, attracting a consistent level of complaint about being difficult to find and navigate. They are out of date in many areas and too frequently put decisions in the hands of those in the process as opposed to the organisation. For instance, the right of a witness not to provide an account or remain anonymous, or the consents required to record interviews. The opportunity to align many processes with identical stages, timescales, rights etc exists and they require significant update if they are to be of use in guiding change to more effective, fair and transparent processes.

The single biggest challenge is around the current B&H policy and how this aligns with the Trust values and various codes of conduct that appertain to different NHS professional groups. The reality is that B&H is a set of undesirable behaviours which are polar opposites to those articulated in the Trust values and a large number of the codes of conduct. Of particular concern is the Maintaining High Professional Standards (MHPS) procedure for doctors and dentists and its relationship with any bullying and harassment or behavioural policy. I address these policy issues in more detail later in the report from an accountability and governance perspective.

The tenor of many policies is started in their title, for instance 'Grievance', which would be better off as 'Resolution', with greater emphasis on resolving matters at the earliest stage. I chose grievance in this instance, but this could be applied across the board and the principle is about reflecting a mind-set that steers to openly raising issues, early resolution and using formal process only when appropriate and necessary, irrespective of the policy subject.

## Conclusions

How cases are managed shapes the views of those involved whether that be as 'perpetrators', complainants or witnesses. This is true of any case management system whether it be criminal, civil or workplace. Good case management systems have key features of accessibility, responsiveness, professional competence, fairness, timeliness and transparency which engenders trust and confidence in the system, even when expected outcomes are not met. Conversely, when these are absent, trust and confidence is eroded and complaints abound.

The level of complaints and evidence of poor case timeliness, together with negative descriptions of processes and policies lead me to the conclusion that case management is sub-standard. Evidence presented to me indicates a lack of consistent advice, poor record keeping, inordinately long investigations of questionable quality - some with inconsistent or inexplicable outcomes, and a noticeable lack of transparency throughout the process. Whilst the creation of the ER team and the introduction of a new case management software are welcome changes, these need to be built upon to drive change, and in order to place the ER Team at the centre of a credible, reliable and trusted ER case management process. This is, in my view, a key priority for the Trust.

There are some significant cases which are worthy of review and it would be appropriate to evaluate the handling of some cases containing specific features or allegations, or a random sample from the last three years. This should include disciplinary cases and may include cases resulting in ETs, if this has not already been done. The review should seek to identify, amongst other things, appropriate use of policy and procedure, identify if early intervention opportunities were missed, if the investigation standards were met and resultant outcomes were appropriate.

There is a clear deficit of available skilled workplace investigators, the demand for which will depend on the investigation model Trust choses to use. This model needs to be determined quickly and a training regime implemented to provide quality investigation training.



The ER suite of policies lack synergy, are too lengthy, too complex and in need of overhaul to streamline processes, bring them up to date and make them more user friendly. Such a process will inevitably involve the introduction of either new policies or procedures.

## Recommendations

5. The Trust builds upon the recent changes to the ER Team to enhance its recording, case management, investigative and the decision-making capacity including:
    a. Mandating the timing and format of the reporting and recording of all ER issues;
    b. Augment of the ER Manager role in relation to decisions to investigate and decisions to enter formal proceedings;
    c. Providing suitable level of investigative capability and capacity; and
    d. Develop relevant case management KPIs to inform the Trust and Team Performance Indicators (TPI's) to inform the team.

6. All or a significant sample of key cases from the last three years is reviewed to ensure that, given the nature of the allegation, the handling, investigation and outcomes are appropriate.

7. The Trust reviews the structure, training and use of workplace investigators to establish the Trusts' preferred model for managing workplace investigations

8. Relevant policies are reviewed and revised to ensure they are fit for the effective management of behavioural issues of all members of staff including:
    a. Introducing a structured management action/advice file note process;
    b. Introduce appropriate links to engage the MHPS procedures; and
    c. Publish all formal disciplinary hearing outcomes.

# Culture

## Findings

***"I have worked at this Trust for the past 18 years. Throughout this time, I have experienced quite a bit of rollercoaster rides but for the past 4-5 years I have encountered varying levels of unfavourable treatments that really challenged my outlook on the culture of the present working environment."***

***"I probably won't be here much longer, I had couple of interview invitations already, but I hope things can change at this Trust, so people here don't have be anxious about coming to their workplace"***

***" if you have a culture where people are living in fear you will never a have full staffing, better sickness or meet your financial targets"***

***"This place has just become unkind, people don't speak to each other nicely and much respect has gone.."***

***"There has been a culture, definitely over the last three years, from a lot of senior managers in the organisation, that has filtered down. You can see that, and it does go unchallenged"***

The above comments represent but a small proportion of the range of feelings and views provided by contributors during my inquiry, which included some harrowing views and thoughts including past considerations of self-harm. Even though some of the interviewees had received no personal instance of bullying, it was difficult to identify many people who did not think that bullying and harassment was prevalent in the Trust to the extent that it appeared part of the culture. In understanding the extent of the problem, it is pertinent to reflect on the recent history of the Trust and the impact this may have had on the current position.

### Context

The 2013 merger between the University Hospital Lewisham (UHL) and the Queen Elizabeth Hospital Woolwich (QEH) was always likely to be problematic. The QEH had previously been through a number of merger processes and was seen as a struggling trust and UHL was the opposite. The merger does not appear to have been welcomed by staff of either trust and, inevitably differences remain that appear not to have been resolved. This was always going to provide a significant organisational design and development challenge which, in development terms, would be ongoing for some time.



***"…Lewisham saw itself as high performing and didn't know how to fail, QE was extremely challenging and didn't know what good looked like"***

Many examples were given by staff from each site and, more importantly, staff who had worked on both sites as to the general differences between the two hospitals. However, one of the most telling observations relative to this inquiry arises from the 2017 CQC inspection when cultural differences were observed in particular;
***"…small number of health professionals were more aligned to one hospital …"***

***"A lack of cohesive working amongst consultant grades across various specialities could lend itself to missed opportunities in terms of developing centres of excellence"***

The evidence provided to me from some staff working on patient care and clinical outcome initiatives, approved across the Trust, have been subject to public belittling of their work and open criticism of other medical colleagues by some consultants. In one case this appears to have resulted in the potential collapse of the initiative due to the clinical staff delivering the project being belittled and bullied to the extent that they moved on or left. The below being a typical example:
***"I was in a meeting providing an update on the programme to doctors when DR xxxx came into the room, late, and immediate started commenting that what I was saying was "rubbish" it was embarrassing and hurtful"***

It is evident that the cultural differences across the Trust requires continued attention from an organisational development perspective. This issue will not be unique to the Trust and there are examples of mergers between trusts with similar difficulties and where cultural differences have been successfully overcome.

### Leadership and Management

***"Poor behaviour should not be tolerated from any member of staff, no matter what their position in the organisation and consistent, appropriate action should be taken. Staff felt that the Board and senior management should lead by example in this. This was the priority action for staff."***

The above excerpt from the report into the Values Refresh captures the essence of the matters at the heart of this inquiry. I take the view that most organisational issues start and end with the leadership, as this dictates the culture and management of the organisation. In this context I include the Board and those senior in operational and medical teams.

This inquiry was founded over concerns of poor behaviour at senior level, which, as it unfolded reveal some of most the disturbing examples of bullying at senior leadership level. What was equally concerning was an obvious lack of visible intervention or challenge.

**“..in my first week in role at the eight o’clock huddle I was shouted at in real anger, it was made *to feel very personal, all of the execs were there and nobody intervened..”***

***“… it wasn’t just one person at executive level or senior level, there were and remain a number of people who behave like this…”***

Many examples were given of members of the senior leadership team demonstrating a leadership style that at best was described as ‘menacing, threatening and heavy handed’. These behaviours were regarded as part of the day to day persona of the individuals concerned often excused as ***“Oh well that’s how they are”*** or ***“they are really, really stressed”*** seemingly legitimising the behaviour, which became an accepted part of life for those more junior.

Many contributors understood the need for accountability but felt that many meetings from corporate level down to ward level had become arena’s in which they were inappropriately challenged and castigated publicly. The picture painted was one of repeated poor behaviour which, in the worst cases, resulted in shouting at or putting down and belittling junior staff during meetings where other executives or senior managers were present. These were not one-off instances, and left many recipients’ shocked, extremely hurt and frequently visibly upset.

A clear feature of these episodes was the absence of any form of visible challenge or attempt to defuse the situation by any other member executive or senior leadership team. Such a lack of intervention was not just wholly unacceptable but set the foundation of a laissez faire norm, from which the perpetrator and observers could regard the behaviour as being acceptable. It is understood, and recognised elsewhere in this report, that challenging poor behaviour is naturally uncomfortable and sometimes takes courage, confidence and skill, particularly when the behaviour is so openly displayed. But when that intervention is expected of junior managers it is expected that it is demonstrated by those more senior. The below sentiment was expressed to me not just frequently but in the majority of interviews throughout the inquiry;
***“Everybody knew about it, colleagues and XXX. Why wasn’t it tackle at that point?. Was it because tacitly it was acceptable and tolerate? Therefore, the organisation is saying that its ok even if we don’t like it, so what does that say?”***

There was a clear expectation amongst the contributors, whether they were targets or observers to such behaviour, that interventions would and should be made by other executive or senior team members, particularly the senior leaders of the executive. The strength of feeling regarding the lack of challenge or visible support has done much to shape the views of many contributors, including middle to senior managers, as to the collective and individual commitment of the executive to the Trust values or to effect any real change.



As some members of staff see that senior staff can bully people and not be held to account, they feel able to bully others in turn, without fear of adverse consequences, or feel that this is the best way to achieve results, and the problem soon becomes embedded.

Inevitably this behaviour, publicly displayed and unchallenged set a tone which became adopted by more junior staff exposed to it. I have received many examples and accounts which highlight this ‘learned behaviour’ has percolated across and through the strata of managers, particularly within the general manager occupational group, and has brought with it much concern, anxiety and distress for many junior managerial and non-managerial staff. These accounts are supported by the exit interview feedback and staff survey analysis.

The development of a culture which believes that to fit in, avoid criticism or ‘get on’ managers had to behave in a way that mirrored that of their more senior colleagues, was in my view evident in the accounts provided to me. This made for a very toxic, corrosive and fearful environment where blame featured more than support and understanding. Such is the level of concern regarding the behaviour of some managers that the impending structural changes to the divisions was causing real anxiety amongst some staff as to who will be managing them. I must highlight this is not inferring that all managers in the general management group behave this way, far from it most do not, however there is a corpus whose behaviour is unacceptable and must be tackled.
***“..some people are destroying their teams and people, not necessarily their direct reports. They are seen as successful and are moved on or up where the resultant behaviour continues with further complaints and upset..”***

Contributors identified many examples of instances where concerns were raised about a range of bullying incidents, either with the senior members of the Executive Team or senior managers in Workforce and nothing was seen to be done, which merely reinforced the views that such behaviour was accepted. I acknowledge that there may well have been actions which contributors were not privy to but, if there was, appropriate feedback was missing. There was also clear evidence that the targets of much of this poor behaviour were reluctant to instigate formal, action on the basis of fear of retribution and the belief that nothing would be done. Those who did make a formal report frequently ran into the handling issues well documented earlier in this report.

The impacts of such behaviour were in keeping with that described in research and reports with many targets feeling abused, humiliated, angry and very anxious. The descriptions below are indicative of some of the many feelings described:
***“….I became so stressed that I was going home and taking it out on my family. What sort of mother does that?”***

***"the final straw was that I was physically sick on my way to work at the thought of going in and facing her.."***

***" I have said that I won't work for her again, I would rather leave the Trust"***

The moving of both 'perpetrators' and targets of bullying allegations arose reasonably frequently with in interviews. Accepting that the full circumstances were not always clear, there were some obvious cases of concern. Whether it is real or perceived there appears to be a practise of moving either party both before and after the investigation. Whilst policy describes this process there is a real danger, in my view, as it being perceived as a right by those making allegations. Furthermore, the effect of such a process on one or both of the parties may be significant especially if the rational for such a move is not clear, with one or either feeling further bullied as a result. In my experience this is a 'tactical option' in the management of only the most difficult and serious cases of B&H or disciplinary investigations. In many cases the movement becomes 'permanent' and this, coupled with a lack of transparency, is viewed as rewarding either party or avoiding taking appropriate action.

The moving of those involved, particularly perpetrators, is a feature of many difficult ER situations, including bullying and this is recognised in numerous studies and reports. This is particularly so for perpetrators who are senior and are moved rather than appropriately dealt with.
***"My view of this situation is there was a clear case in terms of bullying but there was not a risk appetite on behalf of the executive to actually deal with it and address it. This seems to be thematic"***

Unfortunately, it appears to me, that this way of resolving some situations is common and occasionally receiving support at the highest levels, including from bodies which have regulatory oversight. As one contributor observed:
***"the challenge is they move to another organisation where the bad behaviour is repeated.."***

What is equally concerning, and I was presented with some evidence to support this, is that some individuals move from Trust to Trust when they have antecedents of such behaviour, in many cases avoiding investigation or proceedings in the process.

### Medical and Clinical Staff

The instances of bullying mentioned above, and the attendant circumstances, are not confined to non-clinical managers. There are ample examples of overt poor behaviour from senior nursing managers and consultants and an equal lack of willingness to address poor behaviour. These include outbursts and 'temper tantrums' in theatre and the abrupt and public dismissal of the views of more junior clinical staff even though they have expertise in



the field. Even to a lay person, many of these accounts seem reflect incidents that jeopardise patient safety in a way, which if correct, may amount to professional misconduct.
***"In 30 years of nursing I have never been in an organisation where medicine has so little respect for nursing as a profession, resulting in nursing being intimidated by the profession of medicine."***

***"I have witnessed Consultants regular shouting and swearing at staff and they have been getting away with it for years"***

***"I have dealt with many bullying allegations, it's just frustrating that I don't get support when tackling the medical side around their conduct towards nurses"***

***"after one incident the nurses raised the issue with xxxx stating 'we want something done, we shouldn't be shouted at in theatre or have instruments thrown around or made to feel like this'….. nothing was done"***

That is not to say that when firm reports of poor behaviour are formally made, they are not investigated where appropriate. But it is fair to say that I was given examples where concerns were raised, and this did not happen and the same fears about repercussions or lack of action exists insofar as consultants are concerned.

In those areas where contributors reported bullying as prevalent, a number of other adverse indicators are evident such as complaints, turnover and vacancies. As a consequence, problematic wards and departments can be readily identified. Similarly, examples were given of areas of good practice which warrant examination on that basis. It was disappointing to be given some accounts of individual manager having the courage and ability to turn around a problematic team, only to receive little or no recognition but then being subject to bullying behaviour as a consequence. This was one of a few examples offered by interviewees, which were consistent in highlighting those clinical and operational teams which were considered 'good', unfortunately there was little evidence put for as 'good' in so far as any identified or related practice. Most of the 'good' was felt to be bound to the quality of the team managers.

Despite some of these wards and teams being known to senior managers, and in some cases being tackled, there remain some areas where bullying and the related performance issues continue to exist, and key protagonists remain unchallenged.

### Wider bullying

***"… I have seen bullying by managers, bullying by peers and bully by staff against managers…"***

I need to emphasise that the bullying I have found is not just the obvious, overt incivility and disrespect behaviours from leadership roles. Like most other studies, there is an undercurrent of more subtle behaviours that abound, as the contributors below indicate:
***"I'm sure the supervisor's hypercritical attitude of people not included in the clique and general unfriendly environment is the reason for the high number of new staff leaving but also I don't know what do about it. If I go to the manager and say "they're not talking to me" I would feel like a five-year-old. Also, I have experienced this in another workplace on a smaller scale and not until all the "old-timers" had left or retired, did it become a lovely place to work."***

***".. when I returned to work I sought more flexible hours, but this was refused even though somebody else had been granted similar."***

***"…was refused compassionate leave and had to take annual leave when a relative was dying.."***

***".. you were either in the gang or left out of conversations, not invited to things or not told things.."***

There were accounts of related cliques, cronyism, favouritism and, in some case, nepotistic behaviour some of which resulted in promotions, jobs being obtained, or not as the case maybe, and a general feeling of unfairness. These accounts tended to arise in many of the same operational area as the more overt bullying but are more widespread.

Many contributors raised the use of email as a medium used for a variety of bullying behaviours.
***"A lot of the problem was around the tone of the emails and how that was perceived…"***

***" in the email what I had done was described as "shit" and this was sent to all. I didn't even get an apology afterwards"***

From direct incivility and rudeness, through threats and demands to the more subtle unreasonable manager behaviours of constant requiring updates, demands as to timescales and exclusion from circulation. This was considered a significant problem for many, particularly in high pressure scenarios with managers who were equally under pressure.

These behaviours are not confined to managers. Evidence of bullying in peer groups was also common but, again, was more prevalent where it had been allowed to flourish. Indeed, examples of junior staff practising incivility and unreasonable behaviours on more senior staff were capture in this example:



***"..an new band seven nurse started from another hospital. Soon the other nurses started a petition to raise a grievance against her because she was good and trying to change things. She ended up going back to her old job in another Trust"***

It is also important to distinguish between bullying behaviour and reasonable management responses to actual or perceived misconduct or to poor performance. A few contributors described instances when managers who had taken appropriate steps to manage conduct or performance issues found themselves on the receiving end of a grievance accusing them of bullying. Not only did this bring an end to the management activity but caused a great deal of stress to the managers accused resulting in sickness absence and eventual movement to other roles.
***" I came here to do a job, I was asked to help with a difficult team, as a result I am now I am in a job I didn't want and have no choice but to leave the Trust"***

Whilst I came across examples of bullying and harassment that clearly had an element of race involved, the majority of contributors who had been subject to bullying stated that the primary reason for being targeted for such behaviour was not because of a personal characteristic, but because of the disposition of the other party or the prevailing culture in their workplace.

Where bullying problems arise as an emerging problem for an organisation, there is a reasonable expectation that the leadership acknowledge this, and develop a strategy for scoping, analysis and tackling the issue. The staff survey and allied data sets point to a problem that has existed for a number of years and, in staff survey terms, has been getting worse. Couple this with staff accounts and, what appears to be, a growing number of issues raised at senior level, the need for such a strategy seems clear. Where such a strategy is not visible, this adds to the view that the leadership do not recognise B&H as a problem, nor do they wish to tackle it. The recently produced Workforce Strategy, which I address later in this report, appears overdue in this regard.

Blogs, staff meetings and Board discussions have been suggested as evidencing the awareness and previous activity of the Board in relation to B&H issues. Whilst I have no doubt that B&H issues were recognised and discussed, including collective and individual acknowledgements that such behaviour is not acceptable, these activities appear unsupported by meaningful visible action that has impact. Worse, in my view, that such acknowledgements become meaningless if overt bullying is allowed to happen in the way that it has been evidenced in this report. As the below observations indicate:
***" The Trust says that there is zero tolerance on bullying but they don't mean it…" and***

***" they say one thing then do the other"***

In the absence of proper problem identification, a clear plan to deal with it and a process of accountability, I take the view that it is reasonable that both the staff and an independent observer deduce that the Board has lacked a willingness to recognise and tackle such behaviour.

The views of most staff I met reflect the observations within the Refreshing Values report. Far from a fatalistic or overly cynical view of the future, there was a great deal of positivity that things at the Trust would change for the better. I received many comments highlighting the apparent commitment of the newer members of the Board to making enduring change and were optimistic that action will follow.

## Conclusions

5 years on from merger, there remain cultural differences between the Greenwich and Lewisham sites which not only affect the quality of service provided to patients but directly impacts on issues of bullying of the staff.

Whilst I would not describe bullying in the Trust as institutionalised, it is however widespread in that it is evident across all sites, in all divisions, at all levels and perpetrated by managerial, non-managerial and clinical staff. To this extent it is embedded in the culture of the organisation.

The prevalence of overt bullying both witnessed and reported, particularly at the most senior levels, coupled not only with lack of visible action to address it, but a *laissez faire* attitude which appears to condone it, can be interpreted as a lack of willingness to recognise and tackle bullying behaviour.

This apparent inaction has damaged the reputation and credibility of the executive, as it existed at that time, both at a collective and, in some cases, individual level. This reputational harm, particularly as it appertains tackling bullying and harassment, may well have been irreparable in the absence of changes to the Board that have occurred.

Key to addressing B&H is top level leadership. Although there have been a number of recent changes at Board level, there remain questions over their commitment to change, a position influenced by the recent past. Additionally, senior clinicians and general managers below the executive must recognise their role in an organisational culture that has left many staff feeling unhappy, anxious and unsupported. Whilst a new CEO has recently been appointed, it is critical that he now develops the senior leadership team in a way that gives confidence to the wider workforce that change will be affected.



Accepting that the Workforce Strategy has recently been produced, initiatives to tackle bullying and harassment has been undermined by a lack of a clear strategy supported by proper analysis, interventions and monitoring. The importance of such an overt, well informed, realistic and measurable statement of intent cannot be overstated as the first sign of a programme to tackle bullying and this needs to be built upon.

There are, within the Trust, teams and individuals whose behaviour and performance remain a concern. It is a relatively straightforward exercise to conduct a level of analysis with the current data sets, and apply a forensic and justifiable approach to identifying and tackling these problems. Identifying members of staff who have attracted repeated complaints to understand why and make appropriate interventions is an obvious step to take. However, there is also a need to understand the concerns of those who have felt it necessary to make repeated complaints and provide any necessary support. This issue should be addressed as a matter of priority.

## Recommendations

9. The past failures of the senior team are publicly acknowledged, and the CEO now develops the senior leadership team in a way that gives confidence to the workforce that change will be affected, and that the team understand the expectations of staff in this regard.

10. A strategy is devised to identify and appropriately tackle those staff subject of or making repeated complaints and this is acted upon as a matter of priority.

11. A strategy is devised to identify those teams where behaviour or performance presents as problematic with a view to making appropriate interventions to address the issues.

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## Accountability and Governance

### Findings

#### Trust Values and Bullying & Harassment

***" …..the problem with the values, bullying and harassment and the different codes of conduct is how do you know what is in operation and where do you find them?.."***

As detailed earlier in the report, much commentary has been expressed about the need to reinforce the standards of behaviour expected in the Trust, building on the recent exercise to refresh the Trust Values. That process involved a significant level of staff involvement in shaping what they felt staff should commit to. The values arrived at were:

- We treat everyone with respect and compassion;
- We work as a team to improve quality;
- We take responsibility for our actions;
- We work together for patients and colleagues; and
- We learn, develop and share knowledge

The report makes it clear that the behaviours causing staff most concern and deemed unacceptable were those expressed in the 21 negative behaviours which constitute B&H. There was also a clear desire to ensure all staff, irrelevant of role, actively demonstrate positive behaviour that reflects the Trust values and should be held accountable when they do not.

As detailed earlier in the report, this remains a serious issue for staff which demands positive and effective action, and which is not negotiable. All too frequently contributors observed that in relation to its values, particularly those appertaining to behaviour and B&H that ***'it says one thing and does another'***. There was a significant level of frustration and much resignation that little is ever challenged or dealt with.

***"The new values are great, but we need to see evidence from the top down that people are living and breathing them. We can't expect a HCA who works nights on the wards to give a stuff about the values unless they see the Matrons, Doctors, Finance Director, Head of Workforce and the CEO living them.."***

***"..behavioural standards and values need to be role modelled by all staff particularly those in leadership roles.."***

The above observations are some examples of a strong contributor view which captures the essence if the issue; if progress is to be made then all staff need to be held to account for their behaviour. The question is how is this best achieved? I am strongly of the view that this



be approached on a policy, personal and organisational level in a way which can be measured and has proper oversight and governance commensurate with its strategic importance.

#### Policy

There is a real mandate and basis for enshrining the Trust values in a policy statement and linking them to the 21 negative behaviours of B&H and the relevant elements of the various professional codes of practice and the NHS Constitution. Such a 'Behavioural Standards' or Framework policy would make clear the behaviours expected of all staff and the procedure that would be adopted if they are not met. It would allow for such standards and expectations to be held in one place and provide an opportunity to slim down the discipline and B&H policies and provide for a common procedure for all staff.

There is, in my view, nothing in this approach that conflicts with the expectations of Maintaining High Professional Standards (MHPS). It is more a case of how, in clear terms, poor behaviour of medical staff is dealt with, in common with all other staff, before the MHPS process is engaged. There are examples from other trust as to how this works, and this could be spelt out in policy and procedure in this Trust. I am not making any observation as to the workings of the MHPS process as there is nothing to indicate that it is not working as it should. The issue is, as pointed out above, being clear as to when MHPS is engaged, preferable on the same basis as a potential disciplinary process for any other member of staff, if the poor behaviour is found to warrant it.

Whilst I acknowledge this may have a few challenges and would require development in consultation with professional bodies and staff, it would be a simplified expression of what behaviour expected and what is not and in which the Trust values are intrinsic. This approach received almost unanimous support when tested at workshop.

#### PDRs

***"….. I question the value of the PDRs, we seem more interested in completion rates than the content and as a consequence it becomes a tick box exercise…."***

***"..trying to get them done is sometimes difficult. With no protected time they become rushed and the quality goes down.."***

It is understood that the Performance and Development Review (PDR) system is itself going through transition from a paper to electronic process (Online Appraisal system), however, the above views represent the groundswell of feeling about the PDR process. Clearly, as the process was transitioning many observations were made on the basis of the paper system. That said, the below comments reflect the cultural hurdles that the roll out will face:
***"The new system is complicated with no time to really learn it"***

***"It get 'pinged' back and forward, removing face to face contact and making the process complicated. I won't use it anymore I've gone back to paper"***

Having examined documentation, I could not ascertain how the objectives were entered into the e-system and I have to say it did appear complex. Whilst not directly related to my inquiry, I make the observation that the PDRs should include a section clearly dedicated to staff development in which realistic development issues were articulated and commented on. It appears that this can happen in the e system, but clarity is important especially in relation to promotion or preparedness for other roles. This issue has a direct bearing on the WRES data regarding the success of BME staff in job/promotion processes.

Whilst the PDR had objectives and values, it was felt that the Trust values and behaviours should be made explicit and not just scored but subjected to an evidence-based entry to articulated how the appraisee has demonstrated them. Observations suggest that PDRs were an appropriate and powerful tool for holding all staff to account for their performance, but they were not used well.

The view that managers at all levels should be held to account for the performance of their teams in relation to the ER KPIs identified below and this should be contained with the PDR, was strongly supported in both interviews and workshops.

The fact is, despite staff surveys indicating it was valued by staff, it is considered a tick box exercise driven by a completion KPI rather than the quality of the content. There was much other feedback and observations around protected time, it not a replacement for face to face meetings, and the PDR being a positive focus for staff development and not system driven.

Again the 'top down' theme of leadership commitment was evident in much of the feedback and questions raised as to how this would work for clinicians and medical staff. Whilst the medical staff do have a separate appraisal system directed on a national basis, again I see no conflict between Trust values and the equivalent elements of this process and I would advocate this is examined so as to make the expectation as to what is being assessed very clear. The use of 360 appraisal, as use by medical staff, was felt worthy of introduction for all managers and I note the ambition for this in the Workforce Strategy. However, for these to work well the contributors to the appraisal should contain a substantial proportion of direct reports and staff who have daily contact with the appraisee and not just staff nominated by them.

Whilst the use of the PDR as an appropriate tool to ensure accountability it has a number of significant hurdles to overcome, some real and some perspective driven, to ensure it is a fully functioning and well used system and those responsible in Workforce will need to address this. However, this should not prevent steps being taken to use amend its use accordingly.



### KPIs

Current arrangements do not provide for any real key performance indicators around B&H issues, or arguable pertinent related issues such as complaints. The need for the Board, managers and all staff to understand Trust, division and team performance is an absolute requirement if poor behaviour or performance is to be identified with an expectation that it is acted on. Furthermore, these indicators are not just about identifying poor but understanding where it is good, understanding why it is so and recognising the efforts of all staff in making it that way.

These indicators are common place in many other organisations, particularly outside of the NHS and, at the highest level, for open comparison between organisations. The need for KPIs that are relevant and published as a suite or balanced score card as a method of accountability at Trust, Division and Team level was given considerable support by contributors and workshops.

### Workforce Strategy

A Workforce Strategy is critical to delivering a number of key strategic workforce objectives which are at the very heart of the Trusts performance, service delivery and ambition to improve. This is true of any business whose operational delivery relies heavily on people, especially if the service is complex and requires a variety of skills. In my experience such strategies, aligning Workforce activity in clear support of operational strategy and need, have existed in other public sector organisations for a number of years, in some cases well over a decade. The very recent production of such a strategy in the Trust is therefore to be applauded as it clearly focusses on a number of issues related to B&H either directly or indirectly.

Unsurprising, as it has been produced during the time of this inquiry, many of the goals and initial actions it contains reflect the findings and likely recommendations that were emerging from the inquiry. It will however require amending to take account of the full findings and recommendations contained in this report and this fact is acknowledged in the document. On that basis, I will make a few observations as to the content of it. These should be seen for what they are; the views of an independent observer and not a denigration of the document or any contributor.

Whilst it is right that the document contains targets and that those targets 'stretch' the Trust, I would suggest that some are overly ambitious for the timescales set or are not focused on measuring the right activity or indices. For example;
***The goal to reduce the number of staff reporting experiences of bullying and harassment by other staff will reduce year on year, and by at least half by April 2021 (29% in 2017)***

Whilst striving for a year on year reduction is appropriate and achievable, to suggest a halving by April 2021 is, in my view, unrealistic. In effect this means that by time of the staff survey in two years' the Trust will not only better the existing average (24%) and the best performing similar Trust (20%) but aims to achieve 14.5%, a score that is in the domain of the best Community Trusts. The goal should reflect the *'percentage of staff'* as opposed to '*number of staff'* as the Trust is seeking to drive up survey completion rates so the actual numbers will increase.

It is not appropriate for this report to critique the content of the strategy document particularly, as mentioned above, it will need revision. That said, in general terms there should be acknowledgement that the some of the goals mean tackling culture, which will take time and there is a degree of work that needs to be undertaken to understand some of the problems and set baselines from which to measure progress. These are imperatives for setting realistic targets and workstreams with appropriate timescales for delivery.

### Role of Workforce and Education (WED)

It is important that the WED function is confident, well informed and well equipped to deal with the workforce challenges faced by the Trust, particularly as they appertain to ER matters including B&H. Whilst recognising the commitment, professionalism and personal values held by the WED staff, and that they are not responsible for the poor behaviour of others in the organisation, the negative views of many I have interviewed or spoken with cannot be ignored.

The Workforce and Education Department is regarded as the creator and guardian of the policies, overseer of the accompanying procedures and 'flag bearer' for the principles underpinning those policies. The wider staff have a right to expect those responsibilities will be applied fairly, impartially and, where it is obvious that processes or the principles are not being adhered to, that there is appropriate challenge and intervention. Unfortunately, in too many instances this has not been the case and the image of the department in this area has, in the eyes of many, been damaged.

In pursuing the Workforce strategy, it is critical, in my view, the talent and commitment of those in WED is harnessed in pursuit of the strategic objectives. Not only understanding how they contribute to success, both individually and as a team, but recognising that how they do so is equally important in the eyes of the rest of the Trust. There must be emphasis on meeting the expectations of staff, re-establishing trust and restoring confidence given the critical role of WED in tackling many issues including B&H.

### Role of TME, WEC and Board

The role of senior management, committees and board groups are relatively clear in relation to most governance scenarios. In this particular instance much of the responsibilities are



about attitude, the need to demonstrate positive behaviour and the Trust values. I believe this is well understood given that it has been subject of so much staff feedback in the Values Refresh.

If progress is to be made in relation to B&H issues, however, the somewhat unpalatable findings of this report should be accepted and the relevant required actions, including some that may be uncomfortable, need to be supported. Any KPIs that are developed need to remain in the 'eye line' and a regime of robust accountability should endure, this responsibility should rest with an identified non – executive director and the Board.

I have no doubt that the CEO and Chair of the Board will champion this process, but members of the Board and executive should be in no doubt as to the expectations of staff that they unify in support of the drive to tackle bullying and harassment.

## Conclusions

There is no real referencing between the Trust values, B&H behaviours and the professional codes of conduct. The positive reverse of B&H behaviours have much in common with the values of the Trust and those behavioural expectations of the various professional codes and NHS Constitution. However, these expectations are contained in disparate areas and not linked in a common format. There is a real benefit to concentrating the behaviours expected to be demonstrated and those that are not into one accessible and recognised behavioural document.

The use of PDRs as a powerful and appropriate tool for holding individuals to account in relation to values and behaviour is readily accepted by many staff. It is acknowledged that the PDR process is transitioning from paper to an electronic system, none the less the process is regarded by many staff as ineffective and a 'tick box' exercise. Whilst the new system may facilitate assessment of behaviour, demonstrating Trust values and a more structured approach to personal development there is still some work required to embed this.

Whilst there exists a variety of workforce related performance indicators, these in the main, reflect organisational performance around issues such as turnover, vacancies and sickness. The results of the staff survey are also circulated with a suitable level of drill down. However, a more holistic suite of KPIs relation to key ER issues is absent. The lack of a published 'balanced score card' deprives the Trust of a tool to hold managers to account. Moreover, managers are unable to determine performance and therefore what needs to be addressed and staff will not have the opportunity to understand and discuss solutions.

Whilst detailed commentary is made above about the role of Workforce and Education it is right and proper that the conclusions reflect the vital role they will play in tackling B&H and

the responsibilities placed upon them, in particular their senior leadership, in this regard. The expectations of the wider staff have been expressed and in pursuing the new Workforce strategy there must be emphasis on meeting the expectations of staff and restoring confidence in the policy, procedures and system designed to tackle many ER issues including B&H.

## Recommendations

12. That a Behavioural Standards Policy or Framework is created which clarifies the expected standards of behaviour and is drawn from the Trust values, professional codes of conduct and bullying and harassment negative behaviours.

13. The content, use and training of PDRs is reviewed to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus and a positive emphasis on individual development needs.

14. An appropriate KPI regime is introduced which recognises the key indices upon which to measure B&H performance and hold managers to account at a Trust, Divisional and Team level.



# Training and Education

## Findings

### Bullying and Harassment Training

***"I am not aware of what is available. It has not been rolled out as a programme, if it was we would not be here now.."***

Whilst this view opined by a long serving member of the Trust may be very singular, during my investigation, and reflected throughout this report, there has been a consistent theme relating to the availability of appropriate bullying and harassment training. Contributors reflected many different experiences of receiving training, its content and value. Whatever the sentiments expressed, what cannot be disputed is that the mandatory training figures show a clear focus on Equality, Diversity and Inclusion over B&H both in relation to those expected to undertake it, all staff for EDI as opposed to just managers for B&H. And the completion rates, which reflect 81% and 71% accordingly. This situation seemed to be reproduced in the quality and impact of the relevant training and education.

Many contributors observed that training such as Conflict Resolution and Unconscious Bias were well received, with appropriate content and delivered in a facilitative style. But it was observed that such training did not seem to have the feel of a 'suite' of core skills training that supported managers. Conflict resolution was aimed at dealing with issues arising with patients, carers and families as opposed to other staff.

***"The Trust's position is made quite clear, whether all of the staff understand it is the challenge.."***

***"Staff are being bullied but they see it as the norm or do not understand that what is happening is bullying."***

***"In terms of bullying and harassment training, I think that needs to be revamped and not sugar coated"***

These are but some of the views of interview and workshop contributors who were almost unanimous in their view that the existing training does not deliver in two keys areas; Firstly, by raising the awareness of all staff as to what behaviour constitutes bullying and what does not; Secondly, that managers need more than an understanding of policy and procedure, but an experiential or situational understanding of how to deal with these issues.

The issue of educating all staff as to what constitutes bullying and harassment, or in due course, the behavioural standards is considered a foundation to improving behaviour within

the Trust. it is key for staff to understand the boundaries of their own behaviour and the importance of speaking out when they encounter such experiences, either as recipients or as witnesses. Those contributing at workshop also felt it important that all staff should understand how to give and receive feedback if speaking out or challenging was not to be perceived as a personal attack.

I have used the term 'education' as it was clear that this is what is required as opposed to training. More specifically I am firmly of the view that such education should be delivered in a way that is easily digested and contains clear examples of unacceptable behaviour. It should highlight the right of managers to challenge poor behaviour and performance in an appropriate way, but also a clear message that it is right to challenge such poor behaviour and resolve any issues with adult to adult discussion. Education should provide confirmation on seeking advice, support and how to formally report it if necessary.

A range of tools for promoting this understanding were considered at workshops and it was felt that the intranet, posters and short animated videos, were considered ideal mediums. This issue was considered to be a priority.

The need to bring situational or experiential training into managers training was considered fundamental to providing confidence to manage these situations, as it allowed the grey areas of the negative behaviours to be discussed and exampled. Accordingly, it will heighten awareness of negative behaviours and poor leadership/management behaviours that lead to perceptions of B&H and enable leaders/managers to challenge their own and each other's behaviours, as well as of those they manage. This will require a culture of openness and sharing, and a willingness to speak out without fear of retribution and reprisal.

There was also a view from contributors that this training could readily be linked to or be part of training around managing difficult conversation. Any B&H or Behavioural Standards training for managers should be mandatory for all staff with a people management or leadership role. I emphasise leadership here as I consider medical staff to fall into this category, albeit some may not have direct people management responsibilities. As mentioned earlier in the report medical staff, particularly consultants, wield significant power and influence and with that comes leadership responsibilities the setting of proper example.

### Managing Difficult Conversations

***"…. The problem is too many of our bands six and 7's really don't know how to have difficult conversations, to 'nip things in the bud' or tackle poor performance, and so things carry on unchallenged."***



In common with many other similar inquiries and reports into B&H, there was overwhelming evidence provided that many managers, particularly those new to people management role, lack the skills and confidence to tackle a range of difficult conversations, people or situations.

Many contributors, including senior managers, identified that they had never had any such training and that most of their junior managers would benefit from this training. Many identified the lack of this skill being a reason for a seemingly *laissez- faire* approach to dealing with low level issues or why some attempts to do so escalated into conflict and grievance.

I consider this a fundamental and core management skill, vital at foundation management level or when stepping into such a role for the first time. This is not just an issue of managing B&H behaviours, but is an essential skill for dealing with poor performance / capability, poor behaviour, and sick absence. It is not just about addressing such instances but managing difficult people or situations. Even the proper completion of the PDR process can be uncomfortable process for managers and a point of conflict.

Training on managing difficult conversations should be a mandatory part of manager training for new to role or new to Trust managers. Ideally it should be mandated for all managers, but I recognise the costs and logistic involved. It is strongly felt that a programme to cover all foundation and 2nd tier managers should commence as soon as possible, and consideration should be given to making the training available to those staff who genuinely aspire to leadership and are close to taking that step.

### Investigator Training

The need for investigator training has been articulated earlier in this report, however there is a need for clear understanding of what I have found to exist and what is needed. The view occasionally expressed that "investigation is simply gathering the facts and presenting them" is misplaced and fails to recognise the skills required, principles that govern good investigations and the consequences of getting it wrong.

Basic investigation and case handling skills form part of the core skills of every manager and as such this training should be an intrinsic part of foundation management training for managing ER issues. This view was strongly expressed by workshop contributors.

Of greater importance is the enhanced training that should be given to those staff who, as part of their role as a manager or as a 'cadre of selected volunteers', will be expected to conduct investigations on a regular basis. Whilst the training currently delivered takes attendees through the workplace investigative process and does deal with some problematic challenges they may face, it places greater emphasis on the process that the investigative skills or techniques required or principles which guide the process.

***"I have been trained but it was some time ago. Whilst I went through the process I not sure I was taught too much about how to really investigate.."***

Discussions with contributors revealed a lack of skill and understanding of such things as; the setting of terms of reference, investigation planning, documenting the inquiry, understanding proportionality, planning and conducting proper interviews and the delivery of a report able to withstand scrutiny and challenge. This is consistent with what I have found in other trusts and organisations who operate similar case management models. Enhanced or revised training will do much to improve the skills and confidence of investigators to conduct thorough, quality investigations in a timely fashion. In my view, this training is vital to improving case handling of all ER cases and its delivery can be done completed within a day.

In cases where the role of the investigator is more permanent or frequent, such as within the ER team, I take the view that this training should be more in-depth and expanded to provide and embed a greater understanding and skills set.

I earlier mentioned a 'cadre of selected volunteers'. This concept arose from a workshop where a view emerged that not all investigators need be managers especially if availability was an issue. Whilst historically managers have been selected, this has mainly been on the assumption that as part of their role they will be dealing with ER issues of their own staff or those within the division. However, there is no reason, in principle, why non-managerial staff could not be trained if they showed the aptitude and competence for the role. The main difficulty here, I suspect, would be extraction from core duties to facilitate an investigation, but the proposition may be worth considering as the message it would send would be quite powerful.

## Conclusions

Given the identified levels of B&H in the Trust, the apparent lack of understanding amongst staff and managers as to what does and does not constitute unacceptable behaviour, and the displays of poor behaviour identified at all levels, I am driven to the conclusion that current B&H training is not meeting staff needs both at a managerial and non-managerial level.

All staff, but particularly managers and consultants, need a heightened awareness of negative behaviours and poor leadership/management behaviours that lead to perceptions of B&H or are not in keeping with Trust values. This requires specific education to accustom themselves as to what bullying and ill-treatment is (and is not), what behaviours the Trust values and those it does not, and which foster a culture in which individuals can speak out without fear of retribution and reprisal.



B&H training for managers must include interactive sessions where they explore B&H behaviours, understand their role in them and the processes required to tackle them in early intervention.

There is substantial evidence that many managers, particularly those new to people management role, lack the skills and confidence to tackle a range of difficult conversations, people or situations which militates against early intervention in many ER issues particularly B&H.

Investigator training does not contain the emphasis on investigation skills and techniques needed to ensure that those charged with conducting inquiries have the tools and confidence to deliver timely, effective and quality investigations which will stand scrutiny.

All staff particularly managers should understand the value of undertaking such training and the strategic importance attached to it by the Trust. Given the pressures on staff time the Trust may wish to review what training in the 'mandatory' portfolio is truly mandatory and ensure that steps are taken to ensure completion, and where it is not, hold staff to account. This may best be achieved during the PDR process.

## Recommendations

15. An education programme should be put in place for all staff to heighten awareness of B&H negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how staff should respond when they are recipients of such behaviour.

16. Mandatory B&H training for managers should be reviewed and must include interactive sessions where they explore B&H behaviours, understand their role in them and the processes required to tackle them in early intervention.

17. All managers, particularly those in foundation management role or new to post should receive appropriate training for managers to provide the skills and confidence to challenge poor behaviour by managing difficult conversions or difficult people.

18. Training for investigators should be reviewed to ensure appropriate weight is being given to investigation skills and principles as well as process.

## Final Observations and Acknowledgements

Throughout this inquiry I have been struck by the professionalism, care and consideration of those who contributed and all of the staff I have met. It is evident that the Trust has committed, talented and caring people focussed on delivering the highest levels of patient care in quite challenging circumstances. Those present or former members of staff who came forward care very deeply that the Trust should be a well-regarded, happy, and compassionate workplace where its staff can give of their best to the communities it serves.

For many their sense of loyalty and commitment has been tested to breaking point by a culture, cascading from the top down, of performance driven patient care at the expense of the people delivering that care, in which bullying and harassment have been able to thrive and long been tolerated.

This is not to demonise the entire Trust, but to acknowledge evidences of unacceptable behaviour by some, whether non-managerial, managerial or medical staff, inflicts damage on everyone and potentially undermines the ability of the Trust to deliver the very best patient care.

Whilst much of this report, by its very nature, paints a dim picture and only uses a measured proportion of the volume of information and personal accounts provided, I do not believe that the problems are insurmountable. It is recognised that the inquiry looks back over the last few years during which time people and circumstance may have changed, however, there remain urgent problems that the Trust now needs to tackle.

Underpinning all the recommendations in this report is the need for broad cultural change and the need to restore the trust and confidence of the staff in the leadership, processes and systems through which poor behaviour is managed. Delivering such change will require a genuine and demonstrable commitment on the part of the Board and senior management teams across the Trust, including recognition that it will be difficult to build confidence that there will be fundamental change, particularly if some of those expected to be the levers of change are regarded as part of the change that is needed.

I would like to express my gratitude to everyone who has contributed to this inquiry. The overwhelming view was one of positivity and optimism, which was frequently linked to the recent arrival of some key executives. I was taken aback by the level of anticipation as to the conduct and findings of this inquiry and the expectations of action that may follow it. I hope they feel that this report does justice to their contributions, but I emphasise that this has been an inquiry into the nature and extent of the problems, not an investigation into any individual.



There is now a responsibility to act and I am confident that the new CEO will ensure a swift and appropriate response to this inquiry. The findings in this report and the recommendations made will, I hope, be of real assistance in that task. I recognise that some recommendations, and the actions required to make them effective, may challenge thinking around workforce policies and practices that have been shaped by years of NHS HR tradition or culture. Such is the scale of the bullying and harassment problem, both within the Trust and wider NHS, I believe the current situation presents an opportunity for the Trust to take a more enterprising, if not radical, approach to effect sustainable and long-term change.

Andrew MJ Gent
Director
Ashfold Consulting Limited

20th December 2018

## Summary of Recommendations

I recommend that:

### Levels

1. The mechanisms for reporting wrong doing are reviewed to produce clear and accessible reporting channels including:
    a. Clarification of the roles of the EDI network and Freedom to Speak Up Guardians;
    b. The introduction of an independent confidential reporting line; and
    c. An overhaul of the Whistleblowing Policy

2. The Trust considers the introduction of a network of Resolution Advisors.

3. The exit interview process is urgently reviewed, revised and re energised.

4. An Information Management Strategy is devised with a view to the collation, analysis and publication of key data sets to provide for a greater understanding of the issues and target interventions.

### Handling

5. The Trust builds upon the recent changes to the ER Team to enhance its recording, case management, investigative and the decision-making capacity including:
    a. Mandating the timing and format of the reporting and recording of all ER issues;
    b. Augment of the ER Manager role in relation to decisions to investigate and decisions to enter formal proceedings;
    c. Providing suitable level of investigative capability and capacity; and
    d. Develop relevant case management KPIs to inform the Trust and TPI's to inform the team

6. All or a significant sample of key cases from the last three years is reviewed to ensure that, given the nature of the allegation, the handling, investigation and outcomes are appropriate.

7. The Trust reviews the structure, training and use of workplace investigators to establish the Trusts' preferred model for managing workplace investigations.

8. Relevant policies are reviewed and revised to ensure they are fit for the effective management of behavioural issues of all members of staff including:
    a. Introducing a structured management action/advice file note process;
    b. Introduce appropriate links to engage the MHPS procedures; and
    c. Publish all formal disciplinary hearing outcomes



### Culture

9. The past failures of the senior team are publicly acknowledged, and the CEO builds a senior team that gives confidence to the workforce that positive change will occur and that the team understand the expectations of the staff in this regard.

10. A strategy is devised to identify and appropriately tackle those staff subject of or making repeated complaints and this is acted upon as a matter of priority.

11. A strategy is devised to identify those teams where behaviour or performance presents as problematic with a view to making appropriate interventions to address the issues.

### Accountability and Governance

12. That a Behavioural Standards Policy or Framework is created which clarifies the expected standards of behaviour and is drawn from the Trust values, professional codes of conduct and bullying and harassment negative behaviours.

13. The content, use and training of PDRs is reviewed to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus and a positive emphasis on individual development needs.

14. An appropriate KPI regime is introduced which recognises the key indices upon which to measure B&H performance and hold managers to account at a Trust, Divisional and Team level.

### Training and Education

15. An education programme should be put in place for all staff to heightened awareness of B&H negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how they should respond when they are recipients of such behaviour.

16. Mandatory B&H training for managers should be reviewed and must include interactive sessions where they explore B&H behaviours, understand their role in them and the processes required to tackle them in early intervention.

17. All managers, particularly those in foundation management role or new to post should receive appropriate training for managers to provide the skills and confidence to challenge poor behaviour by managing difficult conversions or difficult people.

18. Training for investigators should be reviewed to ensure appropriate weight is being given to investigation skills and principles as well as process.

# Bibliography and References

## Documents and Data

### Data

- Staff Survey 2017;
- Sickness Absence;
- Vacancy Rates;
- Temporary and Agency Staffing Levels;
- Exit Interviews Summaries;
- Complaints and PALs data;
- ER Case Data;
- BH and ED compliance Sept18;
- Workforce Indicators October 2018; and
- Student Dashboards QEH & UHL Q1

### Policies

- Attendance;
- Grievance;
- Disciplinary;
- Capability;
- Dignity at Work -Bullying and Harassment;
- Sickness absence;
- Speak Up – Whistleblowing;
- Maintaining High Professional Standards; and
- Lewisham and Greenwich MES Report August 2017

### Other documents

- Exit Interview Reports and Summaries;
- PDR content and the Online Appraisal manual;
- 2017 CQC Report;
- Visions and Values Refresh Report;
- Workforce Strategy (V2) November 2018;
- UHMB Behavioural Standards Framework;
- Code of conduct for NHS managers 2002;
- Various emails and documented submissions;
- Education and Development Brochure 2018-19---Version-3;
- Conduct in Meetings Poster; and
- Leadership capacity review report Part one – findings.



## References


Acas (2014), *Bullying and Harassment at Work: A Guide for Managers and Employers*.

Archibong, U., Daar, A. (2010). *The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings* University of Bradford

British Medical Association (2018) *Bullying and harassment: how to address it and create a supportive and inclusive culture -*

Cox, L. (2018) *The Bullying and Harassment of House Of Commons Staff: An Independent Inquiry Report*

Fevre, R., Lewis, D., Robinson, A. and Jones, T. (2011). *Insight into ill-treatment in the Workplace: patterns, causes and solutions*. Cardiff University

Francis, R. (2013), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (TSO).

Francis, R. (2015), *Freedom to Speak Up: An Independent Review into Creating an Open and Honest Reporting Culture in the NHS.*

Kline, R., Lewis,D. (2018) *The price of fear: estimating the financial cost of bullying and harassment to the NHS in England* Public Money & Management 2018 http://dx.doi.org/10.1080/09540962.2018.1535044

Lewis, D. (2017). *Bullying & Harassment at the South East Coast Ambulance NHS Foundation Trust: An Independent Report*

Lewis, D. (2018) *Workplace Culture at Whittington Health NHS Trust: An Independent Report*


## Bibliography


Baillien, E., De Cuyper, N. and De Witte, H. (2011), Job autonomy and workload as antecedents of workplace bullying. *Journal of Occupational and Organizational Psychology, 84*, 1, pp. 191–208.

Bowie, V. (2002). Defining violence at work: a new typology. Gill, M. Fisher, B. & Bowie, V.(eds.), *Violence at Work: Causes, Patterns and Prevention*, Willan publishing, Devon, UK, 1-20.

Einarsen, S., Aasland, M.S., and Skogstad, A. (2007). Destructive leadership behaviour: A definition and conceptual model. *The Leadership Quarterly*, 18(3): 207-216.

Fevre, R., Nichols, T, Prior, G. and Rutherford, I. (2009). *Fair Treatment at Work Report: Findings from the 2008 Survey*. Employment Relations Research Series, No. 103. London: Department for Business, Innovation and Skills.

Fevre, R., Robinson, A., Jones, T., and Lewis, D. (2010). Researching workplace bullying: the benefits of taking an integrated approach. *International Journal of Social Research Methodology*, 13(1):71-85.

Fevre, R., Lewis, D., Robinson, A., and Jones, T. (2012). *Trouble at Work*, London: Bloomsbury Academic Press

Health and Safety Executive (HSE). *HSE Management Standards Indicator Tool*. London: HSE.

Hoel, H. and Cooper, C. (2000). *Destructive Conflict and Bullying at Work*. Manchester School of Management, University of Manchester Institute of Science and Technology.

Hoel, H., Glasø, L., Hetland, J., Cooper, C.L., and Einarsen, S. (2010). Leadership Styles as Predictors of Self-reported and Observed Workplace Bullying, *British Journal of Management*, 21(2): 453-468.

Lewis, M.A. (2006). Nurse bullying: organisational considerations in the maintenance and perpetration of health care bullying cultures. *Journal of Nursing Management*, 14: 52-58.

Lewis, M.A. (2006). Nurse bullying: organisational considerations in the maintenance and perpetration of health care bullying cultures. *Journal of Nursing Management*, 14: 52-58.

Lewis, D., Megicks, P. and Jones, P. (2016). Bullying and harassment and work-related stressors: Evidence from British small and medium enterprises. *International Small Business Journal*. DOI 10.1177/0266242615624039

McCann, L., Granter, E., Hassard, J. and Hyde, P. (2015). "You Can't Do Both — Something Will Give": Limitations Of The Targets Culture In Managing UK Health Care Workforces. *Human Resource Management*, 54(5), pp773-791.

Quine, L. (2001). Workplace bullying in nurses. *Journal of Health Psychology*, 6: 73-84.

Quine, L. (2002). Workplace bullying in junior doctors: questionnaire survey, *British Medical Journal*, 324: 878-879.

Skogstad, A., Einarsen, S., Torsheim, T, Aasland, M.S. and Hetland, H. (2007). The Destructiveness of Laissez-Faire Leadership Behaviour. *Journal of Occupational Health Psychology*, 12, 80-92.

*Tackling Bullying and Harassment: London Ambulance Service*. NHS Employers, February 2017.



## Appendix A – Interview Guide

1. Explain my background, Neutral evaluation task and confidentiality
2. Name & Role?
3. Time in LGT?
4. Time in Role?
5. Previous experience?
6. B&H Training – what is available?
7. What has been trained?
8. B&H awareness by staff and managers?
9. Dealt with any B&H incidents?
10. Suffered B&H incidents?
11. Witnessed B&H incidents?
12. What are the main issues of B&H arising?
13. How do you think they are dealt with?
14. What B&H performance data do you receive.?
15. Areas of good practice?
16. Areas of poor practice?
17. PDRs how, quality, effect on Values/ Behaviour?
18. What is the Trusts message and how is it perceived?
19. What the does Trust do well?
20. What could be improved?
21. Overall view of how B&H is addressed in LGT
22. Anything else you wish to add or that my enquiry my find information or valuable?
23. Is there anybody you think I should interview inside or outside of the organisation?

Appendix B – Workshop Recommendations

## ACCOUNTABILITY AND GOVERNANCE

Ensure policies promote clear behavioural expectations and link B&H behaviour to Values and Codes of Conduct – Behavioural Standards Framework?

Review the content, use and training of PDRs to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus, and staff development needs.

Devise and introduce an appropriate KPI regime which recognises the key indices upon which to measure performance and hold managers to account at a Trust, Divisional and unit level

## LEVELS

To review reporting mechanisms to produce clear and accessible reporting channels in which the staff have confidence including:

- Revised or expanded questions in the staff survey (or Friends and Family) to include B&H negative behaviours
- Clarifying roles of EDI Network and Freedom to Speak Up Guardians
- An appropriate confidential reporting line (independent if necessary) including anonymous reporting
- Consider the introduction of Resolution Advisors (internal)

That an information management strategy is created to collate , analyse and publish key data sets to understand the issues and target interventions

- Data sets – WRES, Staff Survey, Exit interviews, ER Case Management, PALS, SI, Datix, Sickness etc (> 12)
- Analysis and publication Trust wide performance, 'Hots spots' identification and root cause analysis



## HANDLING

Build upon the recent changes to the ER Team :

- Improve reporting and recording of all ER issues
- Enhance ER Manager role in relation to decisions to investigate or enter formal proceedings
- Provide (short term) investigative capacity to ER Team
- Introduce reviewing process to ensure standards are met and ID learning

Review the structure, use and training of workplace investigators.

- 20-30 trained investigators (band-8)
- Create Investigation Continuum

Review and revise relevant policies to ensure they provide for the effective management of behavioural issues of all members of staff including:

- B & H is part of Trust Values which are embedded in a "Behavioural Standards" Policy or Framework
- Introduction of management action file notes
- Appropriate link with MHPS
- Publication of disciplinary hearing outcomes

## Training and Education

Review, revise and mandate training and education to:

- Raise the awareness of all staff as to what is unacceptable behaviour, how it should be challenged and managed
- Training for managers should focus on situational learning more than policy

Introduce or revise foundation or induction training for managers to provide the skills and confidence to have difficult conversations and challenge poor behaviour/ performance at an early stage

## Appendix C – BWBS 21 B&H Behaviours

| Question | Never | Rarely | Sometimes | Monthly | Daily |
|---|---|---|---|---|---|
| Someone continually checking up on you or your work when it is NOT necessary? | | | | | |
| Having your views and opinions ignored? | | | | | |
| Someone withholding information which affects your performance? | | | | | |
| Pressure from someone else to do work below your level of competence? | | | | | |
| Being given an unmanageable workload or impossible deadlines? | | | | | |
| Your employer not following proper procedures? | | | | | |
| Being treated unfairly compared to others in your workplace? | | | | | |
| Being humiliated or ridiculed in connection with your work? | | | | | |
| Gossip and rumours being spread about you or having allegations made against you? | | | | | |
| Being treated in a disrespectful or rude way? | | | | | |
| People excluding you from their group? | | | | | |
| Being shouted at or someone losing their temper with you? | | | | | |
| Intimidating behaviour from people at work? | | | | | |
| Feeling threatened in any way while at work? | | | | | |
| Pressure from someone else NOT to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses) | | | | | |
| Being insulted or having offensive remarks made about you | | | | | |
| Teasing, mocking, sarcasm or jokes which go too far | | | | | |
| Receiving actual physical violence at work | | | | | |
| Injury in some way as a result of violence or aggression at work | | | | | |
| Hints or signals from others that you should quit your job | | | | | |
| Persistent criticism of your work or performance which is unfair | | | | | |

As identified by Fevre, R., Lewis, D., Robinson, A. and Jones, T. (2011). *Insight into ill-treatment in the Workplace: patterns, causes and solutions*. Cardiff University



## GLOSSARY

**B&H** Bullying and Harassment
**BME** Black and Minority Ethnic
**BWBS** British Workplace Behaviour Survey
**CEO** Chief Executive Officer
**CQC** Care Quality Commission
**EDI** Equality and Diversity Inclusion
**ER** Employee Relations
**ET** Employment Tribunal
**HR** Human Resources
**KPI** Key performance Indicator
**MES** Medical Engagement Scale
**MHPS** Maintaining Higher Professional Standards
**PDR** Performance and Development Review
**TME** Trust Management Executive
**TPI** Team Performance Indicator
**WED** Workforce and Education Department

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| HEALTHIER COMMUNITIES SELECT COMMITTEE | | | |
|---|---|---|---|
| Title | Lambeth, Southwark & Lewisham Sexual and Reproductive Health Strategy 2019-2024 | | |
| Key Decision | No | | Item No. 6 |
| Ward | Borough Wide | | |
| Contributors | Danny Ruta – Director of Public Health | | |
| Class | Part 1 | Date: 16th January 2019 | |

## 1. Purpose

1.1 The purpose of this report is to provide members of the Healthier Communities Select Committee with the Lambeth, Southwark & Lewisham Sexual and Reproductive Health Strategy 2019-2024.

1.2 The strategy outlines the key sexual health challenges facing our boroughs and identifies four key priority areas for action: healthy and fulfilling relationships; good reproductive health across the life course; high quality and innovative STI testing and treatment; and living well with HIV.

## 2. Recommendations

Members of the Healthier Communities Select Committee are recommended to:

2.1 Note the content of the report.

## 3. Policy Context

Since the publication of LSL's most recent strategy (2014-17), there have been some significant changes in the sexual health landscape:

3.1 The financial climate for public services (and public health services in particular) is extremely challenging, and not predicted to improve in the near future.

3.2 New, sustainable ways of funding sexual health services have been adopted across London and other parts of England, which despite now meeting the exact costs of sexual health service provision, have represented a considerable reduction in income for many NHS trusts.

3.3 Demand for sexual health services remains high and is not expected to decline, and people across the country often struggle to access sexual and reproductive health services exactly when they want them.

3.4 Commissioners and services have had to innovate, and LSL provided proof of concept of STI self sampling via an online service, which has now been adopted across many parts of London to alleviate pressure on sexual health clinics.

3.5 The use of pre-exposure propylaxis (PrEP) has transformed HIV prevention and has likely contributed in part to a reduction in new diagnoses, particularly amongst MSM, and work is ongoing to establish how PrEP will form part of the publically-funded HIV prevention agenda nationally.

## 4. Background

4.1 Lambeth, Southwark and Lewisham (LSL) together face some of the greatest sexual health challenges in England. We have similarly young, mobile and diverse populations, and our local sexual health services are modern and popular. Our rates of HIV and STIs are the highest in England, and there are persistent inequalities in sexual and reproductive health, with young people, men who have sex with men (MSM), and Black and minority ethnic (BME) communities suffering the greatest burden.

4.2 Sexual health inequalities cannot be addressed in isolation; it must be done in partnership. Due to the similarities in the challenges we face, LSL collaborate on sexual health commissioning and strategy in order to maximise our efforts to meet the significant and ongoing needs of our populations. This strategy assesses the most up to date intelligence and sets out LSL's shared ambitions and priority areas in sexual and reproductive health over the next five years.

4.3 There have been considerable improvements in key outcomes since our last strategy was published in 2014, most notably a reduction in new diagnoses of HIV for the first time in the history of the disease in England, and a continued downward trajectory in rates of teenage conceptions. However, gains have not been made equally across our population. BME communities (and black communities in particular) remain at greater risk of poor sexual and reproductive health.

4.4 There is an extremely high rate of diagnosed HIV across LSL – it is the highest in England, and over 8,700 of our residents have been diagnosed with HIV. Just over three quarters of people living with a HIV in LSL are men, the majority of whom are white. Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed.

4.5 New HIV diagnosis rates are falling across in LSL, but too many people still receive a late diagnosis, and there are still people living with HIV that are unaware of their status. There remain significant inequalities in those diagnosed late in LSL; people aged 50-64 years, of black African ethnicity, those exposed through heterosexual contact, and women have the highest rates of late diagnosis. Furthermore, a disproportionate number of HIV cases locally are diagnosed in people living in the 40% most deprived areas.

4.6 Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20-24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at age 15-19. It is unclear what is driving this pattern, but it may be that young people lack the skills and confidence to negotiate safer sex. There is a general downward trend in new diagnoses of STIs in LSL, with the exception of gonorrhoea and syphilis (which most affect MSM). The increases in these STIs is concerning due to antimicrobial resistance and the severity of syphilis. Given the general burden of STIs in our populations, untreated STIs remain a concern in protecting the reproductive health of residents.

4.7 In terms of reproductive health, user-dependent contraceptive methods (e.g. condoms, or the pill) are the most common form of contraception used in LSL. This combined with challenging access to services translates to a high use of emergency contraception and abortion, indicating that reproductive health needs continue to be unmet, particularly amongst young, black women.

4.8 We know that a large part of improving sexual and reproductive health is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Abusive and coercive relationships affect people of all ages, genders, and sexualities, but some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities, and people identifying as LGBTQI+. MSM in particular may be at risk through chemsex, as maintaining control of behaviour and choices while under the influence of drugs may be difficult. However, few local data are available on indicators for safe and healthy sexual relationships.

## 5. Summary of the Lambeth, Southwark & Lewisham Sexual and Reproductive Health Strategy 2019-2024

5.1 Our vision for maximising sexual and reproductive health for all people in our boroughs focuses on four key priorities:

**Healthy and fulfilling sexual relationships**

- **VISION: People have healthy, safe and fulfilling sexual relationships**

**Good reproductive health across the life course**

- **VISION: People effectively manage their fertility and reproductive health, understand what impacts on it, and have knowledge of and access to contraceptives**

**High quality and innovative STI testing and treatment**

- **VISION: The local burden of STIs is reduced, in particular among those who are disproportionately affected**

**Living well with HIV**

- **VISION: We move towards achievement of 0-0-0: zero HIV-related stigma, zero HIV transmissions, and zero HIV-related deaths**

5.2 LSL will work collaboratively to deliver our vision, guided by a common set of principles:

| We will work in partnership, at a local, London and national level | We will commission high quality, effective and financially sustainable services, and capitalise on technological innovations | We will listen to service users' views and experiences and use these to improve what we do | We will focus on reducing inequalities in sexual and reproductive health | We will support the development of a resilient sexual health system |
|---|---|---|---|---|

**Prevention focused**

**Evidence based**

5.3 The strategy and supporting evidence review (see Appendix) describes the aims and objectives that will achieve the vision for each of the four priorities, how we will

work together to achieve them, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.

**6. Financial Implications**

6.1.

**7. Legal Implications**

7.1. Legal implications arising are set out in the draft Strategy, in particular Section 5: 'Commissioning responsibilities and local services'.

**8. Crime and Disorder Implications**

8.1 There are no specific crime and disorder implications arising from this report.

**9. Equalities Implications**

9.1 The Equality Act 2010 protects us all from discrimination or harassment as a result of a personal characteristic. Good sexual and reproductive health is not equally distributed in the population. Some groups are more at risk of poorer sexual and/or reproductive health based on a common characteristic, most notably young people, Black communities, and MSM.

9.2 While we will continue to commission welcoming, accessible and non-discriminatory services, to reduce inequalities in sexual and reproductive health we also need to commission services aligned with the concept of proportionate universalism. This means that whilst we will maintain open access sexual and reproductive health services for all, we also need to also target resources to those most at risk in order to reduce the burden of poor sexual health in our communities. This theme is threaded throughout this strategy.

**10. Environmental Implications**

10.1 There are no specific environmental implications arising from this report.

**11. Conclusion**

11.1 This strategy sets out the actions we will take in each of the above priority areas to continue improving sexual and reproductive health in our boroughs over the next five years. Each borough will have an annual action plan which will include specific steps to deliver this strategy. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed. Progress against this strategy will be overseen by the LSL Sexual Health Commissioning Board in addition to each borough's Health and Wellbeing Board.

# Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019-24

## Final draft

Lambeth, Southwark, and Lewisham
Public Health Departments

December 2018

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# Glossary

The following list provides a glossary of common terms used throughout this strategy.

| ART | Anti-retroviral therapy |
|---|---|
| BAME / BME | Black and minority ethnicities |
| BASHH | British Association for Sexual Health and HIV |
| CCG | Clinical Commissioning Group |
| Chemsex | Sex that occurs under the influence of drugs |
| CSE | Child sexual exploitation |
| EHC / EC | Emergency hormonal contraception |
| EJAF | Elton John AIDS Foundation |
| EMA | Early medical abortion |
| FTC | HIV Fast-Track Cities initiative |
| GHB/GBL | Gammahydroxybutrate / gammabutyrolactone |
| GP | General practice |
| HIV | Human immunodeficiency virus |
| HPV | Human papillomavirus |
| HSV | Herpes simplex virus |
| LARC | Long-acting reversible contraception |
| LGA | Local Government Association |
| LGV | Lymphogranuloma venereum |
| LGBTQI+ | Lesbian, gay, bisexual, transgender, queer/questioning, intersex, and others |
| LSL | Lambeth, Southwark, and Lewisham |
| MC | Molluscum contagiosum |
| MSM | Men who have sex with men |
| NHS | National Health Service |
| OC | Oral contraception |
| PEP(SE) | Post-exposure prophylaxis (for HIV) (after sexual exposure) |
| PHE | Public Health England |
| PLHIV | People living with HIV |
| PrEP | Pre-exposure prophylaxis (for HIV) |
| PSHE | Personal, social, health and economic education |
| Sexual health | Sexual health is used interchangeably with sexual and reproductive health |
| RSE | Relationships and sex education |
| SRH | Sexual and reproductive health |
| STI | Sexually transmitted infection |
| TasP | Treatment as prevention (for HIV) |
| TOP | Termination of pregnancy; abortion |
| UDM | User-dependent method (of contraception) |
| UK | United Kingdom |
| UNAIDS | Joint United Nations Programme on HIV and AIDS |
| U = U | Undetectable = untransmittable |
| Women | In this strategy, the term 'women' (in the context of the reproductive health of those that have sex with men) encompasses both cis women and other women with uteri (e.g. trans men) that have sex with men. |

# 1. Executive summary

Lambeth, Southwark and Lewisham (LSL) together face some of the greatest sexual health challenges in England. We have similarly young, mobile and diverse populations, and our local sexual health services are modern and popular. Our rates of HIV and STIs are the highest in England, and there are persistent inequalities in sexual and reproductive health, with young people, men who have sex with men (MSM), and Black and minority ethnic (BME) communities suffering the greatest burden. Sexual health inequalities cannot be addressed in isolation; it must be done in partnership. Due to the similarities in the challenges we face, LSL collaborate on sexual health commissioning and strategy in order to maximise our efforts to meet the significant and ongoing needs of our populations. This strategy assesses the most up to date intelligence and sets out LSL's shared ambitions and priority areas in sexual and reproductive health over the next five years.

Since the publication of LSL's most recent strategy (2014-17), there have been some significant changes in the sexual health landscape. The financial climate for public services (and public health services in particular) is extremely challenging, and not predicted to end in the near future. New, sustainable ways of funding sexual health services have been adopted across London and other parts of England, which despite now meeting the exact costs of sexual health service provision, have represented a considerable reduction in income for many NHS trusts. Demand for sexual health services remains high and is not expected to decline, and people across the country often struggle to access sexual and reproductive health services exactly when they want them. Commissioners and services have had to innovate, and LSL provided proof of concept of STI self sampling via an online service, which has now been adopted across many parts of London to alleviate pressure on sexual health clinics. Finally, the use of pre-exposure propylaxis (PrEP) has transformed HIV prevention and has likely contributed in part to a reduction in new diagnoses, particularly amongst MSM, and work is ongoing to establish how PrEP will form part of the publically-funded HIV prevention agenda nationally.

There have been considerable improvements in key outcomes since our last strategy was published in 2014, most notably a reduction in new diagnoses of HIV for the first time in the history of the disease in England, and a continued downward trajectory in rates of teenage conceptions. However, gains have not been made equally across our population. BME communities (and black communities in particular) remain at greater risk of poor sexual and reproductive health.

There is an extremely high rate of diagnosed HIV across LSL – it is the highest in England, and over 8,700 of our residents have been diagnosed with HIV. Just over three quarters of people living with a HIV in LSL are men, the majority of whom are white. Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed.

New HIV diagnosis rates are falling across in LSL, but too many people still receive a late diagnosis, and there are an estimated 1,000 residents living with HIV that are unaware of their status. There remain significant inequalities in those diagnosed late in LSL; people aged 50-64 years, of black African ethnicity, those exposed through heterosexual contact, and women have the highest rates of late diagnosis. Furthermore, a dispropoprtionate number of HIV cases locally are diagnosed in people living in the 40% most deprived areas.

Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20-24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at age 15-19. It is unclear what is driving this pattern, but it may be that young people lack the skills and confidence to negotiate safer sex. There is a

general downward trend in new diagnoses of STIs in LSL, with the exception of gonorrhoea and syphilis (which most affect MSM). The increases in these STIs is concerning to due antimicrobial resistance and the severity of syphilis. Given the general burden of STIs in our populations, untreated STIs remain a concern in protecting the reproductive health of residents.

In terms of reproductive health, user-dependent contraceptive methods (e.g. condoms, or the pill) are the most common form of contraception used in LSL. This combined with challenging access to services translates to a high use of emergency contraception and abortion, indicating that reproductive health needs continue to be unmet, particularly amongst young, black women.

We know that a large part of improving sexual and reproductive health is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Abusive and coercive relationships affect people of all ages, genders, and sexualities, but some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities, and people identifying as LGBTQI+. MSM in particular may be at risk through chemsex, as maintaining control of behaviour and choices while under the influence of drugs may be difficult. However, few local data are available available on indicators for safe and healthy sexual relationships.

To build on the progress we have made and meet the most salient challenges facing our boroughs over the next five years, we will work together on four key priority areas:

| Priority | Vision and key outcomes |
|---|---|
| **Healthy and fulfilling relationships** | People are empowered to make their sexual relationships healthy and fulfilling:<br>▪ People make informed choices about their sexual and reproductive health<br>▪ People in unhealthyor risky sexual relationships are supported appropriately |
| **Good reproductive health across the life course** | People effectively manage their fertility and reproductive health, understand what impacts on it, and have knowledge of and access to contraceptives:<br>▪ Reproductive health inequalities are reduced<br>▪ Unwanted pregnancies are reduced<br>▪ Knowledge and understanding of reproductive health and fertility are increased |
| **High quality and innovative STI testing and treatment** | The local burden of STIs is reduced, in particular among those who are disproportionately affected:<br>▪ There is equitable, accessible, high-quality testing and treatment that is appropriate to need<br>▪ Transmission of STIs and repeat infections are reduced |
| **Living well with HIV** | We move towards achievement of 0-0-0: zero HIV-related stigma, zero HIV transmissions, and zero HIV-related deaths:<br>▪ People living with HIV know their status and are undetectable (=untransmittable)<br>▪ People living with HIV are enabled to live and age well |

This strategy sets out the actions we will take in each of the above priority areas to continue improving sexual and reproductive health in our boroughs over the next five years. We know that this is an ambitious strategy, and we cannot deliver it in isolation. We recognise that within LSL, some areas have further to progress than others and there will be local factors that are not applicable to other boroughs. Therefore, each borough will have an annual action plan which will include specific steps to deliver this strategy. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed. Progress against this strategy will be overseen by the LSL Sexual Health Commissioning Board in addition to each borough's Health and Wellbeing Board.

# 2. Context

## 2.1. What is this document?

This report sets out Lambeth, Southwark and Lewisham's (LSL) shared ambitions for sexual and reproductive health (SRH) in our boroughs for the next five years. Our strategy assesses the most up to date intelligence and information we have on SRH, sets out a number of priority areas for action between 2019 and 2024, and what actions we will take to address these priorities.

Appended to this document are two additional resources for readers: a **statistical appendix** which summarises the latest sexual and reproductive health data and intelligence in LSL, and a pack of **evidence summaries** which provides a short summary of the most up to date evidence and guidance in relation to each of our priority areas. The evidence summary pack also includes a full list of references (references are not included in the strategy itself for presentation purposes).

This document is presented in its current format for consultation purposes; a more attractive final version including forewords will be produced in late autumn for final authorisation by each local authority and publication.

## 2.2. Why do we need a joint strategy?

Separately, LSL face some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions. We have young, mobile and diverse populations, and our local sexual health services are modern and popular. Proportionately (in relation to the Public Health Grant) and in real terms, we spend a significant sum on sexual and reproductive health services to meet both the needs and demands of our populations.

As the challenges we face are similar, LSL are in a stronger position to meet the needs of our populations through collaborating on sexual health commissioning and strategy. Through this approach, we are able to effectively pool both financial and human resources to maximise our impact in many areas. However, there remain areas where we commission separately to meet the differing requirements of our boroughs.

To underpin our collaboration, we need a clear strategic direction for action. This strategy provides that direction.

When our last strategy was published in 2014, we set out to *improve sexual health in LSL by building effective, responsive and high quality sexual health services, which effectively meet the needs of our local communities*. This focus on service delivery was appropriate for the time, a year after commissioning responsibility transferred to local government. In the period of the last strategy, we:

- Integrated sexual and reproductive health services across our local system, maintaining a high quality of delivery;
- Invested in and developed a new model of online STI testing and provided proof of concept for this type of service (leading to it being adopted across London);
- Commissioned community-focused HIV prevention programmes and rolled out condom distribution schemes; and
- Commissioned innovative and collaborative young people's services with a greater focus on overall wellbeing.

Four years on from our last strategy, some challenges remain, and there have been substantial changes in sexual health and in the system as a whole. There have been

improvements in many outcomes, but not experienced by all; a focus on reducing inequalities is more salient than ever. Despite the creation of new ways of accessing sexual health services, demand continues to rise, and access to other settings such as general practice is increasingly difficult. The availability of pre-exposure prophylaxis (PrEP) has transformed HIV prevention, especially for men that have sex with men (MSM), but condomless sex is now an increasing challenge, and some STIs are on the rise. The financial climate is ever more challenging, but despite this, we remain committed to investing in prevention and exploring new ways of delivering services.

We're proud of the innovative way we approach sexual and reproductive health service provision in LSL, and we strive to continue to be system leaders over the next five years (and beyond).

However, we can't make improvements in isolation. We recognise that good sexual and reproductive health is intertwined with many other areas of health and wellbeing, as well as our wider communities. This joint strategy has therefore been developed to complement and tessellate with a range of other local strategies in each borough, and other strategies at a regional level (e.g. Mayor's Health Inequalities Strategy).

### 2.3. Inequalities in sexual and reproductive health

The Equality Act 2010 protects us all from discrimination or harassment as a result of a personal characteristic. Good sexual and reproductive health is not equally distributed in the population. Some groups are more at risk of poorer sexual and/or reproductive health based on a common characteristic, most notably young people, Black communities, and MSM.

The following characteristics are Protected under the Act:

- Age
- Race
- Gender
- Disability
- Marital status
- Pregnancy and maternity
- Religion or belief
- Sexual orientation
- Gender reassignment

While we will continue to commission welcoming, accessible and non-discriminatory services, to reduce inequalities in sexual and reproductive health we also need to commission services aligned with the concept of proportionate universalism. This means that whilst we will maintain open access sexual and reproductive health services for all, we also need to also target resources to those most at risk in order to reduce the burden of poor sexual health in our communities. This theme is threaded throughout this strategy.

## 3. Our vision for sexual and reproductive health

Our vision for maximising sexual and reproductive health for all people in our boroughs focuses on four key priorities:

**Healthy and fulfilling sexual relationships**

- VISION: People have healthy, safe and fulfilling sexual relationships

**Good reproductive health across the life course**

- VISION: People effectively manage their fertility and reproductive health, understand what impacts on it, and have knowledge of and access to contraceptives

**High quality and innovative STI testing and treatment**

- VISION: The local burden of STIs is reduced, in particular among those who are disproportionately affected

**Living well with HIV**

- VISION: We move towards achievement of 0-0-0: zero HIV-related stigma, zero HIV transmissions, and zero HIV-related deaths

## 4. Principles underpinning our strategy

LSL will work collaboratively to deliver our vision, guided by a common set of principles:

| We will work in partnership, at a local, London and national level | We will commission high quality, effective and financially sustainable services, and capitalise on technological innovations | We will listen to service users' views and experiences and use these to improve what we do | We will focus on reducing inequalities in sexual and reproductive health | We will support the development of a resilient sexual health system |
|---|---|---|---|---|

Prevention focused
Evidence based

## 5. Commissioning responsibilities and local services

We recognise that the commissioning landscape for sexual and reproductive health can be complex. Various bodies have commissioning responsibilities in this area, which could make delivery of a strategy challenging. This is why the first principle of our strategy is to 'work in partnership' to deliver our shared vision.

While local authorities are responsible for most sexual and reproductive health care, this is not exclusively the case. Since April 2013, local authorities, Clinical Commissioning Groups (CCGs), and NHS England have had commissioning responsibility for the following services:

| | |
|---|---|
| **Local authorities** | ▪ Contraception, including any enhanced services commissioned in general practice or pharmacy settings including all prescribing costs – but excluding contraception provided as an additional service under the GP contract<br>▪ STI testing and treatment, including chlamydia testing and HIV testing<br>▪ Sexual health aspects of psychosexual counselling<br>▪ Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies |
| **CCGs** | ▪ Abortion services<br>▪ Vasectomy<br>▪ Non sexual-health elements of psychosexual health services<br>▪ Gynaecology, including the use of any contraception for non-contraceptive purposes. |
| **NHS England** | ▪ Contraception provided as an additional service under the GP contract*<br>▪ HIV treatment and care, including post-exposure prophylaxis after sexual exposure (PEPSE)<br>▪ Promotion of opportunistic testing and treatment for STIs, and patient requested testing by GPs*<br>▪ Sexual health elements of prison health services<br>▪ Sexual Assault Referral Centres<br>▪ Cervical screening |

*Delegated responsibility to CCGs locally

Public Health England (PHE) supports effective local commissioning by providing data and intelligence, guidance and also commissioning central prevention programmes (e.g. HIV Prevention England).

The commissioning responsibilities outlined above translate into the services and programmes on the following page, mapped against the key priorities of this strategy.

| Priority | Safe, Healthy and Fullfilling Relationships | Good Reproductive Health Across the Life Course | High Quality STI Testing and Treatment Services | Living Well with HIV |
|---|---|---|---|---|
| What does good look like? | ▪ Knowledge, confidence and skills for safe, healthy and fulfilling relationships | ▪ In control of their body and fertility<br>▪ Understand what factors impact on fertility<br>▪ Choice and access to a range of contraceptive methods | ▪ Self-sampling of STIs<br>▪ Access to appropriate testing<br>▪ High quality clinical services | ▪ Increased HIV testing<br>▪ Earlier diagnosis<br>▪ Retention in care<br>▪ Holistic health management |
| **Commissioner** | | | | |
| Council | High quality RSE in schools<br>Targeted work to young people<br>Tackling homophobia, transphobia, misogyny in communities<br>Community outreach / targeted health promotion work<br>Targeted CHEMSEX work | High quality RSE in schools<br>Young people friendly services<br>Knowledge of and access to full range of contraceptive offers<br>Come Correct condom scheme for under-25s<br>Integrated reproductive and sexual health services | High quality RSE in schools<br>Young people friendly services<br>Come Correct condom scheme for under-25s<br>Online STI self-sampling or testing<br>Integrated reproductive and sexual health services<br>Specialist clinical services | Reducing stigma and promoting good sexual health<br>Community outreach / targeted health promotion work<br>Online STI self-sampling or testing<br>Integrated reproductive and sexual health services |
| Council & CCG | Psycho-sexual health services | Online offer of oral contraception<br>Pharmacy and primary care<br>FGM prevention | Pharmacy and primary care testing | Pharmacy and primary care testing |
| CCG | | High quality abortion services<br>Vasectomy and sterilisation services | | Care and Support |
| NHSE | | HPV vaccination<br>Cervical screening | PrEP | HIV treatment services |

**Table 1: Local sexual and reproductive health services mapped against strategy priorities**

# 6. Our priorities

## 6.1. Healthy and fulfilling sexual relationships

**What do we mean by 'healthy and fulfilling sexual relationships'?**

Our ambition is for all people in our boroughs to be empowered to make their sexual relationships healthy and fulfilling.

We know that a large part of improving sexual and reproductive health outcomes is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Much of the work relevant to this topic falls within the remit of safeguarding teams and complementary strategies are available to support this work, addressing domestic abuse, violence against women and girls, and child sexual exploitation, among others.

However, Public Health has a role supporting relationships and sex education (RSE) in schools. Through effective collaborations, Public Health can promote and encourage partners, agencies, and providers to champion healthy relationships, with the aim of supporting people of all ages to understand and identify risky sexual behaviour and prevent abuse.

This chapter therefore serves as the preventative strand of our strategy.

### Introduction

Background and policy context

Social relationships are an important determinant of health and wellbeing across the life course. A positive familial environment provides children with secure attachment and a healthy blueprint for future relationships. Negative, harmful relationships have consequences to physical and emotional health and, in some cases, may drive a cycle of unhealthy behaviour. For this reason, developing an understanding of healthy relationships early in life is critical to equip young people with the knowledge, confidence, and control to engage in healthy sexual relationships.

Comprehensive relationships and sex education (RSE) contributes to a young person's safety by supporting them to navigate through their own developmental changes and helping to raise awareness of exploitation or abuse. Despite this, schools currently (as of 2018) have had no statutory responsibility to provide comprehensive RSE. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions and STIs, and in increasing reporting of sexual exploitation and abuse. Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up, further highlighting the importance of appropriate RSE. However, recent national surveys, qualitative studies, and local surveys across LSL on RSE have revealed significant inadequacies in the breadth of topics covered and the quality of teaching.

Amendments to the Children and Social Work Act by the Department for Education have legislated statutory RSE across the UK as of September 2020, a delay on the anticipated 2019 start-date. This affords schools (maintained, academy, and independent) the opportunity to develop – alongside health professionals – comprehensive, relevant lessons that address these reported inadequacies and capitalise on our knowledge of vulnerable groups, in particular the lack of RSE sufficiently inclusive of our vulnerable women, young LGBTQI+ people, and others. Effective collaboration between partners and providers is critical to achieving this. Topical issues of consent – what it looks like, giving it, understanding it can be withdrawn – will also be included. In primary schools, the subject will be taught as 'relationships education,' extending to 'relationships and sex education' in secondary schools.

Schools will have flexibility in how these subjects are taught and parents retain the right to withdraw a child from RSE, as they do currently.

The strategic direction for sexual assault and abuse services over the next five years has been set out by NHS England (April 2018) and echoes this emphasis on prevention. It recognises the increasing role of the internet in sexual assault and abuse, and the difficulties faced by vulnerable groups (e.g. LGBTQI+, BAME, those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource to enable people to navigate their own sexual experiences and can help people of all ages to identify unhealthy relationship behaviours and give them the confidence to address it. Healthy and fulfilling sexual relationships are important for good reproductive health, and for reducing the risk of acquiring STIs and HIV. Empowering people to make their sexual relationships healthy and fulfilling is an integral part of a holistic sexual and reproductive health strategy.

**Current picture**

Epidemiology / local needs

We know that sexual health is more than the absence of disease, however, few data are available on the broader aspects, including safe and healthy sexual relationships. Proxy measures can instead be used to indicate general trends and suggest areas of improvement or good practice.

Comprehensive, contemporary RSE can empower people to engage in healthy sexual relationships and may act as a protective factor against future risky behaviour. Local research with young people in Lewisham and Southwark during 2016 and 2017 revealed views that 'relationships and sex' was the issue most concerning to young people and their peers. However, these studies also exposed sparse and inconsistent education about healthy relationships across different schools. Details about what constitutes a healthy or unhealthy relationship and how to spot the signs of abuse (beyond physical) were reported as lacking. When asked about how they would prefer RSE to be provided, young people vocalised a desire for an open, interactive discussion with professionals, more information on the emotional and social aspects of sex, and a general inclusion of healthy relationships. A key part of this is reducing stigma around sex and sexual relationships, and developing professionals' confidence and skills in having these conversations. Additional gaps in knowledge were identified in the legal consequences of sexting that, despite its prevalence in this age group, remained largely undiscussed in RSE.

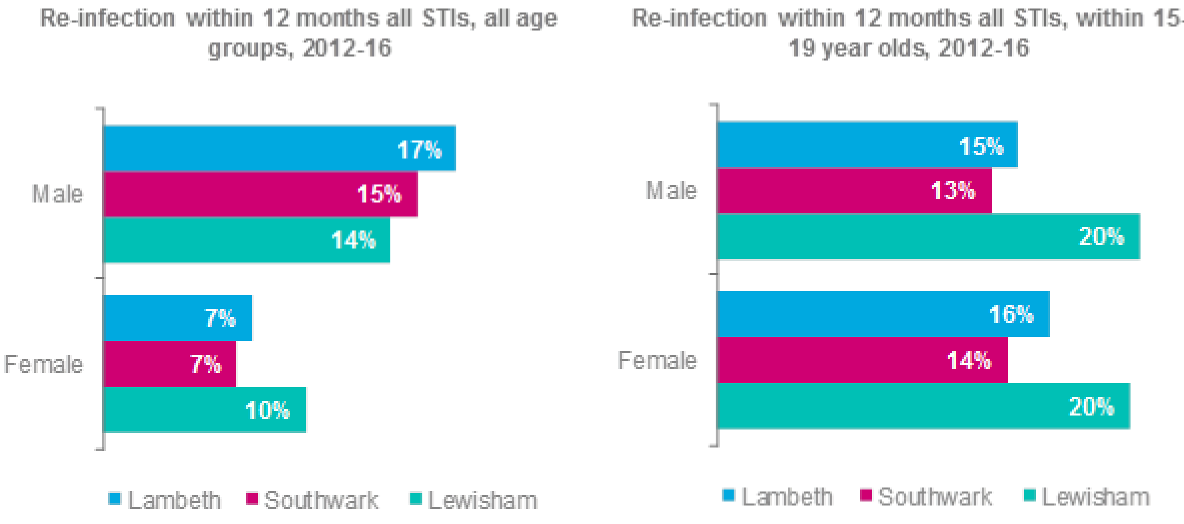
Empowering people to define the terms of their sexual relationships and use contraception when desired is an important part of protecting sexual and reproductive health (SRH). Ensuring the equality and accessibility of our contraception services has been a local priority. For young people under 25, condoms and sexual health information are available free of charge through the pan-London distribution scheme Come Correct, delivered by Brook across LSL. Condom distribution schemes were recently evaluated nationally and found to be successful nationally. This is reflected in the high number of repeat users (compared to new registrations) locally.

Abusive and coercive relationships affect people of all ages, genders, and sexualities but some groups are at higher risk of unhealthy sexual relationships than others. People identifying as LGBTQI+ may be at greater risk of experiencing abuse in a relationship. The prevalence of domestic abuse in MSM is high: from the age of 16, 49% report experiencing at least one episode of abuse. Given our significant local population of MSM, these figures are cause for concern. The prevalence of abuse in transgender people is even higher; an estimated 80% report experiencing emotional, physical or sexual abuse from a partner or ex-partner. Despite the risk for of domestic abuse in these populations, over half (53%) of lesbian, gay, and bisexual young people are never taught about homosexual sex and relationships

issues at school and therefore may not be sufficiently equipped with the knowledge and skills to engage in the sexual relationships that they want.

In 2016/17 across London, the rate of domestic abuse-related incidents and crimes recorded by the police was 23 per 1,000; women are nearly twice as likely to have experienced domestic abuse as men. The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported crime. While we lack quantitative data locally, qualitative research has highlighted the prevalence of emotionally abusive behaviour among LSL's population of young people. The 2017 Lewisham Healthwatch report 'Let's Talk About Sex' revealed young people were rarely identifying controlling behaviour or emotional abuse as evidence of an unhealthy relationship. The 2016 SHEU survey of secondary students in LSL found that 12-17% of students surveyed reported a jealous partner when seeking to spend time with friends and 10-14% said their partner looked through their phone.

Engaging in risky sexual behaviour, e.g. condomless sex, may be one of many indicators of an unhealthy sexual relationship. The rate of new STI diagnoses in LSL has been consistently higher than the London and England average since 2012. Re-infection with an STI indicates ongoing risky behaviour and across LSL men are more likely than women to become re-infected within 12 months of diagnosis. Young people are considered to be at increased risk of re-infection because they tend to lack the skills and confidence to negotiate safer sex. In 2016, twice the proportion of 15-19 year old women were re-infected compared to women of all ages. Lewisham had the highest rate of STI re-infection among LSL from 2012-16, particularly in young people.




'Chemsex' – sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL, and mephedrone – has become prominent in some parts of the MSM community. Through local surveys, we know that our population of MSM are more likely to use drugs associated with chemsex than MSM elsewhere in London or England. These substances pose significant health risks and risk of overdose. Qualitative research in Southwark indicated an increased mental health risk (including low self-esteem) for those who partake in chemsex. Research participants also identified vulnerability and risky sexual activity as common concerns since maintaining control of behaviour and choices while under the influence of chemsex drugs may be difficult. As sexual health commissioners, we need to ensure that people who are more likely to engage in risky sexual relationships are also appropriately supported and empowered to make safe, healthy decisions.

**Achievements since the last strategy and ongoing challenges**

Achievements since the last strategy

The focus on healthy sexual relationships in this strategy is a new development, in line with local needs and a changing policy context.

The introduction of statutory RSE from September 2020 is a significant achievement for public health and RSE advocates across the UK, and has created opportunities for the development of meaningful, relevant discussions of healthy sexual relationships.

In 2017, Lambeth, Southwark and Lewisham councils each launched new integrated services for young people, taking a holistic approach to the wellbeing of young people. The services focus (to varying degrees) on the provision of services and information on sexual health, substance misuse, and mental and emotional wellbeing. Underpinning these services is an acknowledgement that young people take risks, and a shared ambition to support young people with risk-taking behaviours to build resilience, coping strategies, and decision-making skills. These services have been in place for a short time, but early outputs and service user engagement is encouraging.

Ongoing challenges

*Data*

Insufficient data are available to describe and quantify potential inequalities in achieving healthy relationships. We are working with our partners to explore methods of capturing early years risk factors (adverse childhood experiences), which impact on a child's risk seeking and taking behaviour later in life. Despite its growing impact in LSL, local data on the underlying causes of youth violence and the risk posed to young people involved are sparse.

We also don't fully understand the needs of sex workers in our boroughs, and their access to and use of services to support their sexual health.

Detailed needs assessments are on-going and planned to better understand local needs where routinely collected data are not available.

*RSE provision*

Until RSE is made statutory in 2020, provision will remain inconsistent across schools. As such, there are likely inequalities in children's experiences and understanding of relationships and sex. Individual programmes and workshops have been developed for schools, e.g. the Esteem programme in Southwark that delivers lessons on critical thinking around peer pressure and understanding healthy relationships. However, programmes such as this must be purchased by schools and there is therefore significant variation in provision across the boroughs.

Emerging issues

*Youth violence*

Serious youth violence (SYV) is a growing issue across London and LSL. Young people involved in gangs are at risk for a significant physical and mental health impacts; however, young women in particular are increasingly recognised as the invisible victims. UK research has exposed widespread sexual abuse of women and girls involved in gangs and in county line drug trade, who are frequently exploited as part of initiations or to pay off debts. Challenging the impact of gang violence and protecting young women and men is a regional and local priority. Among our local efforts is a Southwark school-based, peer-led workshop by The Participation People on understanding healthy relationships. In Lambeth, St Giles run a workshop 'Expect Respect' for women and girls at risk of exploitation. Helping young people

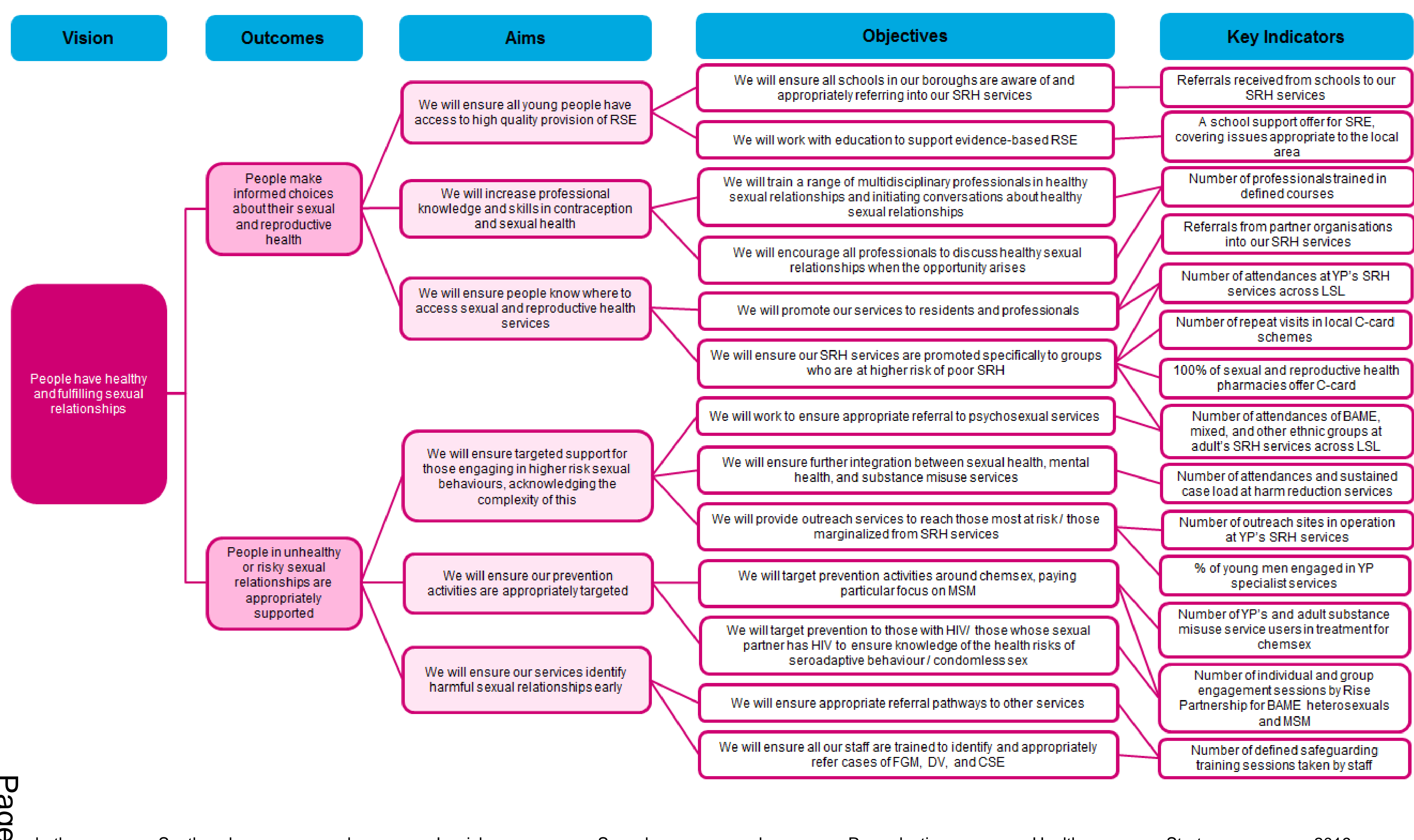
to recognise and avert risky sexual behaviour and relationships is a critical outcome for this strategy.

*Online relationships and safety*

In the current landscape, young people face a plethora of emerging challenges that are becoming increasingly difficult to navigate. Relationships are now conducted with a growing online element, exposing children to new risks such as revenge porn and increasing opportunities for online grooming and exploitation. It is therefore critical that young people have the knowledge and the skills to operate safely online.

## Healthy and fulfilling sexual relationships: what we want to achieve by 2024

The figure below sets out our vision for healthy sexual relationships in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.



## 6.2. Good reproductive health across the life course

**What do we mean by 'good reproductive health across the life course'?**

Our ambition is for all people – but especially women and people with uteri – in our boroughs to have the skills, knowledge, and access to services that allow them to effectively manage their fertility and reproductive health.

The reproductive life course – starting at menarche and continuing through to menopause and beyond – is important for all, although the relative importance of reproductive issues varies between individuals and at different stages of life. Reproductive experiences and choices are embedded in and influenced by societal constructs, with societal and cultural expectations of what is 'normal' affecting how people, and especially women, make their reproductive decisions. There is a need for conversations about reproductive health to be normalised, allowing frank and open discussion, and enabling those who need additional support to reach it.

We recognise the importance of reproductive health on overall wellbeing, and that for many people, this includes the capability to have children and the freedom to decide if and when to do so. The birth rate is declining, as people delay their first pregnancy. This strategy does not focus on conception support, but on the wider factors affecting reproductive health. These include: knowledge and understanding of fertility, reproductive health, and contraceptive options; access to high quality contraception and termination services that meet the needs of all; and the uptake of screening, vaccination and testing programmes, which affect reproductive health in the long term, including if, when and how women choose to become pregnant. Professionals' knowledge, beliefs and attitudes are as important as those of individuals in improving reproductive health.

This chapter has clear links with our other ambitions in our strategy. Being in a healthy and fulfilling relationship and having access to high quality STI testing and treatment impacts on reproductive wellbeing. Thus, our ambitions in these other chapters will also contribute to delivering good reproductive health across the life course.

### Introduction

Background and policy context

Nationally, the integration of sexual and reproductive health services under the umbrella of 'sexual health services' has been a positive development in terms of improving access to a wider range of services and reducing stigma. However, it has meant that the big issue of STIs has often dominated the national conversation around sexual health, as well as local and regional strategies. We want to redress this balance and focus on improving reproductive wellbeing in LSL.

Reproductive health is an important component of overall health across the life course, and can impact wellbeing at any stage, and can impact the wellbeing of children. Consequences of poor reproductive health exacerbate inequalities in health, education, and socio-economic status (and conversely, these factors also impact on reproductive health). In the UK, more than three-quarters of women of reproductive age want to either avoid or achieve pregnancy at any given time. Overall, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore require effective contraceptive methods. In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year. Unplanned pregnancies are also a missed opportunity to optimise pre-pregnancy health for both woman and child.

Unplanned pregnancies leading to maternity may have long-term costs not only in health terms, but also to local authority housing, education, and social care, and may have additional unintended consequences for the family itself. For example, teenage pregnancies may, in some cases, be costly to both mother and child in regard to earning potential and future employment. In the whole population, risk factors for unplanned pregnancy include lower

educational attainment, younger age, substance misuse, and smoking. Some BME groups have higher rates of abortion (an indicator for unwanted pregnancy), and this is the case for Black African and Caribbean women in LSL.

Some unplanned pregnancies, regardless of the age of the mother, will become wanted. However, a proportion will result in termination. Access to safe, legal abortion, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy.

Terminating a pregnancy has direct costs to the health economy: in 2010, approximately £143m was spent on abortions in England (the number and rate of abortion has stayed approximately stable since). In contrast, publically-funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years. Benefits include savings that result from avoiding unwanted pregnancies, including healthcare costs (for example birth costs, abortion costs, miscarriage costs and ongoing child health care costs) and non-healthcare costs (such as education costs, welfare costs, children in care costs). Good reproductive health therefore not only is essential contributor to good overall health and wellbeing, but also yields savings for public services.

In 2013, the Government published a national 'Framework for Sexual Health Improvement in England', which recognised the need to ensure that people have access to the full range of contraception, that women with unwanted pregnancies are supported to make timely, informed decisions, and that local areas develop innovative, value for money interventions and services to respond to needs. The 2018 PHE guidance 'Sexual and reproductive health and HIV: Applying All Our Health' also emphasised the importance of facilitating easy access to the full range of contraceptive methods in a range of accessible settings. These ambitions remain central to local areas' reproductive health improvement strategies.

The LGA / PHE Teenage Pregnancy Prevention Framework (2018) was published to help local areas address and reduce teenage pregnancy, and suggested key factors for a successful, whole-systems strategy. This approach was first outlined in the 2016 report 'Good progress but more to do: teenage pregnancy and young parents,' by the same authors. This report highlighted the health inequalities experienced by young parents and their children and included best practice case studies. It remains a valuable resource to date.

In June 2018, PHE published the beginnings of a new 5-year framework for reproductive health improvement. This included a survey of women's views on reproductive health (the key findings of which are captured in sections below) and a professional consensus statement on six key pillars of reproductive health, as follows:

1. Positive approach: The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment.
2. Knowledge and Resilience: The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health.
3. Free from violence and coercion: The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation.
4. Proportionate universalism: The ability to optimize reproductive health, and social and psychological well-being through support and care that is proportionate to need.
5. User-centred: The ability to participate effectively and at every level in decisions that affect reproductive lives.

6. Wider determinants: The opportunity to experience good reproductive health and ability to access to reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being.

Good reproductive health in LSL is thus reflective of a comprehensive, prevention-centred, whole-system approach to reproductive wellbeing that offers support from adolescence through to older age, targeting those most at risk in order to reduce inequalities. At any reproductive stage, individuals should have the ability and freedom to make choices about the aspects of their reproductive lives, and be able to access a range of contraceptive methods and other reproductive support services. Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services to ensure people continue to enjoy safe and healthy sexual lives.

Despite the availability of guidance, improvement frameworks, and quality local services, challenges remain in preventing unwanted pregnancy and in ensuring knowledge, uptake and access to contraceptive options across LSL.

**Current picture**

A declining birth rate and older age of first maternity

There were a total of 13,433 births to women living in LSL in 2016. The general fertility rate (measured as the birth rate) in LSL has been declining since at least 2012. The birth rate is lower in Lambeth and Southwark than it is in Lewisham: in 2016 the birth rate in Lambeth was 47.4 births per 1,000 women aged 15 to 44 years, compared to a rate of 54.3 per 1,000 in Southwark. Lewisham (63.7 per 1,000) had a similar rate to London (63.6) and England (62.5). This is linked to women choosing to delay their first pregnancy.

The mean age of mothers having their first live child has increased over time nationally. In 2016, the mean age of first time mothers in England was 28.8 years and has been increasing by 0.2 years annually for the previous ten years. A similar pattern can be seen in LSL; hospital admission records show that in 2016/17, the proportion of deliveries to women aged 35 years or above was 33%, 31% and 32% respectively. Between 2014/15 and 2016/17, there has been an increase in the proportion of deliveries to women aged 35 years or above by 2.2% in Lambeth, 1.9% in Southwark and 2.3% in Lewisham suggesting that more women are having children at a later age.

Prevention of HPV

The national human papillomavirus (HPV) immunisation programme was introduced to protect women against the main causes of cervical cancer, which in turn impacts on reproductive health. The national target in England is for 95% of all Year 8 girls to have received at least on dose of the vaccine. LSL did not meet this target in 2016/17, with 90% coverage in Lambeth, 86% in Southwark and 82% in Lewisham. The London coverage rate was 83.8%. There has been a slight improvement in LSL in recent years, although Lewisham remains consistently behind Lambeth and Southwark.

As of July 2018, the Joint Committee on Vaccination and Immunisation recommended HPV vaccination be extended to boys aged 12-13. However, the specifics of this programme remain unknown. Trans men and women, and MSM are eligible for the HPV vaccine up to and including age 45 through sexual health clinics.

Knowledge and attitudes toward contraception

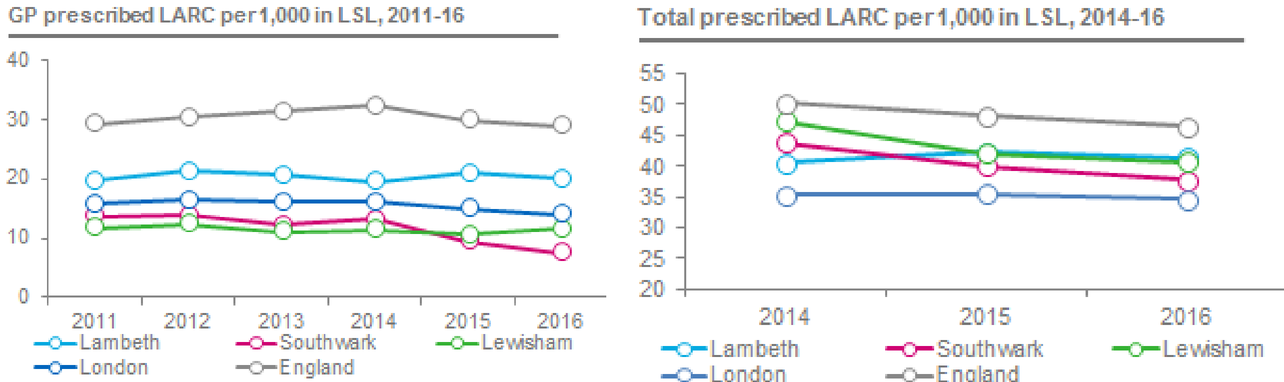
Contraception is important for all women of reproductive age who have sex with men as it enables them to effectively control if and when they choose to become pregnant. If women do want to become pregnant at some stage, contraception also provides a longer opportunity to address health issues in advance of the pregnancy, leading to better health outcomes for both mother and child. Contraception is not purely a woman's responsibility, but women need to be empowered to make conscious decisions about their reproductive life, and have the knowledge, skills and access to services to allow them to do so.

Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people about safer sex, types of contraception and local support services, in order to prevent unintended pregnancy and the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms, and this is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Poor knowledge of contraceptive options continues through to adulthood, and is perhaps reflected in high rates of user-dependent methods (UDM) such as the contraceptive pill and condoms. Recent focus groups with women across LSL demonstrated poor knowledge of LARC methods in older women of reproductive age (range: 25-45 years), and while younger women (18-24 years) knew about a wider range of contraceptive methods including LARC, there were misconceptions about their use and safety. We acknowledge that our population is fluid; young people that go to school in our area may not stay in our area as adults, and vice versa. However, there is a clear need for improved education as part of RSE in schools, in addition to public awareness campaigns. RSE was anticipated to be made statutory as of September 2019 but this has been delayed until September 2020.

Access to and choice of contraception

LARC methods are the most effective contraceptives available. Despite this, their use is much lower than UDM. Of women attending SRH services, LSL women are more likely than the national average to choose UDM such as the contraceptive pill or condoms, and this is highest in Lewisham.

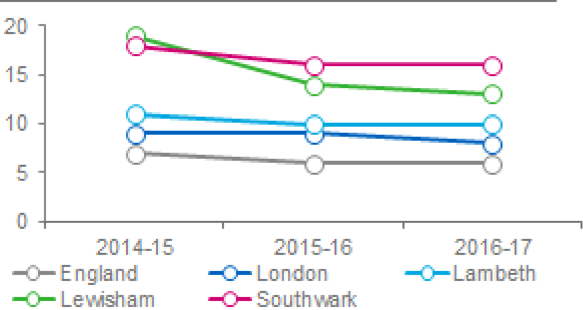



Rates of LARC prescription in general practice across LSL are lower compared to prescriptions at sexual and reproductive (SRH) services, with the exception of Lambeth. This is the opposite trend to England and likely reflects the accessibility of SRH services in our boroughs (and in London in general). Lambeth has better-developed sexual health provision in general practice, and this is reflected in these rates. However, LARC prescribing rates in

SRH across LSL are now lower than London. Compared to Lambeth and Lewisham, Southwark rates of GP-prescribed LARC have declined substantially, compared to stable rates of prescription from SRH.

Common issues in general practice preventing the provision of a LARC service include training and difficulty maintaining competency, general practice capacity (longer appointment time, availability of trained staff and chaperones, suitable rooms), and financial incentives (the opportunity cost of providing a different service in the same time).

Rates of emergency contraception usage are higher in LSL than England and London, and only in Lewisham have rates of EHC fallen in the past three years. Repeat use of EHC is a significant issue in LSL. 80% of women using EHC in Lambeth and Southwark pharmacies in 2016/17 self-declared previous use; half of these had used EHC in the last six months (Southwark). This is a strong indicator of unmet reproductive health needs and a major missed opportunity for intervention.




**_Listening to local women_**

Focus groups on contraception and reproductive health undertaken with a diverse sample of women across LSL in 2018 supplemented what data have told us about the needs of local women, with the following key findings.

<u>Views on contraception</u>

- Women are anxious about unwanted pregnancies and want to be confident in their contraception choices, so that they can fully enjoy sex. They also want to know that the contraceptive they use will not have a detrimental impact on their physical and emotional wellbeing, now and in the future.
- While they know that contraception is there for them, they have difficulty accessing services when they need it.
- Fairly low level of knowledge and low confidence, combined with false beliefs are reducing their perceived choices
- Many women feel they aren't always getting the full picture from professionals, and feel the way professional advice is delivered to them can be 'cold' and/or judgemental, failing to take in to account feelings and past experiences.
- Social taboos, stigma and fear of shame and embarrassment are major barriers to accessing contraception services.

<u>The services women want</u>

- Women who don't currently have their contraceptive needs met can be broadly characterised into two main groups:
  - Transactional: Women who know what contraception they want, but are having trouble accessing this;
  - Unsure: Women who don't know which contraception they want or aren't actively seeking contraception, who may need help to decide.

Services need to be more tailored to meet the needs of all of these women.

- Women described a need for 'whole woman' focused services that consider their wider needs around sex and reproductive health, that helps women feel positive and empowered though a discrete, non-judgemental and comfortable service.
- Women were in agreement about needing more choice in accessing contraception, e.g. whether she has to attend in person, or can access the service remotely through online/phone access and home or local pharmacy deliveries of contraception.

Women who are not using existing contraceptive services should receive opportunistic contraceptive advice when they are in contact with health services for other issues or conditions, for example, after taking emergency contraception, after having an abortion, or after having a baby.

Teenage conception

The rate of under-18 conception is consistently higher across LSL compared to London and England, which suggests an unmet need in contraception care as well as a failure to comprehensively tackle the wider determinants of teenage pregnancy. Moreover, this suggests a lack of awareness of, or confidence in accessing other more effective methods of contraception. LARC methods do not depend on daily concordance and have been proven more effective than oral contraception at only one year of use. Despite these benefits, uptake remains low in the UK and in LSL. This suggests that barriers remain in communicating the benefits of LARC or in ensuring that women of reproductive age have easy access to the full range of contraception, including LARC.

Since 1998, LSL has achieved dramatic decreases in teenage conception, however, the rates remain higher than in London and England. Teenage pregnancy is more likely to end in abortion than other age groups, and approximately two-thirds of under-18 conceptions in LSL are terminated.

Abortion

Across the life course, the rate of abortion can be viewed as an indicator of a lack of access to contraception services and advice, as well as problems with individual use of contraceptive method. Analysis suggests there are inequalities in the abortion rates in women aged 15-44 in LSL, with the highest rates among women identifying as Black African or Caribbean.

Across LSL, over 40% of abortions in 2017 were among women who had previously had an abortion that year ('subsequent abortions'). This is higher than the London and England average, and highest in Lewisham (44%). Subsequent abortions are also not distributed equally in the population, with Black African and Caribbean women again bearing the greatest burden. This indicates a lack of access to and/or use of appropriate contraception. New data on subsequent abortions in women aged under 19 years show that the rate of subsequent abortion in this age group declined slightly between 2016 and 2017 (in LSL, London and England), but rates are still too high given their younger age and missed opportunities for intervention. In 2017, 8.2% of Lewisham women, 11% of Lambeth women, and 13.1% of Southwark women aged under 19 who had an abortion had also had a previous abortion in that year. Rates of subsequent abortion in over-25s are not available.

The time immediately following abortion is an important period for contraceptive intervention, particularly LARC methods. However, LARC uptake in abortion services in LSL has remained below 45% since 2014/15, and has now declined to around 20%. This may be due to the increase in women choosing early medical abortions (EMAs, under 10 weeks), as opposed to surgical abortion or a later medical abortion. EMAs do not require clinical follow-up and therefore these women may miss out on the opportunity to discuss LARC methods post-abortion. In 2017-18, local clinic data for LSL women indicate that 61% of abortions at BPAS and 64% of abortions at MSI were EMAs, slightly higher than the national rate (60%), and trends indicate that EMA uptake rates are expected to increase. Exploring other methods of on-going contraception (e.g. OC) while undergoing termination may serve as a bridging method until LARC is appropriate.

Admissions related to poor reproductive health

Pelvic inflammatory disease (PID) refers to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy and tubal factor infertility. About one-quarter of cases are caused by untreated STIs. Admissions for PID have been consistently higher in Lewisham than the other LSL boroughs and remains above the national average, but have declined since 2012/13 – by contrast, rates in Southwark and Lambeth have increased (but remain below the national average).

Ectopic pregnancy is a serious condition that usually results in hospital admission. Rates of admission have fluctuated over time. In 2015/16, Southwark had third-highest rate (140 per 100,000) of ectopic pregnancy in England. All three boroughs' admission rate for ectopic pregnancy is above the national average, and Lewisham is also above the London rate.

## Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

The following have been the most notable achievements in reproductive health in LSL since the publication of our last sexual health strategy:

- A reduction in the number of teenage mothers and teenage pregnancies leading to birth. This has been underpinned by:
  - An ongoing and sustained reduction in teenage pregnancy, both in young women aged under 18 and under 16
  - Of teenage conceptions that have occurred, an increasing majority have not led to maternity
  - Improved access to emergency contraception and termination services
  - The roll-out of the C-Card scheme across the boroughs (though we cannot say that this has had a linear impact on teenage conception rates)
- A slight decline in the rate of abortion in women of all ages
- A slight increase in the proportion of women choosing LARC at sexual health centres
- An increase in the coverage rates for the HPV vaccine for teenage girls, protecting them from future HPV infection.
- The HPV vaccine has now been extended to MSM opportunistically (during 2018), to prevent infection leading to HPV-associated cancers, including anal, throat and penile cancer. However, heterosexual males remain unable to access HPV vaccination on the NHS.

However, despite these achievements, significant challenges remain. There are still a number of poorer outcomes in reproductive health in LSL, which are driven by ongoing and emerging issues described in section 0.

Ongoing challenges

*General access to contraception*

Since our 2014-17 strategy, services have regularly been at capacity. wider system pressures on general practice have meant that it has been increasingly difficult for many people to access their practice, which has had an impact on GPs being able to meet residents' urgent or ongoing reproductive health needs (e.g. repeat prescriptions, LARC, or emergency contraception). More recently, there have been similar pressures on sexual health services, with demand outstripping the number of appointments and walk-in spaces available.

Within LSL, rates of EHC usage are highest in Southwark and local surveys have shown that there is already considerable demand for sexual health services, with patients being turned away from busy clinics, and online services also regularly at capacity. As may be expected, demand for emergency contraception is high and the rate of abortion in LSL (despite a declining trend) remains high and is above the national average. Furthermore, the rate of women taking up LARC following their attendance at an abortion clinic has declined in the last 5 years in LSL, which may lead to ongoing unmet reproductive health needs.

We are operating within the constraints of extraordinarily lean budgets, but we continue to innovate to meet increasing demand. To improve access to reproductive health services, we have moved to provide support in new and innovative ways. New models of practice include leveraging the accessibility, ease, and anonymity of pharmacies, and increasingly incorporating an online aspect to our services (for low risk individuals). The condom distribution scheme Come Correct has been popular locally and has capitalised on non-traditional settings (e.g. leisure centres and libraries) to distribute contraception to young people. Our ambitions and ongoing innovations are outlined in more detail in section 4 and in the accompanying action plans.

*Inequalities*

Like overall health and sexual health, good reproductive health is not equally distributed in the population. If the need for abortion is used as a proxy measure for not having reproductive needs met (abortion being the last intervention to prevent an unwanted maternity), black women in LSL suffer the poorest reproductive health. The rate of abortion is higher in LSL amongst women describing themselves as of black Caribbean and black African ethnicities. Nationally, women that have sought abortion on more than one occasion are more likely (than those who have had one abortion) to be black, have left school at an earlier age, be living in rented accommodation, report an earlier age at first sexual experience, be less likely to have used a reliable method of contraception at sexual debut and report a greater number of sexual partners.

Not all services work for all people, so a range of responsive universal and targeted services are needed. In developing new and improving reproductive health services, and following on from recent focus groups with local women, we will be working alongside young, black women in LSL in particular to understand their specific needs and co-design services and programmes.

We also know that there is a growing Latin population in our boroughs, and we will be working to better understand their sexual and reproductive health needs and tailor our services appropriately.

Emerging issues and trends

*E-services for contraception*

The use of e-services in sexual health is growing in popularity. E-services to this point have primarily been for STI testing and treatment, and complement traditional sexual health clinics by enabling appropriate low risk (asymptomatic and non-vulnerable) individuals to self-sample through the usage of kits ordered online and posted to home. In LSL, just under half of the patients attending sexual health clinics that were offered and took up the offer of online instead of clinic testing were women. While it is clinically appropriate for low risk women to use e-services, this has removed opportunistic contraception consultations in these patients. Service-level data from sexual health clinics indicate a reduction in contraception provision since the channel shift to the e-service was implemented, and we intend to explore this further. It is essential that women using online STI services receive appropriate messaging around contraception, and that there are a range of services in place to meet contraceptive needs of

women in LSL. Furthermore, we will endeavour to ensure that vulnerable people will always be seen face-to-face, as appropriate to their needs.

A pilot of online oral contraception in Lambeth and Southwark proved popular, and there are online contraception options in the commercial market. These developments will feed into how we will meet the vision of this strategy, allowing us to better respond to local needs in a cost effective and modern way.

*Fertility awareness apps*

A number of app-based methods supporting 'natural family planning' (fertility awareness) have emerged in recent years. These support women in monitoring and recording different fertility signals during her menstrual cycle to estimate when she's likely to get pregnant, and take appropriate action to avoid this if relevant (e.g. abstaining from sex, or using contraception such as condoms). These apps' reliability and effectiveness in avoiding pregnancy is unknown.

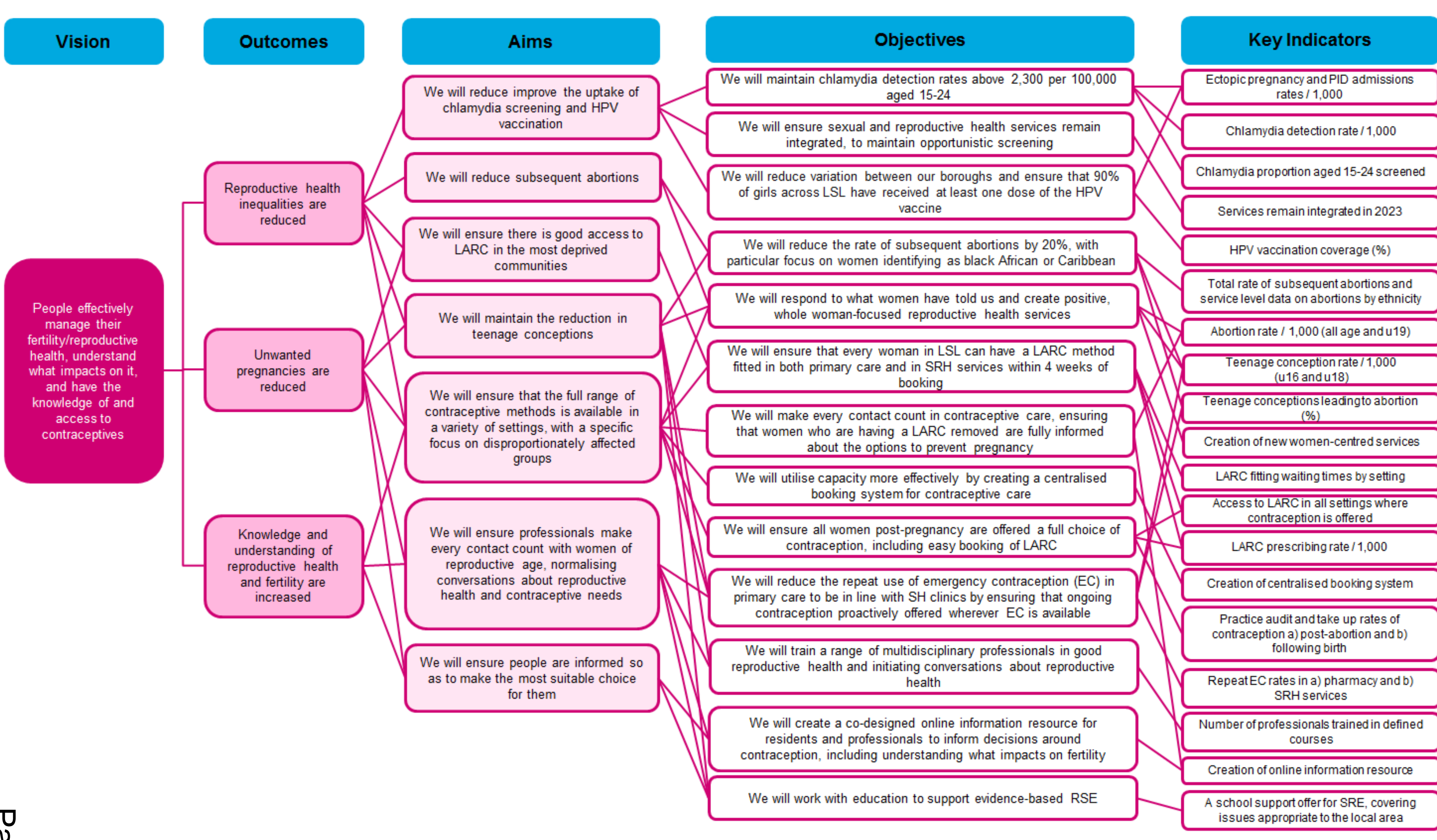
Some of these apps have been promoted as being as effective as the oral contraceptive pill with perfect use (but remain untested in independent clinical trials), and like many user dependent methods, perfect use is uncommon – 7 in 100 women had an unintended pregnancy in a year of typical use of one of the most popular fertility awareness apps. Fertility awareness methods are also affected by factors such as illness, stress, alcohol, and travel. Non-user dependent methods remain the most effective form of contraception, and condoms protect against STIs.

*Anti-choice protests at abortion clinics*

People have a right to access safe and legal abortion, free from harassment. This has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Anti-choice protests at abortion clinics in our boroughs and across London are unwelcome and actively harmful to local people. A Home Office decision on creating safe zones around abortion clinics is awaited. Regardless of this decision, LSL will uphold the rights of local people to access abortion-related care free from harassment as a key tenet of promoting reproductive health.

## Good reproductive health across the life course: what we want to achieve by 2024

The figure below sets out our vision for reproductive health in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.



## 6.3. High quality and innovative STI testing and treatment

**What do we mean by 'high quality and innovative STI testing and treatment'?**

Early access to comprehensive high quality STI testing and treatment services help to reduce transmission, trace and treat sexual partners, prevent repeat infections, and reduce inequalities in sexual and reproductive health.

We are fortunate in LSL to have a number of world-class clinical sexual health centres. Building upon this, we will focus on ensuring quality across the totality of our system, from prevention to testing, treatment and partner management. We believe that this will ensure the best use of capacity within the local sexual health system and support the reduction of the burden of STIs, particularly in young people, MSM, and Black and other minority ethnic communities unequally affected. We see an opportunity to strengthen the links between sexual health services and education, prevention, and promotion activities.

Our sexual health services have a history of innovation: from the integration of sexual and reproductive health provision, to the development of online services. We want to continue to support and foster further cross-sector innovation to meet our dual challenge of ensuring a financially sustainable system and changing the trajectory of STIs in our population.

### Introduction

Background and policy context

Historically and currently, LSL has some of the highest rates of STIs in England. In 2017, Lambeth had the highest rate of new STI diagnoses nationally, followed by Southwark in third, with Lewisham 11th. This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse, and mobile populations.

STIs are a significant contributor to and result of health inequalities. We cannot reduce these inequalities without improving the overall sexual and reproductive health (SRH) of key groups, including young people, MSM, and Black and minority ethnic groups. LSL residents are predominantly young, with a larger proportion of the population aged 25-34 years. We are also more ethnically diverse than England, with approximately one quarter of LSL residents identifying as Black. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay, and bisexual communities in England.

In the five years since the responsibility for commissioning sexual health services transferred to local government, demand for sexual health services and STI testing have increased against a backdrop of significant and ongoing financial challenges. This has driven a need for innovation to ensure our services remain fiscally sustainable.

LSL have historically been leaders in innovative SRH services in London. We pioneered online STI testing for asymptomatic patients, and provided proof of concept for e-services as a core part of a cost-effective sexual health system. This approach has since been adopted across London ('Sexual Health London'). Although e-services primarily aim to create capacity at SRH clinics by targeting asymptomatic patients, they may be attractive to people who feel uncomfortable accessing SRH services, thereby improving testing accessibility.

Condom use remains a primary method of preventing STI acquisition and transmission. The pan-London condom distribution scheme, Come Correct, is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'c-card'. C-card schemes for condom distribution were evaluated nationally and found to be successful in engaging young people. Increasing numbers of repeat users compared to new registrations suggest the scheme is popular and acceptable. These schemes are particularly

important in reaching young men, who are less likely to visit their GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.

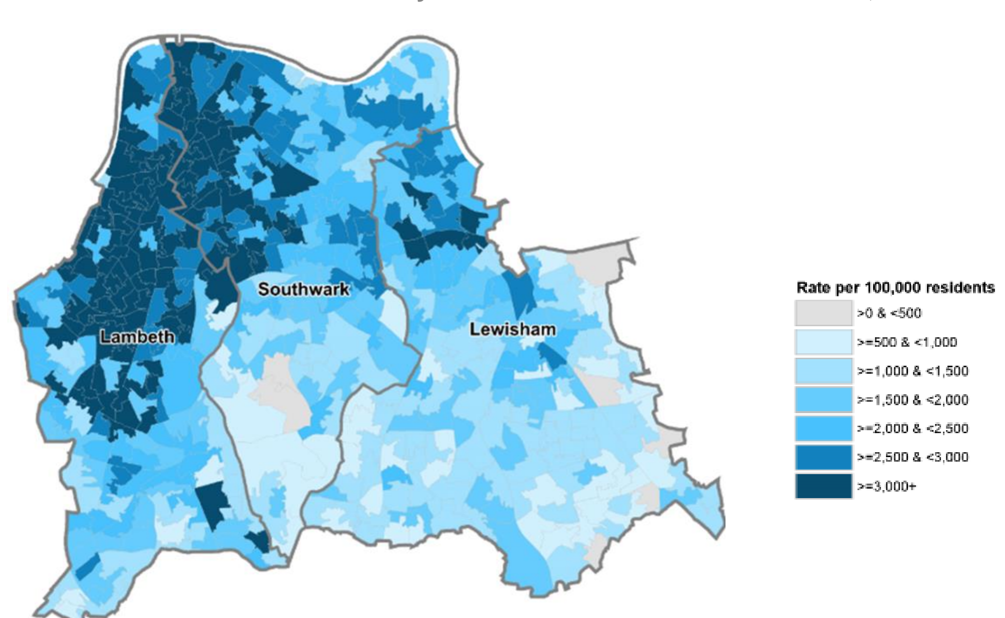
Free condoms are also a core component of the London HIV Prevention Programme, Do It London, of which LSL are major contributors. This element of the programme provides condoms to MSM, primarily in gay venues. Condom outreach to MSM will remain central to a health promotion strategy alongside PrEP in the coming years.

The open access nature of services means we have to collaborate across London and enable innovation to meet the diverse needs of our local populations, building on the work of the London Sexual Health Transformation Programme.

### Current picture

In 2017, just over 22,000 new STIs were diagnosed across LSL. STIs are unequally distributed within the population and disproportionately affect young people, MSM, and some Black and minority ethnic populations. Across LSL, there is a strong correlation between areas of deprivation and rates of STIs, highlighting transmission within geographically connected sexual networks and how this contributes to overall health inequalities.

Incidence of new sexually transmitted infections across LSL, 2017




Trends in STI diagnoses are multifactorial and reflect a combination of sexual behaviours, service accessibility and use, diagnostic techniques, and surveillance systems. Lambeth, Southwark and Lewisham have historically had some of the highest rates of STIs and HIV nationally. This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse and mobile populations.

Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people early in life about safer sex, types of contraception and local services, in order to prevent the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms. This is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Many STIs such as trichomoniasis, shigella, and hepatitis remain a burden and the cause of considerable activity in sexual health clinics. However, this strategy will largely focus on the five most commonly diagnoses STIs in LSL: chlamydia, gonorrhoea, syphilis, genital wards, and herpes.

Chlamydia

Prevalence of chlamydia in the general population is between 2-3% and it is likely that many infections are undiagnosed and untreated. About 10% of untreated infections will result in reproductive health complications. Of all chlamydia diagnoses made across LSL in 2016, 61% of these cases were in men and, while chlamydia is more prevalent among men across the life course, the rate among young women (aged 15-19 years) is approximately double that for men. While the chlamydia detection rate across all three boroughs exceeds the recommended rate of 2,300 diagnosis per 100,000 people aged 15-24 years, it has fallen since 2014 and continues on a downward trend. Increasing the screening rate overall and in young men is a priority.

Gonorrhoea and syphilis

Gonorrhoea is the second most commonly diagnosed bacterial STI, however, its prevalence within the general population is low. Moreover, due to its relatively short period of infectiousness, gonorrhoea is concentrated within groups with higher rates of partner change and partner concurrency. Gonorrhoea infection is a global concern as it has developed resistance to an increasing range of antibiotics and it is estimated that a third of all infections are now resistant to one antibiotic. Gonorrhoea primarily affects men: nine in ten cases in LSL are diagnosed among men, with over three-quarters of those being MSM.

The rate of syphilis diagnosis in Lambeth and Southwark has increased by 103% and 116% respectively since 2008; these are now the highest rates of syphilis nationally. While rates fell from 2015 to 2016, they increased again in 2017 with approximately 850 cases diagnosed. The rate of syphilis diagnosis in Lewisham is similar to London (41 per 100,000) and, while Lewisham has experienced a larger proportional increase since 2008, rates remain at half that of Lambeth and Southwark. Syphilis tends to be associated with high-risk sexual networks.

In Lambeth and Southwark, 90% of syphilis cases in 2017 were in people who identified as gay. This was lower in Lewisham: 78%. Rates by age reveal the greatest burden of syphilis is in the 34-44 years age group. This is significantly older compared to other STIs but reflects the London age distribution. Small outbreaks of syphilis have occurred in male heterosexual groups. In heterosexual women, cases are disproportionately concentrated among Black and minority ethnic women. In London, rates of congenital syphilis remain extremely low due to a comprehensive antenatal screening programme.

Across LSL, a third of all diagnoses occur in the primary stage of infection, a third in the secondary phase, and a third early latent. This is particularly worrying as we know that if left untreated, syphilis can spread to the brain or other parts of the body and cause serious, long-term health problems. Genital sores caused by syphilis also make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV. This is concerning as co-infection with HIV increases the risk of central nervous system complications.

Our proportion of early latent cases of syphilis is higher than the London average and suggests a lack of testing uptake in high-risk groups. There is evidence that people with multiple syphilis infections play an important role in transmission and may be at higher risk of subsequent infections. SRH services should therefore focus on reaching this high risk population. Increasing testing in high risk MSM groups is another priority as is reducing late syphilis diagnosis and improving partner testing and treatment.

Genital warts

Genital warts are caused by infection with specific subtypes of human papilloma virus (HPV), commonly passed on through condomless sex. Genital warts are the third most commonly diagnosed STI in LSL, with just under 2,000 cases diagnosed in 2017. The majority of these are in heterosexuals. Rates of diagnosis were highest among those aged 20-24 across all three boroughs. There are inequalities in the rate of genital wart acquisition, in particular among mixed ethnic groups in Lewisham and other ethnic groups in Lambeth.

Genital herpes

Rates of genital herpes have been broadly stable since 2012. Among these five most common STIs, genital herpes is the only one in which more women are diagnosed than men. As with genital warts, rates of diagnoses are considerably higher in those aged 20-24 years. In young people aged 15-19 years, the difference in diagnoses rates between the sexes is particularly pronounced.

The majority of genital herpes (83%) cases are diagnosed in people who identify as heterosexual, and most in heterosexual women. Rates of diagnosis across the three boroughs vary by ethnicity, with the highest rates in Lambeth 'other' and Lewisham mixed ethnic groups. Asian ethnic groups have the lowest rates of genital herpes across LSL.

Other STIs

While this strategy focuses on chlamydia, gonorrhoea, syphilis, genital warts and genital herpes, the collective burden of other STIs on individual wellbeing and service capacity is important and we must remain agile to emerging diseases. Of particular importance are high risk STIs such as shigella and viral hepatitis, which are not diagnosed and treated in sexual health services but for which our services play a vital role in prevention. Shigellosis clusters predominantly associated with sexual transmission in MSM have increased significantly since 2014.

During 2017, there was a Europe-wide outbreak of sexually transmitted hepatitis A virus, with 942 cases in England and Wales alone, primarily affecting MSM in the 25-34 age group. Of these, 414 were from London. Control of the outbreak was confounded by a global hepatitis A virus vaccine shortage and the fragmentation of commissioning responsibilities between NHS England, Public Health England and Local Authorities. As of January 2018, the incident had been de-escalated from enhanced to standard response however London has been the worst affected region and there will likely be a significant lag-time before diagnoses return to pre-outbreak levels. It remains critical to raise awareness amongst MSM and ensure opportunistic vaccination continues.

Lymphogranuloma venereum (LGV) is a type of chlamydia that infects the lymph node for which surveillance was established in 2004. Diagnoses in LSL peaked in 2014 and have been declining steadily since then, in parallel with chlamydia as a whole. There were 109 diagnoses in LSL in 2017, all of which were in men of predominantly 24-34 years. Despite the decline, it is still vital to maintain a high index of suspicion for LGV and offer asymptomatic testing for HIV-positive MSM as this group is most affected (67.5% of new diagnoses).

Shigella clusters in MSM have increased significantly since 2014, with 1,056 excess male cases reported in London between 2012 and 2016. This population is disproportionately affected by the *S. flexneri* species which causes severe disease. People living with HIV are particularly vulnerable to a severe, invasive form of shigellosis. Despite the risk, PHE has reported extremely low awareness of shigella among MSM.

There was also a significant London-wide excess of male cases of hepatitis B in 2016, explained at least partly by sexual transmission amongst MSM. LSL has consistently had a

significantly higher incidence of hepatitis B than the London average: a mean incidence of 2.54 per 100,000 compared to 1.7 per 100,000 in London.

For shigella and hepatitis A and B, SRH services play a crucial role in raising awareness amongst the most exposed populations as well as key preventative activities such as condom distribution and opportunistic vaccination.

With regards to hepatitis C, admissions and mortality in LSL remain higher than regional and national levels, with local data suggesting that MSM may again be disproportionately affected. This indicates a need for SRH services to work closely with substance misuse services to protect the most vulnerable populations.

Although not clinically severe infections, trichomoniasis and molluscum contagiosum together accounted for over 1,000 new diagnoses in LSL in 2016, affecting mainly heterosexual women. Trichomoniasis has been linked to poor outcomes in pregnancy and to increased HIV transmission therefore warranting prompt treatment in all patients. Molluscum contagiosum is closely linked with the incidence of other STIs and therefore affected patients should undergo full STI testing.

Risk groups

Sexually transmitted infections contribute to health inequalities and some groups are disproportionately affected by STIs.

*Young people*

Young people have higher rates of STIs reflecting their higher rates of sexual activity and partner change, and relatively poorer skills in negotiating safer sex. In LSL in 2016 double the proportion of 15-19 year old women were re-infected with an STI compared to women in all age groups.

*Men who have sex with men*

MSM report higher rates of partner change and partner concurrency and are more likely to belong to sexual networks which facilitate rapid STI transmission. In LSL, 77% of cases of gonorrhoea and approximately 86% of cases of syphilis were in MSM. Seroadaptive behaviours increase exposure to STIs and may account for this group being disproportionately affected. Moreover, recent literature on HIV PrEP has suggested that use is associated with reduced use of condoms. This may further contribute to the increased risk this cohort faces of STI acquisition. The national HPV vaccination programme was extended to MSM in April 2018 and is expected to help reduce the incidence of genital warts and other HPV-related illnesses, though there may be a lag before benefits are observed in full.

*Black and minority ethnic groups*

White and Black heterosexual women and Black and mixed heterosexual men experience a large burden of STI diagnoses. In Lewisham, chlamydia rates are highest in mixed and Black ethnicities. Across LSL, those of Black ethnicity made up the largest proportion of gonorrhoea cases in heterosexuals. The higher rates of STIs in some Black and minority ethnic groups are partly explained by the relationship between socio-economic deprivation and ethnicity, but not fully. There is a complex interplay between cultural and behavioural factors, and access to and use of healthcare services.

**Progress to date**

Achievements since the last strategy

Since our last sexual health strategy, LSL successfully launched a proof of concept model of online testing of STIs. SH:24 was an innovative method of encouraging asymptomatic individuals seeking STI testing to self-test at home, thus reducing the burden on sexual health clinics and freeing up capacity within the service to treat symptomatic patients. This pilot spurred the now pan-London initiative to provide online STI testing, which was rolled out in LSL in July 2018.

We have achieved fundamental changes to the way in which we finance sexual health services, to ensure value-for-money and effective commissioning. The integrated sexual health tariff (ISHT) matches payment to the specific costs of an appointment. We acknowledge that despite now meeting the exact costs of an appointment, these new contracts have delivered a significant drop in income for our local trusts, which has contributed to the financial pressures they face. We continue to work closely with our partners to ensure that any service changes will continue to meet the sexual health needs of the population.

Ongoing challenges

LSL have proportionately large groups at higher risk of poor sexual health. Given the prevalence of STIs in our population we need to balance accessible, open-access services with targeted and proactive testing aimed at the most at risk groups (some of whom also access traditional services the least). Recent outbreaks have highlighted that under-testing of certain infections, particularly in MSM, continues to be a challenge.

Sexual and reproductive health services in LSL are at capacity. Fiscal challenges across England have contributed to the closure of sexual health clinics and commissioners are continuing to innovate to improve the reach and accessibility of our services.

Partner notification of STIs helps to prevent the onward transmission of infections. Our local SRH services actively encourage patients receiving an STI diagnosis to disclose their result to previous partners but this is highly user-dependent. SXT is a local innovation that allows for anonymous online notification of partners. Effective partner notification needs to be built into all parts of the local system.

Emerging issues and trends

*PrEP*

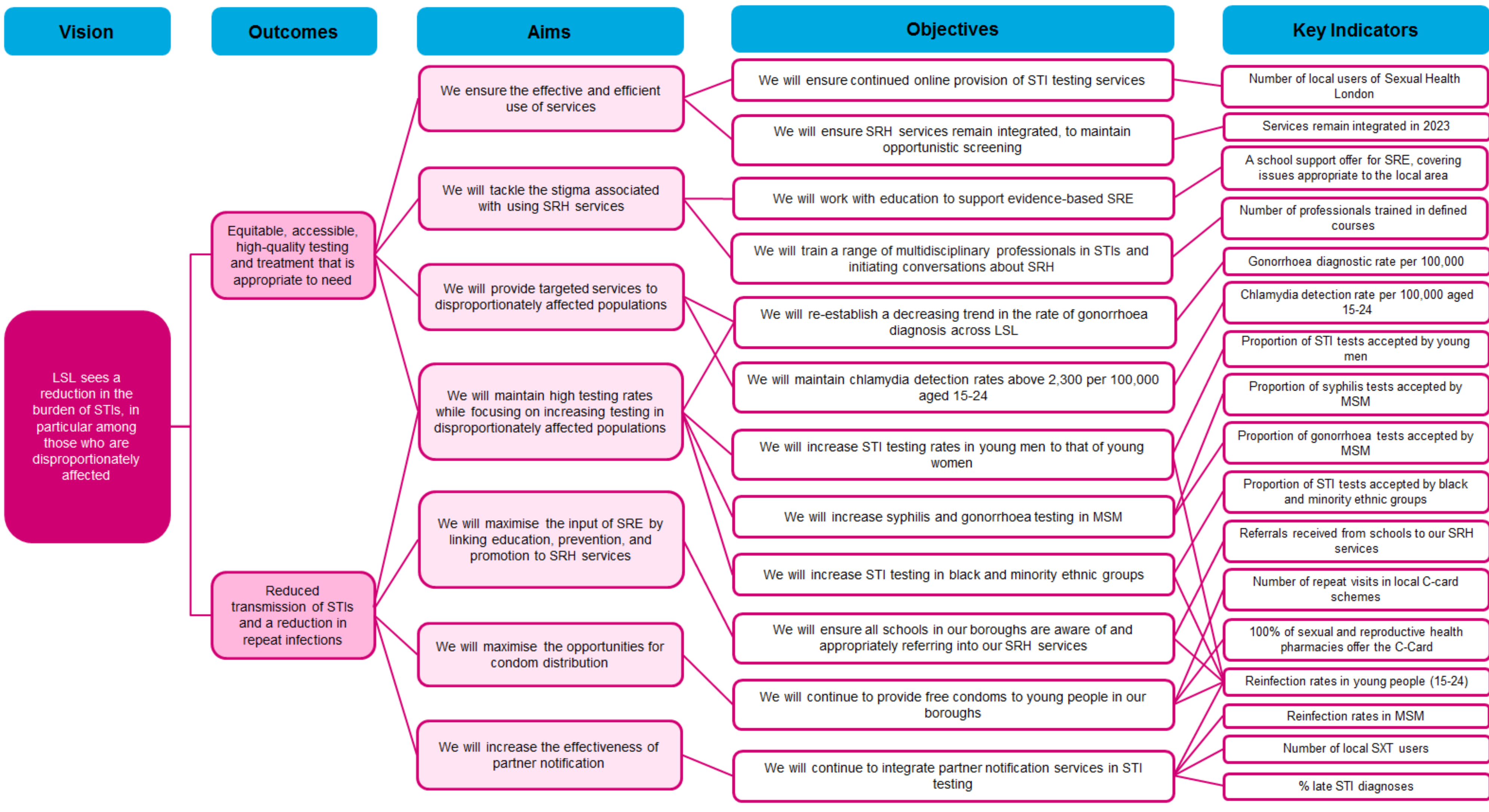
Pre-exposure prophylaxis has dramatically changed the landscape of HIV prevention. However, PrEP may be associated with a reduction in the use of condoms and an increase in STI acquisition. While these emerging results should not diminish the success of PrEP in preventing HIV transmission, sexual health commissioners and practitioners should be aware of and mitigate against this potential outcome.

*Antibiotic resistance*

Chlamydia, gonorrhoea and syphilis are three common STIs typically curable by antibiotics. However, over recent years, these STIs have developed a resistance to antibiotic treatment; this is particularly the case with gonorrhoea. In March 2018, the first case of multi-drug resistant gonorrhoea in the UK was identified and the World Health Organisation has warned this infection may soon become untreatable. Local authorities and SRH services must continue to work with PHE and national partners to survey and report any resistant strains, and ensure timely and effective treatment of new cases of STIs in our local population.

## High quality and innovative STI testing and treatment: what we want to achieve by 2024

The figure below sets out our vision for STI testing and treatment in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.



## 6.4. Living well with HIV

**What do we mean by 'living well with HIV'?**

Our ambition is to prevent the transmission of infection, ensure diagnosis as early as possible and ensure that PLHIV in LSL have the services and support to enable them to live a healthy and fulfilling life. This means moving towards zero new diagnoses, zero HIV-related stigma and zero deaths related to HIV, in alignment with the Fast Track Cities' aims. We will provide our populations with services and support that will enable them to live and age well with HIV, and prevent new infections and onward transmission.

Thirty years on from the beginning of the HIV / AIDS crisis in the UK, knowledge and understanding of HIV has increased dramatically, bringing real advances in HIV treatment and prevention. An HIV diagnosis today means living with a long-term condition and HIV is no longer the fatal infection that it was 20 years ago. This strategy reflects these changes, reframing HIV as a long-term condition. However, HIV infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed. In addition, recruitment and retention in care is still a critical focus for some of our most at-risk groups.

Encouraging all people to be aware of their HIV status will require a commitment to ensuring accessible testing opportunities are available through a variety of channels and that people at all risk levels are encouraged to know their status. This will continue to drive the number of new diagnoses and late diagnoses down and contribute towards the goal of zero new transmissions.

With advances in treatment, the proportion of people living with HIV who are aged 50 years and over will continue to rise. To ensure that people are able to both live and age well with HIV, it is recognised that specialist HIV services and primary care will need to work together to provide a holistic care approach, managing HIV together with other chronic health conditions.

Our focus in this chapter is therefore to reinforce our commitment to ensuring access to the medical aspects of tackling HIV including strengthening combined prevention efforts and early treatment. We also commit to better understanding the social aspects of HIV, to eradicating the ongoing stigmatisation of those living with HIV and to tackling the new challenges of an aging population.

### Introduction

Background and policy context

HIV remains a priority nationally, in London and especially in LSL where diagnosed HIV prevalence rates are the highest in the England. Excluding the City of London, Lambeth and Southwark respectively have the highest rates of prevalence in England.

New HIV diagnosis rates have decreased nationally and in London and 2016 saw three firsts in the 30-year history of the UK HIV epidemic: the number of new HIV diagnoses in MSM fell, the death rate among people with HIV who are diagnosed promptly and on treatment became comparable to the rest of the population, and in London the UNAIDS 90-90-90 targets were met. In 2017, London became the first city in the world to exceed 95-95-95 – that is, 95% of Londoners living with HIV infection were diagnosed, 98% of those diagnosed were receiving treatment and 97% of those on treatment were virally suppressed and unable transmit the virus.

Widespread use of combination prevention approaches has contributed towards the decline in HIV rates. Combination prevention refers to a set of behavioural, biomedical and structural approaches tailored to local levels of infrastructure and culture as well as to populations most affected by HIV. In the UK, the combination of approaches has included encouraging condom use, promoting the use of PrEP, promoting expanded HIV testing and diagnosis, advocating for self-sampling kits and ensuring prompt treatment when people are diagnosed with HIV and other STIs. Antiretroviral therapy (ART) is now so effective that those on treatment who

maintain an undetectable viral load (<200 copies) have effectively no risk of sexually transmitting the virus (undetectable = untransmissible ('U=U')). The London HIV Prevention Programme campaign, Do It London, promotes four key ways to prevent the spread of HIV: regular testing; use of condoms; PrEP; and for people living with HIV to receive treatment and have an undetectable viral load (U=U). LSL echoes this strategy locally.

With knowledge of their status and access to effective treatment, people living with HIV (PLHIV) are able to live as long as the rest of the population. As a result, HIV is transitioning away from the life-threatening illness it once was and into a long-term condition that must be managed alongside other age-related conditions and care needs.

In January 2018, London signed up as a Fast-Track City, committing partners across the capital to work together to exceed the UN's 90-90-90 targets and end new infections in the capital by 2030, reduce the negative impact of stigma and discrimination to zero, stop preventable deaths from HIV related causes and to work to improve the health, quality of life and wellbeing of people living with HIV.

**Current picture**

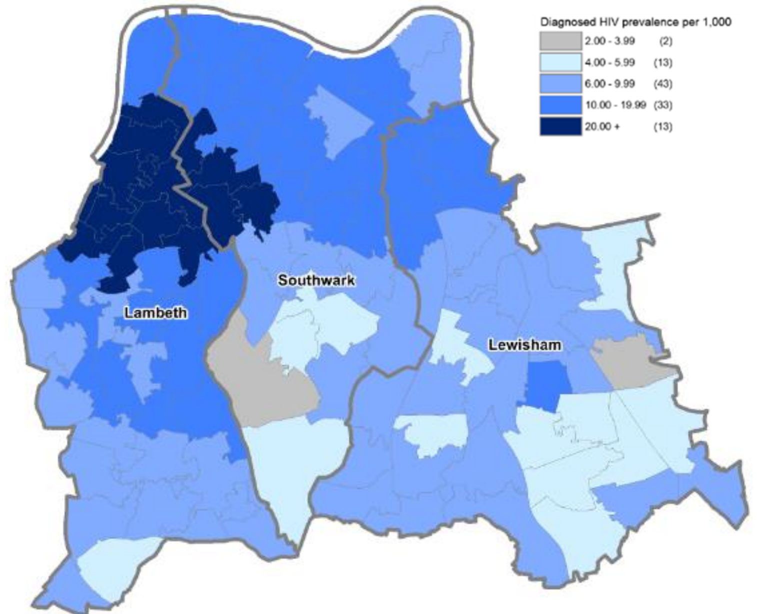
<u>Epidemiology and local needs</u>

*Prevalence*

Each borough in LSL exceeds the threshold for 'extremely high prevalence' (as defined by NICE and PHE) of HIV, and the region has the highest rates of HIV in England.

Prevalence in Southwark and Lewisham has fluctuated little in the past five years and is approximately 12.2 per 1,000 people aged 15-59 in Southwark and 8 per 1,000 in Lewisham. In Lambeth, HIV diagnosed prevalence increased up to 2015 but declined in 2017, and is currently 14.6 per 1,000 people - the highest prevalence rate in the country.

There is considerable variation in diagnosed prevalence rates across LSL as illustrated below, and a disproportionate number of new diagnoses are in the most deprived areas (particularly in Lambeth).




Diagnosed HIV prevalence per 1,000 population by MSOA (2017)

Certain population groups are more likely to be affected by HIV, namely MSM and people identifying as black African. The high prevalence of diagnosed HIV in LSL is driven by a range of factors. All three boroughs have high population turnover, including high rates of external migration. LSL also have a high population of LGBTQI+ people and very diverse populations in terms of ethnicity. Lambeth and Southwark are estimated to have the first and second highest gay and lesbian populations in the country respectively and while there are no estimates available for Lewisham, we can make an assumption of at least 2.7% which is the estimate for London. Additionally, with high rates of HIV among the black African population, our boroughs' ethnic make-up is a significant driver; across LSL, people identifying as black African account for 11% of the population aged 15 years and over.

*Testing*

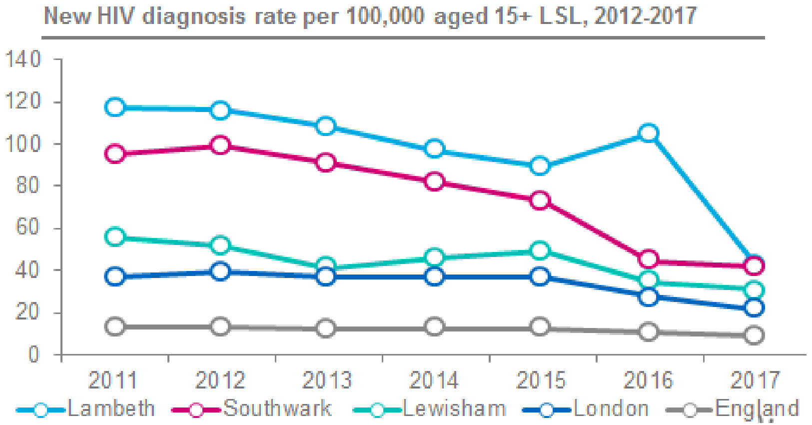
HIV testing, including frequent testing among those most at risk of HIV, continues to be one of the most important interventions to identify infection and prevent onward transmission, and is one of the four Do It London strategies to prevent HIV. Providing access to and encouraging testing in our resident population will reduce the number of undiagnosed residents, reduce the time period over which infected individuals are not receiving treatment and prevent onward transmission.

HIV testing coverage is used to monitor progress towards national recommendations on increasing testing and is defined as the proportion of 'eligible new attendees' to specialist sexual health services in whom an HIV test was accepted. Performance against this indicator is poor in LSL where coverage in all boroughs has consistently trended below the overall London rate. There is a decreasing trend in testing coverage in Lambeth and Southwark, though coverage has increased in Lewisham. Given the high prevalence of HIV in LSL, poor performance against this indicator is concerning and we will seek to better understand and address this. We will also encourage increased testing in primary care and A&E settings.

The coverage indicator measures only those tests offered and accepted within specialist sexual health services and therefore does not capture those accessing testing privately, via online channels or in alternative settings (e.g. general practice, hospital settings). Access to testing through specialist services will also show a systematic bias towards certain high-risk groups, such as MSM, who are more likely to access these services regularly.

*New diagnoses*

Total new diagnosis rates have continued to decline nationally year on year. Since 2015, LSL have seen a decline in key risk groups where rates have previously remained stable: MSM and the Black African population. The 2017 PHE report *Towards elimination of HIV transmission, AIDS and HIV related deaths in the UK* suggests that the decline among the Black African heterosexual population is likely due to changes in migration patterns, with fewer people arriving from high HIV prevalence countries, though this is being reviewed.

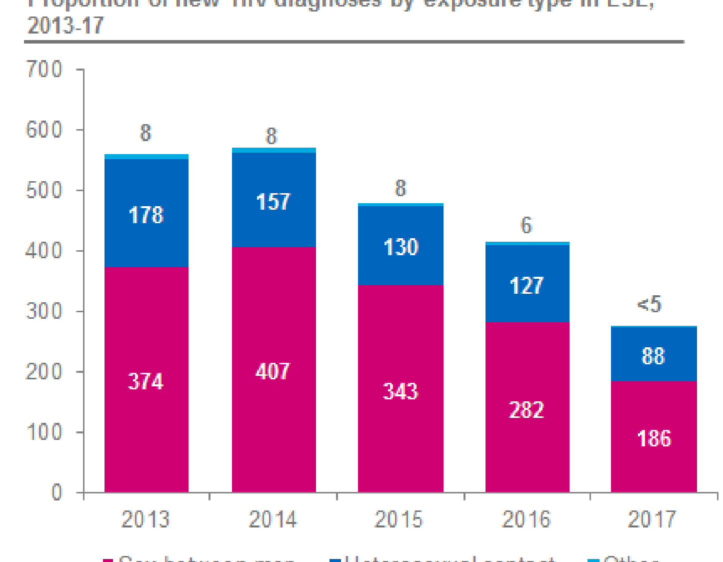


However, the decreasing trend in new diagnoses has not been seen across all populations and there has been no significant change in Lambeth and Lewisham, though rates have decreased in Southwark. New diagnoses in heterosexual women and Black African men also remain disproportionately high. Sustained effort therefore continues to be required to reduce new infections and onward transmission.

Rates of new diagnoses among residents of LSL continue to trend above both national and London rates, though there are differences between the three boroughs as seen in the figure above.

Our epidemiological review revealed that in LSL in 2017:

- Rates of HIV diagnosis are highest among those aged 35-64 years.
- The majority (76%) of HIV diagnoses are in men.
- Of all men diagnosed with HIV, 64% were white, and of all women diagnosed with HIV, 64% were Black African.
- Sex between men accounts for the majority (53%) of new HIV cases, followed by heterosexual female (14%) and heterosexual male (13%) exposure (as per figure at right).




By understanding the profile of those diagnosed, we can target ongoing efforts to tackle HIV through combination prevention approaches – for example through commissioning community-focused services targeted to black African and Caribbean communities and MSM across LSL.

*Late diagnoses*

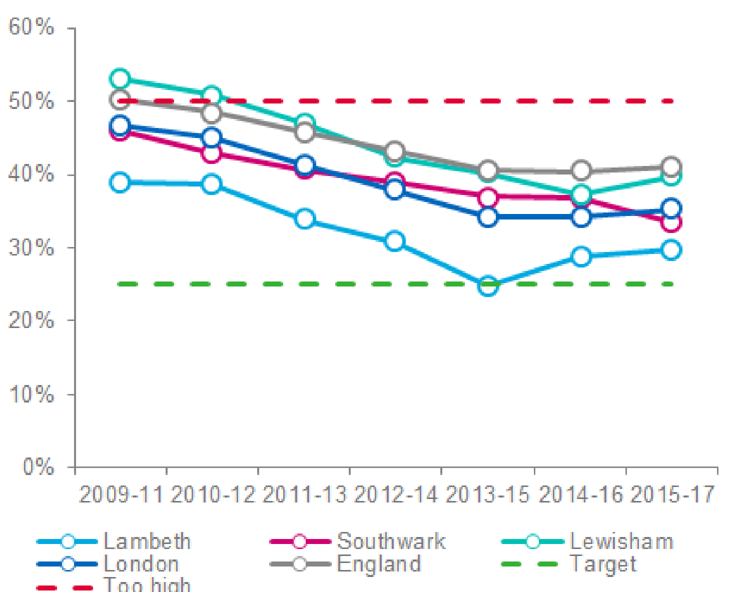
Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services, reduced response to antiretroviral treatment and increased risk of onward transmission of HIV. People diagnosed late have a ten-fold risk of death compared to those diagnosed promptly. Reducing late diagnosis is therefore a critical target in our strategy.

Over time, fewer people in LSL are receiving a late HIV diagnosis and efforts to increase testing through a variety of routes (including online and a range of community and healthcare settings) appear to have contributed to this downward trend from 2009-11 to 2015-17.

However, across LSL in 2015-17 more than 25% of people diagnosed with HIV were diagnosed at a late stage of the disease. Late diagnosis was highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2015-17.

In 2016, certain groups had a higher proportion of people with late diagnosis, including those aged 50-64 (53%), those identifying as black African (49%), those identifying as 'other' ethnicity (46%), those whose route of transmission was through heterosexual contact (59%), and women (55%).

These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. We know that women and BAME groups are less likely to accept HIV testing and this is reflected in higher rates of late diagnosis. Regular testing is a good way to identify HIV early and routine or opportunistic offers of HIV tests by healthcare professionals (outside of sexual health services) have been shown to be acceptable and facilitate greater uptake of testing, especially in at-risk African communities.




A multi-faceted approach is needed to tackle late diagnosis across LSL, including measures to encourage those at risk to come forward to be tested, and education and support for clinicians, particularly those working in primary care and A&E to improve their knowledge of HIV and testing, including raising the issue.

*Engagement in care*

Widespread use of effective ART has led to a significant reduction in morbidity and mortality among people living with HIV and is an effective means of reducing HIV transmission. The ‘U=U’ (undetectable = untransmittable) message is growing in recognition. However, individual and public health treatment benefits can only be achieved if PLHIV know their status, access care, and have sustained engagement with care on an ongoing basis. Poorer health outcomes are experienced among people living with HIV who engage poorly with care.

The UK has made significant progress in ART coverage in recent decades. 96% of those diagnosed are now accessing treatment and 94% are virally suppressed. In London in 2016, 97.2% of residents with diagnosed HIV were receiving ART. Of these, 96.6% were virally suppressed and were very unlikely to pass on HIV, even if having sex without condoms or use of other preventative interventions in partners such as PrEP.

More than 8,700 LSL residents accessed HIV care in 2016. This number has increased steadily in line with new diagnoses and an increased life expectancy. 98% of those accessing care in 2016 were on treatment. However, 2015 data indicates that there remain challenges in retaining a proportion of those diagnosed in care – with just 85% of those diagnosed retained within care at 1 year after diagnosis.

Substance misuse and mental health co-morbidities are risk factors for poor treatment adherence and level of engagement in HIV care is associated with multiple underlying causes and demographic, socio-economic and HIV-related factors. It’s therefore key that the services provided in LSL, both in specialist and mainstream community services, cater to the differing needs of PLHIV. A range of approaches are required to improve engagement with care, and we will continue to work to maximise engagement and support adherence to treatment across the boroughs.

PLHIV also have the primary role in managing their condition. Individuals, families and communities are assets that support self-management including:

- Providing information and perspectives about HIV and treatment
- Peer support, including understanding of and assistance with self-management skills
- Reduction in HIV-related stigma

Families of people living with HIV, including children, may also have particular health or social needs, as may younger people transitioning from children and young people's specialist HIV services to adult services. The needs of these and other specific groups will be considered when planning services.

One of the greatest successes of HIV care, research and activism is that PLHIV can now lead healthy lives and have similar life expectancies to those of the general population. In 2016, more than one-third of people accessing HIV care in LSL (35%) were aged 50 years and over, compared with 24% in 2012.

There is however evidence that PLHIV are more likely to develop diseases such as diabetes, kidney disease, liver disease and other long term medical conditions associated with age. In addition, a proportion of people experience side effects when taking ART long-term.

Some older people living with HIV can feel stigmatised by both their age and HIV status, and may suffer isolation and loneliness as a result.

Both specialist HIV and mainstream services in LSL and across London will need to adapt to this changing demographic of PLHIV. Co-coordinating care more closely with other health and care services that older people need and focusing on overall quality of life as well as clinical treatment will be essential. Exploring shared care models with primary care and planning for how HIV care will be coordinated with social care, for example in care homes, is essential.

**Achievements since the last strategy and ongoing challenges**

<u>Achievements since the last strategy</u>

LSL's 2014-17 sexual health strategy set ambitious targets to support PLHIV in leading healthy and fulfilling lives. These included increasing testing rates to ensure residents know their status and are on ART as quickly as possible. We implemented the following projects and system changes:

- Introduction of HIV testing in acute and primary care settings.
- Development and implementation of online STI and HIV self-sampling service, SH:24. This innovation inspired London to procure an online STI and HIV self-sampling service on behalf of 27 London boroughs, Sexual Health London (SHL), which LSL has now adopted. In addition, LSL bought into the national online HIV self-sampling service, Test.HIV.
- Lambeth host and commission on behalf of London boroughs the London HIV Prevention Programme which runs an award-winning campaign, 'Do It London', to increase testing and safer sex behaviours, and also has an outreach programme that works with MSM to encourage testing, give advice and increase knowledge around prevention methods.
- Implemented recommendations of the 2010 HIV care and support review, making changes to our local service offer towards an integrated care model in line with the HIV now being a manageable long-term condition. This work has included piloting HIV clinics in GP surgeries and improving the competence and capacity of mainstream advice, welfare and other agencies to respond to the needs of people living with HIV in line with support for those with other long term conditions.

- At King's College Hospital NHS Foundation Trust, work has been undertaken to review the needs of patients aged over 50, review IT solutions to support integration of primary and specialist care, improve communication between clinicians and potentially develop training for GPs to support integrated care.

These achievements were enabled by workforce developments that saw the introduction of more appropriate staff skill mixes to better serve the needs of patients and service users and improving training standards in sexual health.

<u>Ongoing challenges</u>

*Tackling stigma and discrimination*

HIV-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at PLHIV. Though it is 30 years from the start of the HIV crisis, stigma and misconceptions around HIV remain and are a barrier to HIV prevention, testing, treatment, care and support. In 35% of countries with available data, over 50% of people report having discriminatory attitudes towards PLHIV.

PLHIV can face stigma, prejudice and discrimination in various spheres of life from services, in the workplace and from their family and friends. They may also experience that some non-specialist services are unable to meet their needs fully because of lack of specialist knowledge or training. These social aspects of the disease are less well understood, but can significantly impact on the ongoing health and wellbeing of PLHIV and their family and friends. Stigma and discrimination can undermine HIV prevention efforts by making people fearful to seek information on HIV information, access services and adhere to treatment.

*Providing the right combination of services for the health care of all people living with HIV*

PLHIV in LSL are a diverse group of people whose health needs will change as they age. It is critical that HIV specialists and other services continue to evolve to meet the needs of PLHIV including the management of co-morbidities and other complex health conditions and that they reflect all members of the community that they serve.

Whilst early diagnosis and effective treatment means that people living with HIV can age well, the inevitable effects of ageing cannot be avoided and growing older with HIV can increase the chance of experiencing age-related illnesses earlier. PLHIV also have higher rates of mental health-related co-morbidities than the general population and substance use and addiction disproportionately affect people with HIV.

With increasing numbers of people living and ageing with HIV there will be increasing pressures on a range of services including specialist, primary, mental health and social care services. Complex and fragmented commissioning arrangements, and ongoing budgetary constraints across health and social care, could contribute to a lack of joined up care for PLHIV.

Given HIV is increasingly managed as a chronic disease, and along with other changes in health policy, there is a shifting in the emphasis of care towards partnership between specialist centres and primary care. LSL HIV services must learn from other existing models for co-ordinating long-term care (such as those for cancer) that have similarly evolved from providing specialised treatment to including long-term care, and adapt them as appropriate.

Work at KCH and with other partners towards understanding and designing the elements of a truly integrated care model for PLHIV in LSL has been ongoing for a number of years and actions stemming from this strategy will seek to support and further these efforts.

*Undiagnosed and those not on treatment*

There are estimated to be around 1,000 people living in LSL who are unaware they are living with HIV. Reviewing and increasing our testing activity (particularly in primary care and A&E), ensuring we are testing the right people, and targeting those identified through profiling people who are diagnosed late will be critical to reduce the numbers of undiagnosed. This will include raising awareness among clinicians in general practice and secondary care settings of some indicator conditions that may suggest someone living with an undiagnosed HIV infection.

With the increasing incorporation of e-services in the sexual health system across London, service users must receive appropriate behaviour change messaging to ensure HIV tests are selected whenever possible.

Some residents who receive a diagnosis of HIV decline treatment or are lost to care, putting their health at risk and increasing the risk of onward transmission. Clinical and community outreach services will continue to target most at risk populations.

*Data monitoring*

Monitoring and the ability to assess the impact of the interventions are dependent on good quality data. HIV and AIDS reporting system (HARS) provides some of the best surveillance data internationally, but this system relies upon complete data being freely given by individuals who trust in the confidentiality of the system, and also being collected, recorded and returned in a timely and accurate manner.

Emerging issues and trends

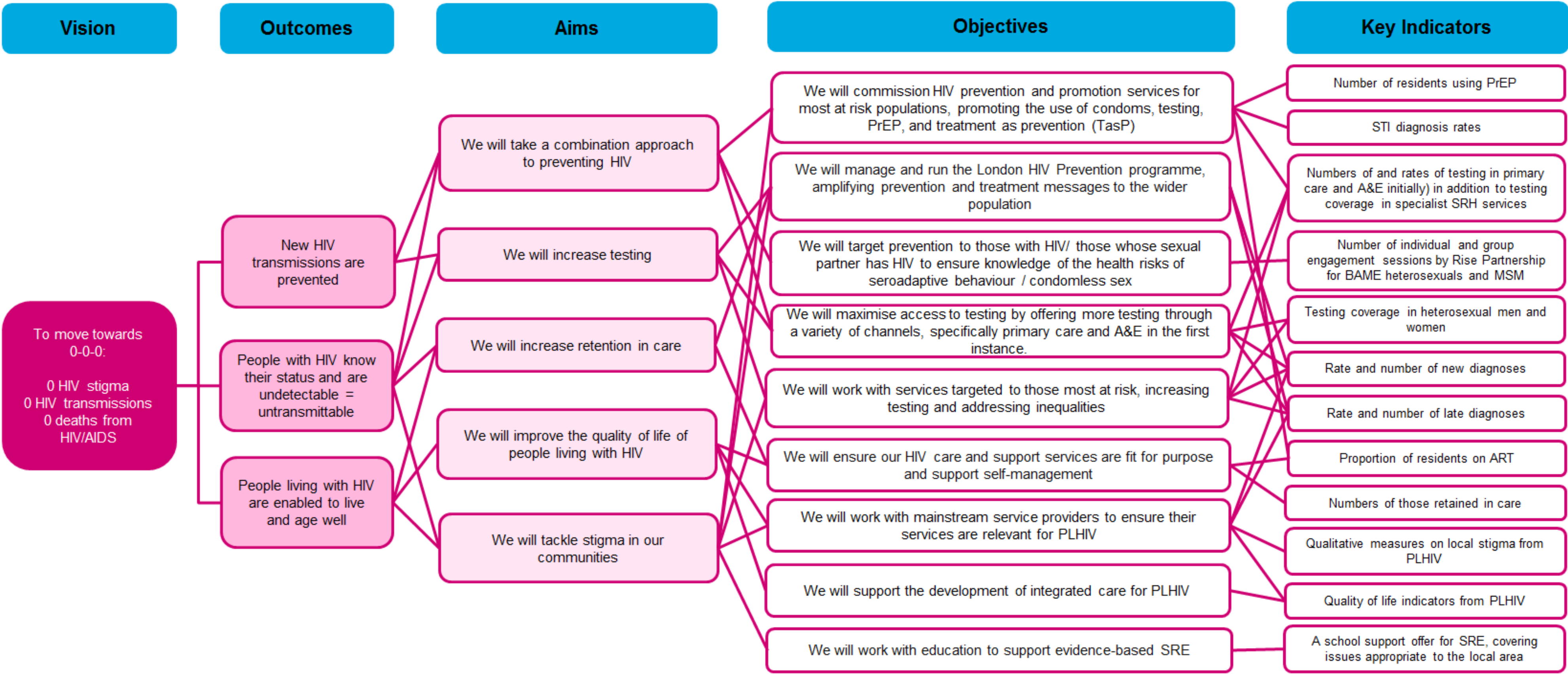
*PrEP*

Pre-exposure prophylaxis (PrEP) is highly effective in reducing the risk of acquiring HIV. PrEP is not currently available on the NHS (aside from the Impact trial) but the private purchase of PrEP has been increasingly popular in recent years, particularly amongst MSM, and is supported by testing at sexual health clinics. The PrEP Impact trial is currently recruiting 13,000 participants who are at a high risk of HIV, across England, to assess the need and demand for PrEP in those accessing sexual health clinics, and the likely benefit of its use in England. By late October 2018, 9,226 participants had been recruited across 140 sexual health clinics.

Although PrEP is highly effective for preventing HIV infection, research is beginning to highlight an associated decrease in consistent condom use and increase in STIs among MSM using PrEP. A reduction in condom use could also undermine PrEP's population level effectiveness if people stop using condoms and do not use PrEP consistently.

## Living well with HIV: what we want to achieve by 2024

The figure below sets out our vision for improving the lives of PLHIV in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year. London has signed up to the Fast-Track Cities target of 0-0-0 (0 HIV stigma, 0 HIV transmissions, 0 deaths from HIV/AIDS). The vision for Lambeth, Southwark and Lewisham is also to move towards achieving this. Therefore, in addition to the specific indicators listed below, we will look to measure overall progress towards this vision, using any future indicators agreed at a London level.



## 7. How we will deliver our vision

The figures on the previous pages provide the map for how we will achieve our shared vision for sexual and reproductive health in LSL by 2024, and the indicators through which we will measure our progress.

However, we recognise that within LSL, some areas have further to progress than others and there will be local factors that are not applicable to other boroughs. Therefore, each borough will have an annual action plan which will include specific steps to deliver this strategy, which will form part of the Public Health business plans. This approach to a joint strategy allows us to collaborate on many areas, but take local action as needed.

Progress against the strategy will be reviewed annually by the LSL Sexual Health Commissioning Partnership Board, which comprises commissioning, Public Health and CCG representatives from each of the three boroughs. Shared actions to deliver this strategy will also be overseen by this board.

This strategy also forms a key part of each borough's Health and Wellbeing Strategy, and so progress will be reported to each of the Health and Wellbeing Boards as locally appropriate.

**- End of document -**

# Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019-24

## Summary of the evidence

Lambeth, Southwark, and Lewisham
Public Health Departments

August 2018

## What is this document?

This document summarises the evidence and good practice underpinning the LSL Sexual and Reproductive Health Strategy 2019-24. The four chapters of our strategy draw on these evidence reviews and the accompanying intelligence pack to set out our plans for the coming years. References for all evidence and statements within our strategy are provided within this document, and not within chapters themselves.

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## HEALTHY AND FULFILLING SEXUAL RELATIONSHIPS

Social relationships are an important determinant of health and wellbeing across the life course. A positive familial environment provides children with secure attachment and a healthy blueprint for future relationships.[1] Exposure to domestic abuse and unhealthy relationships, as a victim or witness, is associated with poorer emotional wellbeing and physical health.[2] The mental and physical consequences of abuse may increase a victim's risk of further exploitation and may be associated with related risk factors for poor health, such as substance misuse and risky sexual behaviour.[3, 4] In some cases, domestic abuse is cyclical and those who were themselves victims may go on to perpetrate abuse or continue to enter into unhealthy interactions.[5] For this reason, developing an understanding of healthy relationships early in life is critical to equip young people with the knowledge, confidence and control to engage in healthy interpersonal relationships.[6]

Comprehensive relationships and sex education (RSE) contributes to a young person's safety by supporting them to navigate through their own developmental changes and helping to prevent exploitation or abuse. Despite this, schools have had no statutory responsibility to provide comprehensive RSE and the most recent government guidance is now 17 years old.[7] In Lambeth, Southwark and Lewisham (LSL), RSE is largely taught through science and through personal, social, health and economic (PSHE) education programmes at school. PSHE sits alongside the national curriculum and covers three broad themes: health and wellbeing, relationships, and living in the wider world. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions, sexually transmitted infections (STIs) and in increasing reporting of sexual exploitation and abuse.[7-9] Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up,[10-12] highlighting the importance of appropriate RSE. However, important issues such as coercion, navigating the practicalities of consent, social media, online safety and same-sex relationships are topics poorly covered by current curricula.[7] The majority of young men and women surveyed in the recent Natsal-3 report felt they should have known more when they first felt ready to have some sexual experience;[12] 62% of these cited lessons at school as their primary source of sex education. Among the additional topics they wanted to learn more about were sexual feelings, emotions and relationships. Alongside a focus on risk and unhealthy relationships, high quality RSE should emphasise the positive aspects of healthy sexual relationships, including negotiating the sex that you want. A recent national survey revealed that 60% of students hadn't learned about sexual pleasure.[13] Young people should not be dissuaded from sexual relationships for fear of coercion or abuse. Instead, they should be properly equipped with the necessary information to negotiate safe and pleasurable sex when and how they want it. In order to deliver frank discussions around sex, however, teachers must be open and comfortable discussing the topic. Unfortunately, qualitative studies from the UK and abroad have highlighted that many teachers feel uncomfortable or embarrassed having these conversations.[11]

As of September 2020, RSE will become statutory across the UK, a delay on the anticipated 2019 start-date.[14] This affords schools (maintained, academy, and independent) the opportunity to develop – alongside health professionals – comprehensive, relevant lessons that address these reported inadequacies and capitalise on our knowledge of vulnerable groups, in particular the lack of RSE sufficiently inclusive of our vulnerable women, young LGBTQI+ people and others. Topical issues of consent – what it looks like, giving it, understanding it can be withdrawn – will also be included. In primary schools, the subject will be taught as 'relationships education,' extending to 'relationships and sex education' in

secondary schools. Schools have flexibility in how these subjects are taught and parents retain the right to withdraw a child from RSE, as they do currently.

The strategic direction for sexual assault and abuse services over the next five years (2019-2024) has been set out by NHS England[15] and echoes this emphasis on prevention. It recognises the increasing role of the internet in sexual assault and abuse and the difficulties faced by vulnerable groups (e.g. LGBTQI+, BAME, and those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource in navigating sexual experiences and can help people of all ages to develop an awareness of unhealthy behaviour and the confidence to address it. Facilitating healthy and fulfilling relationships is therefore important in preventing future unhealthy relationships and poor reproductive health, and reducing the risk of acquiring STIs and HIV. It is an integral part of a holistic sexual and reproductive health strategy.

Knowledge of healthy relationships is an important tool for all children and young people. However, some are more likely to suffer from unhealthy sexual experiences and relationships and thus may have additional need for information about risk factors and warning signs. Women are disproportionally affected by domestic violence across the life course and are nearly twice as likely to have experienced domestic abuse than men.[16] The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported crime.[17, 18] Coercive or controlling behaviour was introduced as a new offence in December 2015[19] and research has suggested that these behaviours are highly gendered, with women being the predominant victims.[20] The Crime Survey for England and Wales was updated in 2017 to include related questions to better capture the nuanced aspects of unhealthy relationships and abuse.[16]

From the age of 16, 49% of gay and/or bisexual men report experiencing at least one episode of domestic abuse. This is compared to only 17% of men overall.[5] The prevalence of abuse among transgender people is even higher: 80% reported experiencing emotional, physical or sexual abuse from a partner or ex-partner in 2010.[21] Despite the prevalence of domestic abuse in these populations, over half (53%) of lesbian, gay, and bisexual young people are never taught about homosexual sex and relationships issues at school.[22] The lack of information available in traditional settings such as schools may drive some young people to seek advice and support from adult-oriented groups, for example online forums where they may be vulnerable to exploitation.[23] Rates of intimate partner violence are higher among those with a physical or mental disability; they are between two to three-fold higher odds of being a victim.[24] In addition, any child living in a household in which there is intimate partner violence or a regime of intimidation or control is at increased risk of experiencing, and also perpetrating, violence as an adult.[5] While many of these children may be reached by school-based interventions, special attention should be paid when they come into contact with health or social services. RSE lessons must therefore be inclusive of all levels of disability, sexual orientation, and life circumstances to ensure equal access to information.

The term ‘chemsex’ has become prominent in some parts of the MSM community and describes sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL and mephedrone. Locally, we know that our population of MSM are more likely to take drugs associated with chemsex than MSM elsewhere in London or England.[25] These substances pose a significant health risk and risk of overdose. Anecdotal evidence from qualitative research in Southwark revealed an increasing mental health risk (including low self-esteem) for those who partake in chemsex.[26] Vulnerability and risky sexual activity were also a common concern as maintaining control of behaviour and choices while under the influence of chemsex drugs may be difficult. As sexual health commissioners, we

need to ensure that people in risky sexual relationships are also appropriately supported to make safe and healthy decisions.

Child sexual exploitation (CSE) is a significant concern in LSL as it is elsewhere, and we know through internal analyses that exploitation is linked with gang-related activity and with drug running across county lines. The responsibility of safeguarding children and identifying exploitation should be embedded within all professional practices. Children and young people at risk for, or currently being sexually exploited may present with physical injury, addiction, poor mental health and repeat use of emergency hormonal contraception, among others, and may interact with a range of professionals.[27] Training on identifying and referring cases of CSE should therefore be available across all services. Sexual health professionals are uniquely placed to discuss sexual activity and relationships with a young person and should be mindful of deteriorating health, disclosure of multiple partners or repeat visits for STI treatment.[27] Schools reach the majority of children and therefore have an important role to play in both preventative education and identifying CSE and abuse.[28] They tend to see the same group of children over time and can identify changes in behaviour or health. Evidence suggests that education programmes may increase the likelihood of a child disclosing abuse[29] and that a whole-school approach of zero tolerance for abuse, alongside longer-term lessons through RSE that teach young people about healthy relationships may be effective in preventing CSE.[28, 30, 31]

In the current landscape, young people face a plethora of emerging challenges that are becoming increasingly difficult to navigate. Relationships are now conducted with a growing online element. Sexting may be construed as modern-day flirting, however, sending explicit photographs among under 18-year-olds is a criminal offence.[32] Similarly, new forms of online abuse such as revenge porn (the non-consensual sharing of sexual content) are becoming increasingly recognised offences.[33] It is therefore critical that young people be informed of how to operate safely online. Notre Dame RC School in Plymouth was recently highlighted by Ofsted for their modernised PSHE programme.[34] At the suggestion of sixth form and year 10 students, they implemented peer-led workshops focusing on social media, coercion, and how to end a relationship safely. Students particularly liked being taught by older students and reported feeling more comfortable engaging with them on these topics.[34] Highlighting the grey areas before abuse begins may empower students to identify and prevent an abusive relationship from developing.

Findings from the 2016 Healthwatch Southwark report, 'Young Voices on Sexual Health,' revealed that education about healthy relationships was sparse and inconsistent across different schools.[35] Details about what constitutes a healthy or unhealthy relationship and how to spot the signs of abuse (beyond physical) were reported as lacking. When asked about how they would prefer RSE to be provided, young people vocalised a desire for an open, interactive discussion with professionals, more information on the emotional and social aspects of sex and a general inclusion of healthy relationships. Healthwatch Lewisham ran a series of workshops with young people aged 11-19 years in 2017 and found that 'relationships and sex' was the issue most concerning to young people and their peers.[17] Additional gaps in knowledge were identified in the legal consequences of sexting that, despite its prevalence in this age group, remained largely undiscussed in RSE.[17] Qualitative research identifying best practice in RSE has suggested that young people prefer to be taught by someone other than a teacher or tutor, as it might be uncomfortable or blur boundaries between them.[36] Peer educators were well respected, however, their credibility was in some cases undermined by youth. External sexual health professionals were preferred as they were perceived as providing greater confidentiality.[36]

Empowering people to define the terms of their sexual relationships and use contraception when desired is an important part of protecting sexual and reproductive health (SRH). Ensuring the equality and accessibility of our contraception services remains a local priority. For young people under 25, condoms and sexual health information are available free of charge through the pan-London distribution scheme Come Correct, delivered by Brook across LSL. Condom distribution schemes were recently evaluated nationally and found to be successful in engaging young people. This is reflected in the high number of repeat users (compared to new registrations) locally.

For LSL's young and diverse population, knowledge and guidance about healthy relationships is an important resource in navigating their own sexual experiences; this is largely provided by school-led RSE. These lessons could benefit from integrating input from young people, such as employing external educators and widening the breadth of discussion to increase engagement in both the messages being delivered, and in local services. While information should be made available universally, vulnerable groups such as children exposed to domestic abuse, LGBTQI+, and children and young people with disabilities may benefit from targeted support.

## GOOD REPRODUCTIVE HEALTH ACROSS THE LIFE COURSE

Reproductive health is important across the life course and can impact overall health at any stage. Consequences of poor reproductive health exacerbate inequalities in health, education and socio-economic status.

In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year.[37] Some unintended pregnancies do not lead to live-births; 52% and 12% of unplanned pregnancies are estimated to end in abortion and miscarriage respectively.[38] Having a child can put enormous financial and emotional pressure on couples and children born to mothers under the age of 20 have a 63% higher risk of living in poverty.[39] Moreover, teenage mothers themselves are 22% more likely to be living in poverty by age 30, compared to first time mothers over 24 years.[39] One in five 16-18 year-olds not in education, employment or training is a teenage mother.[39] Both physical and emotional health may also be affected. Sexually transmitted infections (STIs) such as chlamydia and gonorrhoea can cause pelvic inflammatory disease, which may increase a woman's risk of ectopic pregnancy or infertility.[40] Human papilloma virus (HPV) can cause genital cancers in men and women that, in some cases, may lead to infertility.[41, 42] Difficulties conceiving may strain relationships and cause stress to both mother and father. Furthermore, postpartum mental health in the three years following birth is likely to be poorer in mothers under 20 years.[39]

Reproductive ill-health incurs financial costs to the individual and to the state. For example, unplanned pregnancies leading to maternity may have long-term costs to local authority housing, education, and social care.[43] Teenage pregnancies may, in some cases, be costly to both mother and child with regards to earning potential and future employment.[43] Terminating a pregnancy has direct costs to the NHS: in 2010, approximately £143m was spent on abortions.[44]

In contrast, publicly-funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years.[38] Benefits include savings that result from avoiding unwanted pregnancies, including healthcare costs (for example birth costs, abortion costs, miscarriage costs and ongoing child health care costs) and non-healthcare costs (such as education costs, welfare costs, children in care costs). Good reproductive health therefore not only is essential contributor to good overall health and wellbeing, but also yields savings for public services.

In the UK, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore requiring contraceptives.[40, 45] The median age of first heterosexual intercourse is considered to be 16 for both men and women,[46] though national estimates suggest almost one-third of young people have had sex before this age.[47] Most information pertaining to reproductive health for young people is provided by relationships and sex education (RSE) lessons, parents, and health professionals,[10] however, there are notable issues in awareness of free and available reproductive health services among young people. A 2016 survey of school-aged children in Lambeth, Southwark, and Lewisham (LSL) revealed only 20% of young people reported knowing where to get free condoms[48-50] and STI rates in young people are higher in LSL than the regional and national average, and than in other age groups. This suggests a missed opportunity to embed discussions of contraception when treating young people with STIs and to promote good overall sexual and reproductive health (SRH).

Unfortunately, challenges remain in ensuring equality in knowledge of contraceptive options and access to preferred methods. The rate of under-18 conception is consistently higher across LSL compared to London and England,[51] which represents an unmet need in contraception care as well as a failure to comprehensively tackle the wider determinants of teenage pregnancy. Moreover, this suggests a lack of awareness of or confidence in accessing other more effective methods of contraception. Long acting reversible contraceptives (LARC), in contrast to user-dependent methods ((UDM) e.g. condoms, oral contraceptives (OC)), do not depend on daily concordance and have been proven more clinically effective than OC at only one year of use.[52] Despite these benefits, uptake remains low in the UK at about 12% of women aged 16-49, compared to 25% for OC and 25% for male condoms.[53] In Lambeth and Lewisham, the rates of GP-prescribed LARC have remained relatively stable since 2011.[51] In Southwark, the rate has decreased to 7.5 per 1000 women, the fifth-lowest rate among London boroughs.[51] This suggests that barriers remain in communicating the benefits of LARC or in ensuring that women of reproductive age have easy access to the full range of contraception, including LARC.

RSE in schools provides an opportunity to reach young people at risk for becoming pregnant and deliver messages around contraception and reproductive health. These should be accurate and aligned with information from healthcare professionals. Advice relating to contraception should be culturally appropriate, non-judgemental, and given according to the needs of each individual.[47] An example of best practice is highlighted in Shropshire County Council, who invested in their RSE curriculum to tackle high levels of teenage pregnancy. Collaboration was achieved between school nurses, parents, and school staff in order to train teachers to deliver targeted, evidence-based messages on reproductive choices and challenges.[39]

Pharmacies play a vital role in offering accessible SRH services, in particular to young people who may feel uncomfortable visiting their GP or a sexual health clinic. Pharmacies tend to have consistent and long opening hours, allow for relative anonymity, do not require appointments, and are usually more conveniently located than GP surgeries or sexual health clinics.[47, 54, 55] However, the current model of sexual health provision in pharmacies across LSL is disjointed and is not contributing to improved reproductive health outcomes. LSL has high rates of abortion and repeat abortion, and highly accessed emergency hormonal contraception (EHC) services at pharmacies. In Lambeth and Southwark, 80% of women accessing EHC declared previous use and, in Southwark, 50% of these had used EHC in the past 6 months. Under the current model of provision, most pharmacies are unable to provide on-going contraception alongside EHC and must refer to GP or sexual health clinics. This fragments the patient pathway and increases the risk of unmet contraceptive need and unintended pregnancy. In response, sexual health provision in pharmacies across the three boroughs is being reshaped to most effectively support women seeking contraceptives and reproductive and advice.

Online offers of contraception may also be a way of improving access. The Southwark- and Lambeth-based online service SH:24 has been delivering online OC since March 2017 as part of a pilot scheme, providing free OC to local women. The service has also begun an offer of paid OC for women not living in Lambeth and Southwark, which has proven extremely popular. While private supply of contraceptives is not suitable for everyone, the observed demand has demonstrated it is an acceptable way of improving access for a subset of the population.

Finally, school- or community-based drop-in clinics can be an effective method of reaching young people and improving their access to SRH services. Bristol City Council successfully established a network of drop-in clinics at secondary schools, run by a sexual health nurse

and youth worker. They were able to reach nearly two-thirds of the population of young people; 5,000 pupils attended a drop-in service in one year to discuss healthy relationships, contraception, and sexual health.[39]

Contraceptives such as condoms should also be made available in non-traditional settings, for example at leisure centres and libraries, to improve access for young people. The pan-London condom distribution scheme Come Correct is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'c-card'. C-card schemes for condom distribution were recently evaluated nationally and found to be successful in engaging young people.[56] High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable.[56] In LSL, there has been an increase in c-card registrations and in repeat users, compared to 2016.[57] These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.[10]

The reproductive health of both men and women may be affected by some STIs. HPV is of particular concern for its ability to cause cancer of the cervix, vulva, vagina, penis and anus. While not all types of HPV cause cancer, an estimated 90% of cases of anal cancer relate to HPV infection.[42] and, of the approximate 3,100 cases of cervical cancer reported each year in the UK, nearly all are related to viral infection.[41] In 2011-2013, Lambeth had the highest rate of cervical cancer registrations of all London boroughs.[51] Sexually active individuals should be reminded of the importance of condoms in reducing the risk of contracting HPV (and other STIs) through intercourse.[41] Since 2008, a vaccine against the two most common cancer-related types of HPV has been available free of charge to girls aged 12-18 through the NHS.[58] At present, the NHS does not offer the vaccine to young men, despite the relationship between HPV and male cancers.[58] However, in April 2018, Public Health England introduced a nationwide HPV vaccination programme for men who have sex with men aged 45 or younger, as this group is likely to receive little indirect protection from female vaccination.[59] All women aged 25 or over, irrespective of vaccination status, are invited for cervical screening through the NHS Cervical Screening Programme.[60] The programme aims to identify abnormal cervical cells early to prevent the development of cancer. Most treatment for cervical cancer will result in infertility.[60]

Some unintended pregnancies, regardless of the age of the mother, will become wanted; however, a proportion will result in termination. Access to safe and legal abortion care, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Since our previous strategy, access to high quality abortion services has improved; however, inequalities persist across LSL in terminations of pregnancy (TOP). The TOP rate per 1,000 population is consistently higher among Black African and Black Caribbean populations in the three boroughs, reaching over 50 per 1,000 population in some areas.[61] LSL should seek to address the underlying drivers of these inequalities, for example cultural preferences for barrier methods of contraception.[62]

After delivery or between pregnancies is an often unrecognised period during which women require effective contraception.[63, 64] Short inter-pregnancy periods increase a woman's risk of complications in the subsequent pregnancy, including preterm birth, low birthweight and stillbirth,[65, 66] and thus present a critical time to intervene. Furthermore, during pregnancy, women are frequently in contact with healthcare professionals and are therefore accessible to information about, and supply of contraception. This is especially important for vulnerable women who are at high risk for future unintended pregnancy (i.e. young women, women who have had previous children removed).[67] National guidelines recommend that professionals providing care to pregnant women be able to offer their chosen method of contraception following pregnancy or termination, or facilitate access to these services.[67] Female and male

sterilisation should be included among the range of available methods of contraception discussed within the context of a patient's individual circumstances.[68] Support for effective, appropriate contraception should continue for as long as a patient is sexually active, extending through menopause and into old-age.

Good reproductive health is thus reflective of a comprehensive, whole-system approach to reproductive wellbeing that offers support from adolescence through to old-age. At any reproductive stage, individuals should understand the range of contraceptive methods available to them and be aware of how best to access them.[69] Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services. As people move through life, their personal circumstances should continue to be at the centre of the discussion of preferred contraceptives, ensuring they continue to enjoy safe and healthy sexual relations.

## HIGH QUALITY AND INNOVATIVE STI TESTING AND TREATMENT

Sexually transmitted infections (STIs) facilitate the transmission of HIV, cause a number of cancers and contribute to poor sexual and reproductive health and overall wellbeing.[70, 71] The sequelae of untreated STIs include infertility, ectopic pregnancy, and harmful impacts on mental health and sexual relationships.[52, 72, 73] Furthermore, STIs are a significant contributor to health inequalities, which in turn increase a person's risk of poor sexual health and limit their access to prevention, testing and treatment; STIs remain one of the most common acute conditions. A total of 422,147 new diagnoses of STIs were reported for England in 2017, of which 48% were chlamydia, 14% genital warts, and 11% gonorrhoea.[70, 71] The overall number of new STI diagnoses in 2017 was similar to that of the previous year, however, there have been notable differences in the trends of particular infections.[70, 71] Syphilis and gonorrhoea diagnosis rates increased by about 20% relative to 2016, there was a 7% relative decrease in genital warts, while chlamydia incidence remained stable.[71]

Lambeth, Southwark and Lewisham (LSL) have historically had some of the highest national rates for STIs. In 2017, Lambeth had the highest rate of new STI diagnoses in England in 2017, followed by Southwark in third, with Lewisham 11th.[51, 74] This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse, and mobile populations.

To reduce inequalities, we need to improve the sexual and reproductive health (SRH) of key groups including young people, men who have sex with men (MSM), and Black and minority ethnic groups (BAME).[40] Lambeth, Southwark, and Lewisham residents are predominantly young, with a larger proportion of the population aged 25-34 years.[51, 75] We are also more ethnically diverse than England: approximately one quarter of LSL residents are from a Black ethnic background. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay, and bisexual communities in England.[74] We therefore have a large population at higher risk of poor sexual health.

Tackling the burden of STI requires both disease-specific interventions as well as wider intervention at several levels as detailed in national guidance.[40] At the population level, it is integral to build an honest and open culture and reduce sexual health stigma, while at the community level it involves ensuring adequate access to contraception such as through condom distribution schemes as well as access to testing and treatment of STIs in a variety of settings, especially for high risk groups.[40] Screening for common STIs like chlamydia should be offered routinely and opportunistically to young people. Protecting people against reinfection through having timely and effective treatment, and appropriate and effective partner notification pathways in place is crucial. Incorporation of education and access to correct and timely information is important plan and can be achieved through use of evidence-based online services and websites such as "Sexwise",[40] but importantly, starting early through effective delivery of RSE in schools.

Correct and consistent condom use remains the principal intervention for preventing STIs and reducing transmission. The pan-London condom distribution scheme Come Correct is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'C-card'. C-card schemes for condom distribution were recently evaluated nationally and found to be successful in engaging young people.[56, 77, 78] High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable. In LSL, there has been an increase in C-card registrations and in repeat users, compared to 2016. These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for contraceptives and may

otherwise miss out on SRH advice. Further work needs to be done, however, to engage BAME in these distribution schemes given contraceptive usage in general is lower in this population.[62]

Part of the success in managing to maintain such services through a financially challenging period has been through introduction of innovative methods of access. This is most apparent in web-based access to STI testing and treatment. A randomised trial conducted in Lambeth and Southwark in 2014-15 found that e-STI testing delivered through SH:24 increased uptake of STI testing across all groups including those at highest risk.[79] An added advantage of this method is that traditional structural and social barriers to STI testing may be overcome through online service delivery and home-testing.[80] Service innovations to improve STI treatment rates once diagnosis is confirmed vie e-STI testing continue to be active areas of research.[79] Self-testing online services have since been extended across London (now 'Sexual Health London') with the aim of freeing capacity at SRH clinics by targeting asymptomatic patients, ensuring those most in need of a face-to-face intervention receive one.

A diverse range of pathogens can be sexually transmitted and, while complications vary widely, all contribute to the burden of poor health.[40] Five STIs from the bulk of diagnoses seen both across England and in LSL: chlamydia, gonorrhoea, syphilis, genital warts, and genital herpes.[74] Several others such as shigella, hepatitis, lymphogranuloma venereum (LGV), trichomoniasis and molluscum contagiosum (MC) form a much smaller percentage of overall STI burden.[71, 79]

Chlamydia remains the most common STI diagnosed across England and LSL. In 2017, 9,000 cases were diagnosed in LSL with reported rates in Lambeth and Southwark over double that of London and triple that of England.[51, 74] Untreated chlamydia can lead to several gynaecological and urological complications such as pelvic inflammatory disease and epididymitis.[81] The chlamydia detection rate in 15-24 year olds is an important indicator of good sexual health.[72] All three boroughs in LSL have met and exceed the recommended rate of 2,300 per 100,000 people. Young people remain at greatest risk of chlamydia and annual opportunistic screening of sexually active people aged 15-24 years is recommended.[82] Chlamydia testing should be offered in a range of settings to increase opportunistic testing, including primary care, online, outreach and termination of pregnancy services, however, a decrease of around 8% in testing was observed between 2016-17 nationally.[71] This represents a continued decline that has only been somewhat compensated for by increases in the provision of online SRH services.[51, 83]

Rates of gonorrhoea diagnosis have risen sharply from 2016 to 2017 nationally and locally. This is particularly concerning alongside the increasing prevalence of azithromycin- and recently, ceftriaxone-resistant gonorrhoea.[84, 85] Gonorrhoea was the second most prevalent STI in LSL in 2017, with diagnosis rates 4-8 times greater in Lambeth (654 per 100,000), Southwark (565), and Lewisham (302) compared to England (79). Men in general have higher rates of diagnosis across all ages. In LSL, gonorrhoea remains concentrated in certain groups, particularly MSM and BAME.[51, 74] Similarly to chlamydia, frequent gonorrhoea testing allows for timely diagnosis, treatment, prevention of serious complications, and onward transmission through case and partner management.[85]

A syphilis outbreak was declared in 2017. Nationally, a total 7,137 cases of syphilis were reported in 2017, of which just under 1,000 were diagnosed in LSL residents.[71, 74] the disease can remain latent and asymptomatic for many years before manifesting with dermatological, neurological and cardiovascular symptoms.[86] Rates of syphilis diagnosis in Lambeth and Southwark were higher than in London in 2017, while rates in Lewisham were similar to England. Nearly all (98%) of cases in LSL were in men with those aged 35-44 most affected.[51] Syphilis is also most common among individuals who are at higher risk of other STIs, such as

HIV.[87] The highest number of cases of syphilis in over half a century were recorded in 2017 and, in response, PHE is developing an action plan to help address these rising rates especially among vulnerable groups.[40] This may require greater national coordination of efforts as well as innovative approaches such as targeted social media messaging to raise awareness of outbreaks when they occur.[88] Screening HIV-positive men and MSM for syphilis every three months has also been demonstrated to improve detection.[87]

Cases of genital warts continue to decline with a 90% decrease reported since 2009 nationally.[51] This decline has been mirrored in LSL though rates are still higher than the national average. The rate of diagnosis in Lambeth and Southwark (219 and 209 per 100,000 respectively) in 2017 was double that reported for England.[74] The introduction of a school-based HPV vaccine for girls is believed to have been the key driver in this reduction.[73] This success has instigated a roll out of the vaccine in MSM population to tackle increasing rates in this group.[71]

The incidence of genital herpes (HSV) has remained relatively stable nationally and in LSL. New diagnosis rates in London were 54 per 100,000 compared to Lambeth, Southwark and Lewisham respectively (148, 124 and 105 per 100,000). It remains the only STI which is more prevalent in women in LSL.[74] Many genital herpes infections are asymptomatic, however, they can cause severe systemic disease in neonates and facilitate HIV transmission.[89] Routine testing for genital HSV is not recommended unless symptomatic or in targeted groups where partners are affected or multiple partners are involved.[90, 91]

Several other less prevalent, high-risk STIs are also treated through SRH services across LSL hence preventative strategies here are also important.[40] Viral hepatitis remains high on the public health agenda with the commitment from PHE to the WHO Strategy on elimination of hepatitis C as a major public health threat by 2030.[92] Rates of hepatitis B reported in LSL are also higher than the London average with an incidence of 2.54 per 100,000 compared with 1.7 per 100,000 in London.[51] Males and MSM in particular have been disproportionately affected. In addition, hepatitis A immunisation recommendations have been updated following the ongoing outbreak primarily affecting MSM in England: to opportunistically vaccinate all MSM attending SRH clinics without previous evidence of vaccination for hepatitis A and B, and to educate around preventative activities and condom distribution.[93, 94]

Lymphogranuloma venereum cases peaked in 2014 but have been declining since. Of LGV diagnoses made in England in 2016, 91.7% were among MSM, 73.4% lived in London and 67.5% were HIV-positive. Clinicians are advised to always consider LGV testing and to maintain high suspicion in these high-risk groups.[95]

Shigella has been traditionally associated with travel to lower income countries where sanitation is poor. However, since 2009, case numbers in England (particularly in MSM) have increased dramatically. Work undertaken by PHE in London highlighted that education and understanding of shigella remain low despite attempts for engagement through social media campaigns, posters and through sexual health clinics. Although cases among men have fallen in recent years, SRH clinics and health protection teams must continue to provide advice to SRH professionals on how to prevent spread and protect themselves.[96]

Molluscum contagiosum and trichomoniasis together encompassed over 100 new diagnoses in LSL in 2017 although they are less clinically severe infections (with the exception of infections in those with late-stage HIV).[97] BASHH recommends that all individuals presenting with molluscum contagiosum should be given a full STI screen.[97] Trichomoniasis is associated with reproductive morbidity and increased rates of HIV transmission hence prompt treatment and contact tracing are recommended on diagnosis.[98]

Several vulnerable groups are disproportionately affected by STIs – young people, MSM, and Black communities. Young people aged 15-24 years still experience the highest diagnosis rates of most STIs.[40] Historically, young women have had higher rates of genital warts however this has seen a significant decline with the introduction of a UK school-based HPV vaccine.[73] Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people early in life about safer sex, types of contraception and local support services, in order to prevent the transmission of STIs. However recent work has revealed that nearly a third of schools lack good RSE and updates in government guidance are now needed (in anticipation of statutory RSE being introduced in September 2020), with consultation work underway.[11] A Cochrane review in 2016 revealed that too much RSE provision placed emphasis on abstinence or delayed sexual initiation rather than provision of information about contraceptives, for example.[99] School-based surveys in LSL have reinforced these results, demonstrating poor knowledge amongst young people about where to obtain free condoms. This is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) and safer sex when educating children and young people as part of RSE to promote good overall sexual and reproductive health.[56]

MSM bear the burden of many types of STIs, with the main challenges among MSM being the large relative increases in gonorrhoea (21%), chlamydia (17%) and syphilis (17%) observed nationally in 2017 compared to 2016, and mirrored in LSL.[51] Several behaviours likely explain these trends including increased condomless intercourse, multi-partner sex facilitated by geosocial networking applications, and a rise in 'chemsex'. This may also be partly explained by an increasing availability of HIV pre-exposure prophylaxis (PrEP). While PrEP has dramatically changed the landscape of HIV prevention, recent literature on coincident outcomes have suggested PrEP use may be associated with a reduction in the use of condoms and an increase in STI acquisition.[100] Research in England via the Impact trial continues. The national extension of targeted MSM HPV vaccination is expected to help reduce the incidence of genital warts and HPV-related cancers, though a lag is expected before full benefit is observed.[71]

With regards to ethnicity, the highest rates of STI diagnoses are among Black Caribbean and Black 'other' groups. Rates of STIs across England are highest in urban areas – especially in London – reflecting areas of higher deprivation. We know that Black communities are more likely to live in the more deprived areas of our boroughs.[101] Interventions and services should be informed by the opinions and experiences of BAME groups to ensure services are attractive and sensitive to the needs of specific communities. [75, 102] Engagement with faith communities and leaders in creative ways has also been shown to yield better participation in SRH services.[75]

Trends in STI diagnoses therefore highlight several areas for concern both nationally and in LSL, especially with regards to drug-resistant gonorrhoea, rising rates of syphilis, and an apparent increase in condomless sex. For LSL, strategies are needed that increase STI testing, aid targeted condom distribution services and use of condoms, and provide effective access to treatment. This is most crucial in those groups who are at greatest risk of STI acquisition. Engaging 'hard to reach' groups, especially in an environment of austerity, will require continued innovative approaches and testing methods informed by those communities to ensure appropriate reach of services.

**LIVING WELL WITH HIV**

HIV remains a national and regional priority, particularly in Lambeth, Southwark and Lewisham (LSL) where diagnosed HIV prevalence rates are among the highest in the country; Lambeth has the highest rate of HIV diagnosis in England. These high diagnosed HIV rates are, in many ways, an indicator of the success of policy and action, but also a reflection of our communities. With knowledge of positive HIV status and access to effective treatment, the mortality rate of people with HIV is now comparable to the rest of the population.[103] As a result, HIV has transitioned away from the life-threatening illness it once was and into a long-term condition that must be managed alongside traditional age-related illness. Health and social care practitioners must adapt their thinking to mirror the evolution of this disease and to appropriately support and manage comorbidities in people living with HIV (PLHIV) in a non-discriminatory way.

In 2014, UNAIDS set out an ambitious treatment target for HIV globally: that by 2020, 90% of all people living with HIV would know their HIV status, 90% of all people with a diagnosed HIV infection would be on treatment (antiretroviral therapy (ART)), and that 90% of all people on treatment would be virally supressed.[104] These aims are supported by current communications and campaigns around HIV: that 'undetectable = untransmittable'. In 2016, London achieved and surpassed these 90-90-90 targets: 90% of Londoners with HIV were diagnosed, 97% were on treatment, and 97% of those receiving ART were virally supressed.[105]

In January of 2018, London signed up to the Fast-Track Cities (FTC) Initiative, an international pledge to accelerate local responses to HIV and AIDS, including reaching the 90-90-90 goal.[106] As a testament to our commitment, London has set a more ambitious target to reach 0-0-0: 'zero HIV-related stigma and discrimination, zero new HIV infections, and zero preventable deaths from HIV-related causes'. London has also pledged to improve the health, quality of life and wellbeing of people living with HIV across the capital. Regionally, LSL contributes to and hosts the pan-London prevention programme 'Do It London', which provides far-reaching campaigns, free condom distribution, outreach and rapid HIV testing services. Furthermore, the Elton John AIDS Foundation (EJAF) has invested £2 million into primary care and community groups in LSL to increase HIV testing and support people diagnosed with HIV to engage in care.

HIV elimination is also a national objective. Public Health England's (PHE) strategic action plan 'Health promotion for sexual and reproductive health and HIV (2016-2019)' aims to decrease HIV incidence in populations most at risk of infection and to reduce the rate of late and undiagnosed HIV.[43] They also encourage adapting combination approaches to prevention. These involve deploying a set of behavioural, biomedical and structural approaches tailored to local such as levels of infrastructure, local culture as well as populations most affected by HIV. In the UK and particularly London, we have made considerable efforts to encourage condom use, promote expanded HIV testing and diagnosis (including self-sampling), and ensure prompt treatment and the use of pre-exposure prophylaxis (PrEP).

Both the private market and the national PrEP trial (the Impact trial) have revealed acceptability and demand for PrEP – particularly amongst men who have sex with men (MSM). The advent and accessibility of PrEP is a turning point for HIV, affording the freedom to engage in sex with an HIV positive partner safely and without fear or distress. Widespread acceptance and use of PrEP also works to combat the stigma once associated with HIV by reducing the marginalisation of those living with the virus.

These accomplishments are laudable, however, inequalities remain across LSL from HIV testing uptake to treatment and engagement in care. Anyone can contract HIV but people from some groups or parts of the world are more likely to be affected. Locally, the highest HIV diagnosis rates are seen in those aged 35-64, men of White ethnicity and women of Black African ethnicity.[74] Sex between men accounts for more than half of the new HIV cases in LSL each year. The number of new HIV diagnoses in MSM fell for the first time since the beginning of the HIV epidemic, likely driven by increased private use of PrEP and frequent testing. This decreasing trend has not been seen across all populations, however. New diagnoses in heterosexual women and Black African men remain proportionately high. In the UK and internationally, engagement of other at-risk groups including women, BAME communities, and trans people in the uptake of PrEP as a method of HIV prevention in trials has been much poorer than MSM, and more specific work to engage these groups will be required in a future commissioned PrEP service.

HIV testing, including frequent testing among those most at risk of HIV continues to be one of the most important interventions to identify current HIV infection and prevent onward transmission. Providing access to, and encouraging frequent testing has the potential to reduce the number of people unaware of HIV infection, the time with which people live with undiagnosed infection, and provides the opportunity for prompt HIV treatment. ART is now so effective that those who are treated and have an undetectable viral load (<200copies) have levels of virus that are untransmittable, even if having sex without condoms. Despite our local demographics and high prevalence of HIV, LSL testing coverage has consistently trended below the regional average.[51] This is a strong indicator to us as sexual health commissioners that more must be done to ensure those most at risk of HIV are receiving prompt testing and treatment.

In December 2015, PHE launched a national self-testing service funded by local authorities that allows users to order free HIV test kits online. This provides an accessible, easy-to-use alternative to traditional testing and help to empower individuals to take control of their sexual health. This service has been particularly successful at engaging MSM, which has decreased the attributable HIV testing in sexual health clinics and may in turn be partially responsible for the proportional rise in new diagnoses in women and Black African men.

Our concerted efforts to increase testing, timely diagnosis, and treatment have helped to improve the life chances of those who contract HIV and over time, fewer people in LSL are receiving a late HIV diagnosis. Nonetheless, in all LSL boroughs in 2014-16 more than 25% (target) of people diagnosed with HIV received a late diagnosis.[74] Late diagnosis is highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2014-2016, closely followed by Southwark. Across LSL in 2016, certain groups had a higher proportion of people with late diagnosis: those aged 50-64 (53%), Black African ethnicity (49%) and Other ethnicity (46%), those whose exposure to HIV was through heterosexual contact (59%), and women (55%).[74] These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV and increases the risk of HIV transmission; it is therefore a critical target for reduction in our strategy.

Effective, timely treatment allows PLHIV to lead long and largely unencumbered lives. However, stigma and discrimination remain primary barriers to engagement across the course of HIV. A national survey of perceived stigma was undertaken by Stigma Index UK in 2015/16.[107] In London, while almost all (94%) participants reported someone in their social circle was aware of their HIV status, those of Black and other minority ethnicities were less likely to have disclosed their status.[107] Among those who reported feeling stigmatised, sexual rejection was the most common cause of concern. The majority (59%) of patients who had

disclosed their HIV status to their GP felt well supported, however, 13% reported having avoided seeing the GP when required. These experiences were broadly similar to that of PLHIV in the UK overall.[107]

Education and campaigns aimed at young people and the general public may help to normalise HIV and reduce the marginalisation of those affected. Stigma and discrimination have also been suggested to influence adherence to ART.[108] A large systematic review of retention in care among adult PLHIV[109] found that substance use, physical comorbidities (e.g. hepatitis C infection), and certain demographics were less likely to remain engaged in care. Key demographics identified as risk factors for becoming lost to care included being from an ethnic minority group. Sexual health professionals must recognise these added risk factors and, where possible, programmes and services should be designed to best support and engage these groups. A synthesis of qualitative evidence suggests that shifting the responsibility of holistic care and support away from clinicians onto lay workers or peer counsellors may nurture a positive outlook and increase retention in care.[108]

As PLHIV generally continue to live longer and age, it is critical that our services evolve to meet the complex needs of this population. The mental wellbeing of PLHIV is associated with adherence to treatment and overall quality of life.[110] Unfortunately, PLHIV are more likely to experience depression and anxiety, which may negatively impact treatment outcomes.[110-114] Mental health and wellbeing should be considered and supporting throughout the life course of PLHIV. As PLHIV age, they may also be affected by physical comorbidities. These may be routine age-related illnesses, however, certain conditions may be exacerbated by HIV infection and treatment, and vice-versa.[115] In terms of STIs specifically, in Lambeth and Southwark in 2017, 90% of syphilis cases were in people who identified as gay; this was slightly lower in Lewisham (78%).[74] Genital sores caused by syphilis make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV.[74] This is concerning as co-infection with HIV increases the risk of central nervous system complications. PLHIV are also most affected by lymphogranuloma venereum (LGV), a type of chlamydia that infects the lymph node. In LSL, 67.5% of LGV diagnoses in 2017 were in HIV-positive MSM. Finally, tuberculosis (TB) is one of the most common co-infections with HIV,[116] with PLHIV being at 16-27 times greater risk of developing TB than those without HIV infection.[117] Alongside these particular conditions, as PLHIV age, like the rest of the population they may develop common age-related illnesses such as cardiovascular disease and dementia.[118-120] It is therefore essential that HIV care evolves to include a wide range of professionals that effectively manage HIV as a long-term condition, acknowledge and support the social care needs and wellbeing of PLHIV, and are prepared to recognise and treat as routine communicable and non-communicable diseases.

Acquiring, living with, and ageing with HIV affects a significant proportion of LSL residents. While significant achievements have been made in reducing the incidence of HIV and improving the quality of life of those living with HIV, approaches must remain agile to address the changing landscape of HIV support. Specialist HIV services and primary care must work together to deliver holistic, person-centred care, managing HIV alongside with other chronic and acute health conditions. Strengthening our combined prevention approaches, promoting timely testing and treatment, and improving our understanding of the social aspects of HIV will support PLHIV in LSL to access the services and care they need to live a long, healthy and fulfilling life.

## REFERENCES


1. The mental health of children and young people in England. Public Health England, 2016
2. Radford L, Corral S, Bradley C, Fisher H, Bassett C, Howat N, et al. Child abuse and neglect in the UK today. NSPCC, 2011
3. Shepherd W, Lewis B. Working with children who are victims or at risk of sexual exploitation: Barnardo's model of practice. Barnardo's, 2017
4. Beckett H, Brodie I, Factor F, Melrose M. "It's wrong… but you get used to it" A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England. University of Bedfordshire and Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, 2013
5. Domestic violence and abuse: multi-agency working. Guideline PH50. NICE, 2014
6. Sex and relationships education factsheet. Family Planning Association; 2011.
7. Sex and relationships education (SRE) for the 21st century. Supplementary advice to the Sex and Relationships Education Guidance DfEE (0116/2000). Brook, PSHE Association, Sex Education Forum, 2017
8. Kirby D. Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007
9. Public Health draft guidance; School, college and community-based personal, social, health and economic education focusing on sex and relationships and alcohol education. NICE, 2010
10. Hagell A, Shah R, Coleman J. Key Data on Young People. Association for Young People's Health, 2017
11. Pound P, Denford S, Shucksmith J, Tanton C, Johnson AM, Owen J, et al. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. BMJ open. 2017;7(5):e014791.
12. Tanton C, Jones KG, Macdowall W, Clifton S, Mitchell KR, Datta J, et al. Patterns and trends in sources of information about sex among young people in Britain: evidence from three National Surveys of Sexual Attitudes and Lifestyles. BMJ open. 2015;5(3):e007834.
13. Heads or tails? What young people are telling us about SRE: Sex Education Forum; 2016 [cited 2018 8 February]. Available from: https://www.sexeducationforum.org.uk/resources/evidence/heads-or-tails-what-young-people-are-telling-us-about-sre.
14. Schools to teach 21st century relationships and sex education [press release]. Department for Education2017.
15. Strategic Direction for Sexual Assault and Abuse Services: Lifelong care for victims and survivors: 2018 - 2023 NHS England, 2018
16. Statistical Bulletin: Domestic abuse in England and Wales: year ending March 2017. Office for National Statistics, 2017
17. Let's Talk About Sex Lewisham. Healthwatch Lewisham, 2017
18. Violence against women and girls. London Assembly Police and Crime Committee, 2016
19. Serious Crime Act 2015. 2015 c.9. Part 5. Domestic abuse. Section 76.
20. Myhill A. Measuring coercive control: what can we learn from national population surveys? Violence against women. 2015;21(3):355-75.
21. Roch A, Morton J, Ritchie G, LGBT Youth Scotland, Equality Network. Abuse out of sight out of mind: transgender people's experiences of domestic abuse. LGBT Youth Scotland and the Equality Network [online]. 2010
22. The School Report. Stonewall, 2012
23. Fox C. 'It's not on the radar.' The hidden diversity of children and young people at risk of sexual exploitation in England. Barnardo's, 2016
24. Domestic Abuse (Updated September 2014). BMA Board of Science 2007
25. Bourne A, Reid D, Hickson F, Torres Rueda S, Weatherburn P. The Chemsex Study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark & Lewisham. Sigma Research, London School of Hygiene & Tropical Medicine.
26. The use and impact of club drugs in Southwark. Southwark's JSNA. Southwark Council: London. 2017.
27. Child Sexual Exploitation: A guide for health practitioners. Scottish Government, 2017
28. Bovarnick S, Scott S. Child Sexual Exploitation Prevention Education: A rapid evidence assessment. Barnardo's, 2016

29. Walsh K, Zwi K, Woolfenden S, Shlonsky A. School-based education programmes for the prevention of child sexual abuse. The Cochrane database of systematic reviews. 2015(4):CD004380.
30. Preventing Child Sexual Abuse: the role of schools. Children's Commissioner, 2017
31. Hale D, Coleman J, Layard R. A model for the delivery of evidence-based PSHE (Personal Wellbeing) in Secondary Schools: CEP Discussion Paper No 1071. Centre for Economic Performance, London School of Economics; 2011.
32. Sexting: NSPCC; [cited 2018 8 February]. Available from: https://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/sexting/.
33. Ending violence against women and girls strategy: 2016-2020. HM Government, 2016
34. Ofsted examples of good practice in personal, social and health education: Ofsted; 2015 [cited 2018 8 February]. Available from: https://www.gov.uk/government/collections/ofsted-examples-of-good-practice-in-personal-social-and-health-education.
35. Young Voices on Sexual Health. Healthwatch Southwark, 2016
36. Pound P, Langford R, Campbell R. What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. BMJ open. 2016;6(9):e011329.
37. Wellings K, Jones KG, Mercer CH, Tanton C, Clifton S, Datta J, et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet. 2013;382(9907):1807-16.
38. Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England. Public Health England, 2018
39. Good progress but more to do: teenage pregnancy and young parents. Public Health England and Local Government Association, 2016
40. Sexual and reproductive health and HIV: applying All Our Health. Public Health England, 2017
41. Vaccinations: HPV Vaccine: NHS; [updated 31 October 2017; cited 2018 8 February]. Available from: https://www.nhs.uk/conditions/vaccinations/hpv-human-papillomavirus-vaccine/.
42. Anal Cancer: Cancer Research UK; [updated 5 May 2016; cited 2018 8 February]. Available from: http://www.cancerresearchuk.org/about-cancer/anal-cancer/risks-causes
43. Health promotion for sexual and reproductive health and HIV Strategic action plan, 2016 to 2019 Public Health England, 2015
44. Montouchet C, Trussell J. Unintended pregnancies in England in 2010: costs to the National Health Service (NHS). Contraception. 2013;87(2):149-53.
45. Mann S. Public Health England's holistic focus on women's reproductive health: The Faculty of Sexual and Reproductive Healthcare; [updated 13 June 2017; cited 2018 8 February]. Available from: https://www.fsrh.org/blogs/dr-sue-mann-on-public-health-englands-holistic-focus-on-womens/.
46. Mercer CH, Tanton C, Prah P, Erens B, Sonnenberg P, Clifton S, et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). Lancet. 2013;382(9907):1781-94.
47. Contraceptive services for under 25s. Public health guideline 51: National Institute for Health and Care Excellence; 2014 [updated October 2017; cited 2018 8 February]. Available from: https://www.nice.org.uk/guidance/ph51.
48. Supporting the Health & Wellbeing of Children and Young People in Southwark. A summary report of the Health & Wellbeing Related Behaviour Survey. Schools Health Education Unit, 2016
49. Supporting the Health of Young People in Lambeth. A summary report of the Health & Wellbeing Related Behaviour Survey. Schools Health Education Unit, 2016
50. Supporting the Health of Young People in Lewisham. A summary report of the Health & Wellbeing Related Behaviour Survey. Schools Health Education Unit, 2016
51. PHE Fingertips: Sexual and Reproductive Health Profiles: Public Health England; 2015 [cited 2018 8 January]. Available from: https://fingertips.phe.org.uk/profile/SEXUALHEALTH.
52. Sexually transmitted infections and under-18 conceptions: prevention. Public health guideline 3: National Institute for Health and Care Excellence; 2007 [cited 2018 8 February]. Available from: https://www.nice.org.uk/guidance/ph3.
53. Long-acting reversible contraception. Clinical guideline 30: National Institute for Health and Care Excellence; 2005 [updated September 2014; cited 2018 8 February]. Available from: https://www.nice.org.uk/guidance/cg30.
54. Parsons J, Adams C, Aziz N, Holmes J, Jawad R, Whittlesea C. Evaluation of a community pharmacy delivered oral contraception service. The journal of family planning and reproductive health care. 2013;39(2):97-101.

55. Todd A, Copeland A, Husband A, Kasim A, Bambra C. Access all areas? An area-level analysis of accessibility to general practice and community pharmacy services in England by urbanity and social deprivation. BMJ open. 2015;5(5):e007328.
56. Condom Distribution Schemes in England 2015/16. A survey of English Sexual Health Commissioners. Public Health England, 2017
57. LSL Come Correct Q3 Report 2017 (internal data).
58. HPV vaccination programme for men who have sex with men [press release]. Public Health England2018.
59. Cervical Screening: NHS Choices; 2015 [updated 6 August 2018; cited 2018 8 February]. Available from: https://www.nhs.uk/conditions/cervical-screening/
60. Cervical Cancer: Cancer Research UK; 2017 [updated 11 October 2017; cited 2018 8 February]. Available from: http://www.cancerresearchuk.org/about-cancer/cervical-cancer/living-with/fertility.
61. BPAS-MSI internal analysis (2017).
62. Saxena S, Copas AJ, Mercer C, Johnson AM, Fenton K, Erens B, et al. Ethnic variations in sexual activity and contraceptive use: national cross-sectional survey. Contraception. 2006;74(3):224-33.
63. Cameron S. Postabortal and postpartum contraception. Best practice & research Clinical obstetrics & gynaecology. 2014;28(6):871-80.
64. Aiken AR, Aiken CE, Trussell J, Guthrie KA. Immediate postpartum provision of highly effective reversible contraception. BJOG : an international journal of obstetrics and gynaecology. 2015;122(8):1050-1.
65. Bigelow CA, Bryant AS. Short Interpregnancy Intervals: An Evidence-Based Guide for Clinicians. Obstetrical & gynecological survey. 2015;70(7):458-64.
66. Smith GC, Pell JP, Dobbie R. Interpregnancy interval and risk of preterm birth and neonatal death: retrospective cohort study. Bmj. 2003;327(7410):313.
67. CEU Clinical Guideline: Contraception After Pregnancy – January 2017. Faculty of Sexual and Reproductive Health, 2017
68. CEU Clinical Guidance: Male and female sterilisation. Faculty of Sexual and Reporudive Health, 2014
69. A framework for Sexual Health Improvement in England. Department of Health, 2013
70. Whitlock GG, Gibbons DC, Longford N, Harvey MJ, McOwan A, Adams EJ. Rapid testing and treatment for sexually transmitted infections improve patient care and yield public health benefits. International journal of STD & AIDS. 2018;29(5):474-82.
71. Sexually transmitted infections and screening for chlamydia in England, 2017. Health Protection Report. Public Health England, 2018
72. Sexual health, reproductive health and HIV in England: A guide to local and national data (Revised December 2017). Public Health England, 2018
73. Mohammed H, Blomquist P, Ogaz D, Duffell S, Furegato M, Checchi M, et al. 100 years of STIs in the UK: a review of national surveillance data. Sexually transmitted infections. 2018.
74. Sexual health in Southwark, Lambeth and Lewisham. Southwark's JSNA. Southwark Council: London. 2018.
75. Black and minority ethnic men who have sex with men: Project evaluation and systematic review. Public Health England and De Montfort University Leicester, 2016
76. Managing outbreaks of Sexually Transmitted Infections Operational guidance. Public Health England, 2017
77. Sexually transmitted infections: condom distribution schemes. NICE guideline 68: National Institute for Health and Care Excellence; 2017 [cited 2018 21 August]. Available from: https://www.nice.org.uk/guidance/ng68.
78. Kinsella K, Cross R, South J. An evaluation of the condom distribution scheme (C-Card) with young people in Northeast England. Perspectives in public health. 2014;134(1):25-30.
79. Wilson E, Free C, Morris TP, Syred J, Ahamed I, Menon-Johansson AS, et al. Internet-accessed sexually transmitted infection (e-STI) testing and results service: A randomised, single-blind, controlled trial. PLoS medicine. 2017;14(12):e1002479.
80. Denison HJ, Bromhead C, Grainger R, Dennison EM, Jutel A. Barriers to sexually transmitted infection testing in New Zealand: a qualitative study. Australian and New Zealand journal of public health. 2017;41(4):432-7.
81. Opportunistic Chlamydia Screening of Young Adults in England An Evidence Summary. Public Health England, 2014
82. National Chlamydia Screening Programme (NCSP): Public Health England; 2003 [updated 18 July 2017; cited 2018 20 August]. Available from: https://www.gov.uk/government/collections/national-chlamydia-screening-programme-ncsp#programme-overview.

83. Barnard S, Free C, Bakolis I, Turner KME, Looker KJ, Baraitser P. Comparing the characteristics of users of an online service for STI self-sampling with clinic service users: a cross-sectional analysis. Sexually transmitted infections. 2018;94(5):377-83.
84. Guidance for the detection of gonorrhoea in England Public Health England, 2014
85. Update on investigation of UK case of Neisseria gonorrhoeae with high-level resistance to azithromycin and resistance to ceftriaxone acquired abroad. Health Protetion Report. Public Health England, 2018
86. French P. Syphilis. Bmj. 2007;334(7585):143-7.
87. Cantor AG, Pappas M, Daeges M, Nelson HD. Screening for Syphilis: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. Jama. 2016;315(21):2328-37.
88. Thomas DR, Williams CJ, Andrady U, Anderson V, Humphreys S, Midgley CM, et al. Outbreak of syphilis in men who have sex with men living in rural North Wales (UK) associated with the use of social media. Sexually transmitted infections. 2016;92(5):359-64.
89. Genital herpes: Public Health England; 2013 [cited 2018 20 August]. Available from: https://www.gov.uk/guidance/genital-herpes.
90. Herpes: Centres for Disease Control and Prevention; 2017 [cited 2018 20 August]. Available from: https://www.cdc.gov/std/herpes/default.htm.
91. 2015 BASHH CEG guidance on tests for Sexually Transmitted Infections. BASHH Clinical Effectiveness Group, 2015
92. Hepatitis C in England 2018 report. Public Health England, 2018
93. Hepatitis A vaccination in adults: temporary recommendations. July 2018 update. Public Health England, 2018
94. Hepatitis B: vaccine recommendations during supply constraints: Public Health England; 2017 [updated 12 July 2018; cited 2018 20 August]. Available from: https://www.gov.uk/government/publications/hepatitis-b-vaccine-recommendations-during-supply-constraints.
95. Recent trends in Lymphogranuloma venereum (LGV) diagnoses in the United Kingdom: 2003-2016. Health Protection Report. Public Health England, 2017
96. Update on the epidemiology of Shigella in adults in London, 2012 to 2016 Excess of cases in men who have sex with men. Public Health England, 2017
97. Fernando I, Pritchard J, Edwards SK, Grover D. UK national guideline for the management of Genital Molluscum in adults, 2014 Clinical Effectiveness Group, British Association for Sexual Health and HIV. International journal of STD & AIDS. 2015;26(10):687-95.
98. Kissinger P. Trichomonas vaginalis: a review of epidemiologic, clinical and treatment issues. BMC infectious diseases. 2015;15:307.
99. Lopez LM, Bernholc A, Chen M, Tolley EE. School-based interventions for improving contraceptive use in adolescents. The Cochrane database of systematic reviews. 2016(6):CD012249.
100. Holt M, Lea T, Mao L, Kolstee J, Zablotska I, Duck T, et al. Community-level changes in condom use and uptake of HIV pre-exposure prophylaxis by gay and bisexual men in Melbourne and Sydney, Australia: results of repeated behavioural surveillance in 2013-17. The lancet HIV. 2018;5(8):e448-e56.
101. Furegato M, Chen Y, Mohammed H, Mercer CH, Savage EJ, Hughes G. Examining the role of socioeconomic deprivation in ethnic differences in sexually transmitted infection diagnosis rates in England: evidence from surveillance data. Epidemiology and infection. 2016;144(15):3253-62.
102. Fish J, Papaloukas P, Jaspal R, Williamson I. Equality in sexual health promotion: a systematic review of effective interventions for black and minority ethnic men who have sex with men. BMC public health. 2016;16(1):810.
103. Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK. Public Health England, 2017
104. 90-90-90 - An ambitious treatment target to help end the AIDS epidemic. UNAIDS, 2014
105. London joins Fast-Track Cities initiative to reduce new HIV infections [press release]. Mayor of London2018.
106. Fast-Track Cities [cited 2018 20 August]. Available from: http://www.fast-trackcities.org/about.
107. HIV in the UK: Changes and Challenges; Actions and Answers. The People Living With HIV Stigma Survey UK 2015. 2015
108. Hall BJ, Sou KL, Beanland R, Lacky M, Tso LS, Ma Q, et al. Barriers and Facilitators to Interventions Improving Retention in HIV Care: A Qualitative Evidence Meta-Synthesis. AIDS and behavior. 2017;21(6):1755-67.
109. Bulsara SM, Wainberg ML, Newton-John TRO. Predictors of Adult Retention in HIV Care: A Systematic Review. AIDS and behavior. 2018;22(3):752-64.

110. Kaaya S, Eustache E, Lapidos-Salaiz I, Musisi S, Psaros C, Wissow L. Grand challenges: Improving HIV treatment outcomes by integrating interventions for co-morbid mental illness. PLoS medicine. 2013;10(5):e1001447.
111. Mental Health and HIV: HIV.gov; [updated 8 May 2018; cited 2018 20 August]. Available from: https://www.hiv.gov/hiv-basics/staying-in-hiv-care/other-related-health-issues/mental-health.
112. Owe-Larsson B, Sall L, Salamon E, Allgulander C. HIV infection and psychiatric illness. African journal of psychiatry. 2009;12(2):115-28.
113. Erdbeer G, Sabranski M, Sonntag I, Stoehr A, Horst HA, Plettenberg A, et al. Everything fine so far? Physical and mental health in HIV-infected patients with virological success and long-term exposure to antiretroviral therapy. Journal of the International AIDS Society. 2014;17(4 Suppl 3):19673.
114. Miners A, Phillips A, Kreif N, Rodger A, Speakman A, Fisher M, et al. Health-related quality-of-life of people with HIV in the era of combination antiretroviral treatment: a cross-sectional comparison with the general population. The lancet HIV. 2014;1(1):e32-40.
115. The future of HIV services in England: shaping the response to changing needs. The King's Fund, 2017
116. Tuberculosis and HIV co-infection: Avert; [updated 2 July 2018; cited 2018 20 August]. Available from: https://www.avert.org/living-with-hiv/health-wellbeing/tuberculosis.
117. Tuberculosis and HIV: World Health Organization; [cited 2018 20 August]. Available from: http://www.who.int/hiv/topics/tb/en/.
118. Petoumenos K, Worm SW. HIV infection, aging and cardiovascular disease: epidemiology and prevention. Sexual health. 2011;8(4):465-73.
119. So-Armah K, Freiberg MS. Cardiovascular disease risk in an aging HIV population: not just a question of biology. Current opinion in HIV and AIDS. 2014;9(4):346-54.
120. Cohen RA, Seider TR, Navia B. HIV effects on age-associated neurocognitive dysfunction: premature cognitive aging or neurodegenerative disease? Alzheimer's research & therapy. 2015;7(1):37.

<table>
<tr><th colspan="4">Healthier Communities Select Committee</th></tr>
<tr><td>Title</td><td colspan="3">South London and Maudsley NHS Foundation Trust - CQC inspection</td></tr>
<tr><td>Contributor</td><td colspan="2">Dr Ranga Rao (Consultant Psychiatrist and Clinical Director, South London and Maudsley NHS Foundation Trust)</td><td>Item 7</td></tr>
<tr><td>Class</td><td>Part 1 (open)</td><td colspan="2">16 January 2019</td></tr>
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## 1. Purpose

Attached is the report of the Care Quality Commission's (CQC) inspection of South London and Maudsley NHS Foundation Trust (SLaM) in July and August 2018.

Dr Ranga Rao, Consultant Psychiatrist Clinical Director at SLaM, will provide the committee with a verbal update at the meeting and answer any questions.

## 2. Recommendations

The Committee is asked to consider and note the report.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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# South London and Maudsley NHS Foundation Trust

## Inspection report

Trust Headquarters
1st Floor Admin Building
London
SE5 8AZ
Tel: 02032286000
www.slam.nhs.uk

Date of inspection visit: 2 July to 16 August 2018
Date of publication: 23/10/2018

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

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

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

## Ratings

| Overall rating for this trust | Good |
|---|---|
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

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



# Summary of findings

## Background to the trust

The trust serves a population of 1.3 million people across the London boroughs of Lambeth, Lewisham, Southwark and Croydon and employs more than 5,000 staff, including over 1,200 nurses. Staff provide services to around 64,000 patients in the community and 3,700 patients in hospital every year. The trust has a turnover of £381 million and made a surplus of £10.5 million in 2017/2018. The trust provides some national specialist mental health services. The trust was in the process of changing the structure of the organisation from one based on diagnostic categories to a borough based system at the time of our inspection.

The service provides the following core services:

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

The trust also provides the following specialist services:

- Specialist eating disorder services
- Specialist neuropsychiatric services
- Substance misuse services
- Other national specialist services

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

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

## Summary of findings

2017 the overall rating for Wards for older people with mental health problems went up from requires improvement to good; the overall rating for Acute wards for adults of working age and psychiatric intensive care units stayed the same, requires improvement; and for Community-based mental health services for adults of working age the overall rating went down from good to requires improvement.

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

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Forensic inpatient/secure wards
- Mental health crisis services and health based place of safety
- Community-based mental health services for older people
- Community-based mental health services for adults of working age

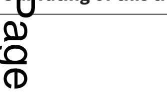
We told the trust they must make improvements to:

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

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

### Overall summary

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







## Summary of findings

### What this trust does

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

### Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

### What we inspected and why

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

We inspected six services as part of our ongoing checks on the safety and quality of healthcare services:

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

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

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

### What we found

#### Overall trust

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

# Summary of findings

- At this inspection we rated one service we inspected as inadequate and five services as good. When these ratings were combined with the other existing ratings from previous inspections, one of the trust services was rated inadequate, one was rated requires improvement, 11 were rated good, one was inspected but not rated and one had not been inspected.
- We rated well-led for the trust overall as good.
- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to make the necessary changes to provide high quality care to their local communities.
- The trust was participating very effectively in local care systems to drive progress to achieve integrated care. This was most developed in Lambeth but was also in progress in the other boroughs. The trust's active participation in the South London Partnership was delivering new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home.
- The trust's strong academic and research links meant that many patients had access to innovative treatment. The trust had been at the forefront of developing new evidence based practice, including for people with eating disorders, in peri-natal care and in work with people with dementia, leading to improvements in treatment adopted both nationally and internationally.
- The trust was making progress with their quality improvement programme and had set ambitious targets for the next three years. The early adopters of this work were understandably from higher performing teams. However, this needed to be embedded in more challenged teams as a way of facilitating improvements.
- Staff engagement was (as shown in the staff survey) better than many other similar trusts. An ambitious programme of leadership walkabouts was promoting good communication. The trust promoted staff to speak up through the Freedom to Speak Up Guardian, although some teams were not yet aware of how to access this support and Freedom to Speak Up advocates did not receive specific training for their role. The trust was aware that there were groups, teams and individuals where deep-seated concerns still needed to be resolved.
- The trust was working with the BME staff network to implement a range of measures to improve career progression and address discrimination for BME staff. It was recognised that this would take more time to fully implement and begin to have a positive effect on performance against the workforce race equality standard.
- The trust had many excellent examples of working with people who use services and carers. This was supported by an active involvement register and a wide range of opportunities for volunteers. The trust was also looking to extend the number of peer workers. Staff were proactive in addressing the needs of people with protected characteristics. Staff enabled access to services for patients with physical disabilities, took account of individual's cultural and religious needs and provided information in accessible formats. The trust worked in partnership with local BME communities to improve the design and delivery of services. Many staff were sensitive to the needs of LGBT+ people and the trust had developed a new policy to address needs of young people who were transgender.
- The governors were performing their role well and holding non-executive directors to account. This had significantly improved since the last inspection and reflected the desire of the board to be open and transparent.
- The trust had systems in place to identify risk and the board assurance framework had recognised the pressures on the acute care pathway. In addition, a system was in place to identify the performance of wards and teams using a range of indicators. However, there was a disconnect between these systems and the front-line services. This meant that where services needed to improve across the acute care pathway, targeted support had not been delivered.
- The quality of the investigation reports following a serious incident were of a high standard and provided the necessary insight into where improvements were needed but further work was needed to ensure this learning was embedded across the trust.





# Summary of findings

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

However:

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

## Are services safe?

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

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

# Summary of findings

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

However:



# Summary of findings

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

## Are services effective?

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

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

# Summary of findings

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

However:

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

## Are services caring?

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

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





# Summary of findings

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

However:

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

## Are services responsive?

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

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

# Summary of findings

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

However:

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

## Are services well-led?

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



# Summary of findings

We rated the trust as **good** because:

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

However:

- At the time of the inspection, patients from the local communities of working age adults being supported on the acute care pathway, either as an inpatient or by adult community mental health teams, could not be assured of receiving consistently high standards of care. These unwarranted variations in standards of care impacted on the largest group of patients receiving care and treatment from the trust.

# Summary of findings

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

## Ratings tables

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

## Outstanding practice

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

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

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

## Areas for improvement

We found areas for improvement including breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 9 Person-centred care; Regulation 12 Safe care and treatment; Regulation 17 Good governance and Regulation 18 Staffing. There were 14 things the trust must put right in relation to breaches of these four regulations. In addition, we found 47 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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



# Summary of findings

## Action we have taken

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

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

## What happens next

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

## Outstanding practice

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

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

**Forensic inpatient/secure wards**

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

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

# Summary of findings

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

**Community-based mental health services for older people**

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

**Specialist eating disorder services**

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

## Areas for improvement

# Summary of findings

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

**Action the trust MUST take to improve**

We told the trust that it must take action to bring services into line with three legal requirements trust wide and eleven legal requirements in one core service. (There were an additional nine requirements outstanding from inspections in 2017 and 2015 in three core services that we did not inspect in 2018).

Trust wide

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

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

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

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

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

## Summary of findings

- The trust must ensure that patients who require a Mental Health Act assessment are assessed without undue delay to ensure their safety and that of others.
- The trust must ensure that patients referred to the Croydon assessment and liaison team, receive an assessment within trust target timescales.

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

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

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

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

**Action the trust SHOULD take to improve**

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

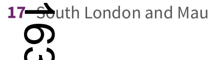
**Trust wide**

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

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

- The trust should ensure staff receive training in autism.





## Summary of findings

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

**Forensic inpatient/secure wards**

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

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

- The trust should ensure that when staff supply medicines to patients at home that it is packaged and labelled in accordance with the Human Medicines Regulations 2012.
- The trust should ensure staff follow the trust policy for assessing and recording the suitability of patient's own medicines before administering them.
- The trust should ensure that the patient s.132 rights poster displayed in the health-based place of safety assessment rooms clearly explains patients' rights in line with the Mental Health Act.
- The trust should continue to monitor and work towards making sure patients do not stay in the health-based place of safety for longer than 24 hours.
- The trust should ensure that staff in the health-based place of safety clearly document how they arrive at their decision when completing mental capacity assessments for consent to treatment.
- The trust should ensure staff are aware of the role of the Freedom to Speak up Guardian and how to contact them.

**Community-based mental health services for older people**

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

# Summary of findings

- The trust should ensure that systems for capturing the completion of staff supervision are effective and accurately record the supervision taking place.
- The trust should ensure that learning from incidents and complaints is discussed at team business meetings to support improvements.

**Specialist eating disorder services**

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

**Specialist neuropsychiatric services**

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

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





# Summary of findings

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

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

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

## Summary of findings

- The provider should ensure that ward managers are made aware of the issues recorded on the clinical academic group risk register and further develop links between senior management and ward level.
- The provider should ensure that informal patients on Hayworth Ward are given clear information about their right to leave the ward in the posters on display.

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

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

**Child and adolescent mental health wards** (from September 2015)

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



## Summary of findings

- The trust should ensure that sufficient staff are trained in using the gym equipment, so young people can access this resource at more times.
- Specialist community mental health services for children and adolescents (from September 2015)
- The trust should ensure that the environment at Lambeth is safe for those people who use or work in the service.
- The trust should ensure that infection control audits are carried out across all CAMHS.
- The trust should continue to monitor and review the services to ensure that all children and young people can access the service in a timely manner.
- The trust should ensure that all staff have IT equipment and patient record systems that enable them to access the information they need in a timely manner.
- The trust should ensure that there is a consistent approach to the documentation of patient care and treatment, including risk assessments, care plans and consent.

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

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

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

### Is this organisation well-led?

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

We rated the trust as **good** because:

- The trust had a high calibre board, with a wide range of appropriate skills and experience, who were open and determined to make the necessary changes to provide high quality care to their local communities.
- The trust was participating very effectively in local care systems to drive progress to achieve integrated care. This was most developed in Lambeth but was also in progress in the other boroughs. The trust's active participation in the South London Partnership was delivering new models of care for patients receiving national and specialist services. This meant that patients were receiving their care closer to home.

# Summary of findings

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

However:

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



# Summary of findings

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

## Ratings tables

| Key to tables | | | | | |
|---|---|---|---|---|---|
| Ratings | Not rated | Inadequate | Requires improvement | Good | Outstanding |
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| Symbol * | →← | ↑ | ↑↑ | ↓ | ↓↓ |

Month Year = Date last rating published

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

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

### Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires improvement →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 |

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

### Ratings for mental health services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Acute wards for adults of working age and psychiatric intensive care units | Requires improvement →← Oct 2018 | Requires improvement →← Oct 2018 | Good →← Oct 2018 | Inadequate ↓↓ Oct 2018 | Inadequate ↓ Oct 2018 | Inadequate ↓ Oct 2018 |
| Long-stay or rehabilitation mental health wards for working age adults | Requires improvement →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 |
| Forensic inpatient or secure wards | Good ↑ Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good ↑ Oct 2018 | Good →← Oct 2018 | Good ↑ Oct 2018 |
| Child and adolescent mental health wards | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 |
| Wards for older people with mental health problems | Requires improvement →← Jun 2017 | Good →← Jun 2017 | Good →← Jun 2017 | Good →← Jun 2017 | Good →← Jun 2017 | Good →← Jun 2017 |
| Wards for people with a learning disability or autism | Good →← Jan 2016 | Outstanding →← Jan 2016 | Outstanding →← Jan 2016 | Good →← Jan 2016 | Outstanding →← Jan 2016 | Outstanding →← Jan 2016 |
| Community-based mental health services for adults of working age | Requires improvement →← Oct 2017 | Requires improvement →← Oct 2017 | Good →← Oct 2017 | Requires improvement →← Oct 2017 | Good →← Oct 2017 | Requires improvement →← Oct 2017 |
| Mental health crisis services and health-based places of safety | Good ↑ Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 |
| Specialist community mental health services for children and young people | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 | Good →← Jan 2016 |
| Community-based mental health services for older people | Good ↑ Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Outstanding ↑ Oct 2018 | Good →← Oct 2018 |
| Community mental health services for people with a learning disability or autism | Good →← Jan 2016 | Outstanding →← Jan 2016 | Outstanding →← Jan 2016 | Good →← Jan 2016 | Outstanding →← Jan 2016 | Outstanding →← Jan 2016 |
| Specialist eating disorder service | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 |
| Specialist neuropsychiatric service | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 |
| **Overall** | Requires improvement →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 | Good →← Oct 2018 |

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

# Forensic inpatient or secure wards

Good

## Key facts and figures

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

We visited the following wards at the Bethlem Royal Hospital:

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

And at Lambeth Hospital:

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

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

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

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

During the inspection visit, the inspection team:

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

# Forensic inpatient or secure wards

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

## Summary of this service

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

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

# Forensic inpatient or secure wards

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

However:

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

## Is the service safe?

**Good**

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

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

However:

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



# Forensic inpatient or secure wards

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

## Is the service effective?

**Good**

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

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

However:

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

## Is the service caring?

**Good**

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

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

# Forensic inpatient or secure wards

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

## Is the service responsive?

**Good**

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

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

## Is the service well-led?

**Good**

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

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

# Forensic inpatient or secure wards

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

## Outstanding practice

We found four examples of outstanding practice in this service.

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

## Areas for improvement

We found four areas for improvement in this service.

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

# Specialist eating disorder service

**Good**

## Key facts and figures

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

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

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

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

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

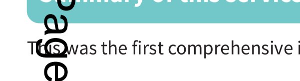
During the inspection visit, across both services the inspection team:

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

### Summary of this service

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






# Specialist eating disorder service

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

However:

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

# Specialist eating disorder service

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

## Is the service safe?

**Good**

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

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

However:

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

## Is the service effective?

**Good**

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



# Specialist eating disorder service

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

However:

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

## Is the service caring?

**Good**

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

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

However:

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

# Specialist eating disorder service

## Is the service responsive?

**Good**

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

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

## Is the service well-led?

**Good**

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

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







However:

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

## Outstanding practice

We found three examples of outstanding practice in this service:

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

## Areas for improvement

Action the provider SHOULD take to improve

- The trust should put in place a formal eating disorders competency framework for staff to ensure that they have all the specialist skills they need to care for a patient with an eating disorder.
- The trust should ensure staff record incidents of restraint accurately including the type of restraint, position of restraint, members of staff involved, length of time the restraint took place and whether the patient received a physical check for any injuries after the restraint.
- The trust should ensure that the service continues to review the dietitian and social worker input to the ward, as well as on the Step Up to Recovery team.

The trust should ensure that all staff receive regular monthly supervision.

- The trust should ensure that patients are given a copy of their care plan and an induction to the ward on admission.
- The trust should ensure that learning and improvements result from audits.

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

**Inadequate**

## Key facts and figures

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

As part of this inspection we visited the following wards:

The Bethlem Royal Hospital:

Croydon PICU – 10 bed male only psychiatric intensive care unit

Gresham 1 – 20 bed female acute admission ward

Gresham 2 – 20 bed male acute admission ward

Fitzmary 1 - 14 bed female admission ward

Tyson West - 17 bed male acute admission ward

Maudsley Hospital:

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

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

John Dickson – 20 bed male acute admission ward

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

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

Lambeth Hospital:

Eden Ward – 12 bed male psychiatric intensive care unit

Rosa Parks Ward – 18 bed mixed acute admissions ward

Luther King – 18 bed male acute admissions ward

Nelson – 18 bed female acute admissions ward

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

Ladywell Unit:

Johnson PICU - 10 bed male psychiatric intensive care unit

Clare - 17 bed mixed acute admissions ward

Powell – 18 bed male acute admissions ward

Wharton – 18 bed female acute admissions ward



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

Jim Birley Unit – 16 bed female acute admissions ward

Virginia Woolf – 16 bed female acute admissions ward

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

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

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

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

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

During the inspection, we carried out the following activities:

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

## Summary of this service

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

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

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

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

However:

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





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

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

## Is the service safe?

**Requires improvement**

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

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

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

However:

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

## Is the service effective?

**Requires improvement**

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

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




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


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

However:

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

## Is the service caring?

**Good**

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

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

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

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

However:

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

## Is the service responsive?

**Inadequate**

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

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

However:





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

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

## Is the service well-led?

**Inadequate**

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

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

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

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

However:

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

## Outstanding practice

We found one example of outstanding practice in this service:

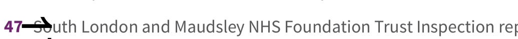
ES1, the female PICU, won the Project of the Year award at the Design in Mental Health Awards 2018 for their sensory room. The room had bean bag seating, a projector which displayed soothing scenes on the wall and calming music. Two rainbow light bars changed the colour of the room at the touch of a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

## Areas for improvement

**Action the provider MUST take to improve**

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

Action the provider SHOULD take to improve





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

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

Good

## Key facts and figures

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

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

During the inspection visit, the inspection team:

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

## Summary of this service

We rated this service as good because:

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







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

However:

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

## Is the service safe?

Good

We rated safe as good because:

# Specialist Neuropsychiatric Service

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

However:

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

## Is the service effective?

**Good**

We rated effective as good because:

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





Specialist Neuropsychiatric Service

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

However:

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

## Is the service caring?

**Good**

We rated caring as good because:

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

However:

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

## Is the service responsive?

**Good**

We rated responsive as good because:

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

# Specialist Neuropsychiatric Service

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

However:

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

## Is the service well-led?

**Good**

We rated well-led as good because:

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

However:

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

## Areas for improvement

We found the following areas for improvement in this service.

**SHOULDs:**

- The trust should ensure that all staff receive regular clinical supervision, to support them in carrying out their duties effectively.
- The trust should ensure that all areas of the ward identified as a risk are consistently monitored to mitigate the risks to patients.

Specialist Neuropsychiatric Service

- The trust should ensure that staff check the expiry date of all items in the clinic room to ensure that these are removed and replaced before expiry.
- The trust should ensure that staff complete their mandatory training especially in life support.
- The trust should review the blanket restriction with regards to no patients having keys to their bedrooms, which meant that they had to rely on staff to lock and unlock their rooms.
- The trust should ensure that incidents relating to the service, especially medicines incidents, are categorised correctly to ensure that appropriate learning is shared with staff.
- The trust should ensure that patients have access to appropriate leisure activities and not spend too much time watching television during the day.
- The trust should ensure that patients have opportunities to give feedback on the service they received, for example by holding regular community meetings.
- The trust should ensure that family members of patients on the ward are encouraged to give feedback about the service.
- The trust should ensure that that patient details recorded on the office whiteboard are not visible to people outside the room.

# Community-based mental health services for older people

**Good**

## Key facts and figures

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

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

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

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

Lambeth and Southwark Integrated Memory Service and Croydon and Lewisham Memory Services offer comprehensive assessment, treatment and support options to anyone over the age of 18 with mild to moderate memory problems likely to indicate dementia. The teams work in collaboration with the Alzheimer's Society and offer a comprehensive assessment.
Following assessment, the teams coordinate individualised care planning. This may include prescribing medicines if appropriate, post diagnostic support and signposting, problem solving strategies, and individual or group therapy, which is offered for both patients and carers.

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

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

During the inspection visit, the inspection team:

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



# Community-based mental health services for older people

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

## Summary of this service

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

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

# Community-based mental health services for older people

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

However:

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

## Is the service safe?

**Good** ● ↑

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

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





# Community-based mental health services for older people

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

## Is the service effective?

**Good**

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

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

However:

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

# Community-based mental health services for older people

## Is the service caring?

**Good**

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

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

However:

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

## Is the service responsive?

**Good**

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

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





# Community-based mental health services for older people

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

## Is the service well-led?

**Outstanding**

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

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

However:

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

# Outstanding practice

We found three examples of outstanding practice in this service.

# Community-based mental health services for older people

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

## Areas for improvement

We found these areas for improvement in this service:

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



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

**Good**

## Key facts and figures

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

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

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

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

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

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

During the inspection visit, the inspection team:

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

## Summary of this service

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

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

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

However:

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



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

## Is the service safe?

**Good**

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

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

However:

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

## Is the service effective?

**Good**

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

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

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

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

However:

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

### Is the service caring?

**Good**

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

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

### Is the service responsive?

**Good**





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

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

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

However:

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

### Is the service well-led?

**Good**

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

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

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

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

However:

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

## Outstanding practice

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

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

## Areas for improvement

Areas for improvement

Action the trust SHOULD take to improve

- The trust should ensure that when staff supply medicines to patients at home that it is packaged and labelled in accordance with the Human Medicines Regulations 2012.
- The trust should ensure staff follow the trust policy for assessing and recording the suitability of patient's own medicines before administering them.
- The trust should ensure that the patient s132 rights poster displayed in the health-based place of safety assessment rooms clearly explains patients' rights in line with the Mental Health Act.
- The trust should continue to monitor and work towards making sure patients do not stay in the health-based place of safety for longer than 24 hours.
- The trust should ensure that staff in the health-based place of safety clearly document how they arrive at their decision when completing mental capacity assessments for consent to treatment.
- The trust should ensure staff are aware of the role of the Freedom to Speak up Guardian and how to contact them.



This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

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

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

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |



# Our inspection team

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

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

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

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| HEALTHIER COMMUNITIES SELECT COMMITTEE | | | |
|---|---|---|---|
| Title | Lewisham Annual Public Health Report 2018 | | |
| Key Decision | No | | Item No. 8 |
| Ward | Borough Wide | | |
| Contributors | Danny Ruta – Director of Public Health<br><br>Catherine Mbema – Consultant in Public Health | | |
| Class | Part 1 | Date: 16th January 2019 | |

## 1. Purpose

1.1 The purpose of this report is to provide members of the Healthier Communities Select Committee with the Annual Public Health Report (APHR) for 2018. The theme of the APHR is 'Sexual Health: with a focus on contraception'. The report focuses primarily on communicating with Lewisham residents about sexual health and different forms contraception.

1.2 The 2018 APHR continues to have an online format to enhance accessibility of the report for members of the public.

## 2. Recommendations

Members of the Healthier Communities Select Committee are recommended to:

2.1 Note the content of the report and direct as required any further analysis or commentary.

## 3. Policy Context

3.1 The Health and Social Care Act 2012 stated that the production of an APHR is a statutory duty of the Director of Public Health, which the local authority is responsible for publishing.

3.2 The APHR topic selected for this year is Sexual Health in order to coincide with the publication of the new Lambeth, Southwark and Lewisham (LSL) 5-year sexual health strategy (2019-24).

3.3 The new LSL sexual health strategy has four key pillars:

- Healthy and fulfilling sexual relationships
- Good reproductive health across the life course

- High quality STI testing and treatment
- Living well with HIV

3.4 The strategy development process was underpinned by the following key principles:

- Working in partnership, at a local, London and national level.
- High quality commissioning for effective and financial sustaining services, including capitalising on technological innovations.
- Listening to service users' views and experiences and using these to improve what we do.
- Focus on reducing inequalities in sexual and reproductive health.
- Supporting the development of a resilient sexual health system.

3.5 This APHR will focus on some of the most pertinent issues for Lewisham highlighted by the strategy. Most notably, Lewisham has relatively low levels of uptake of long-acting forms of contraception prescribed by GPs and relatively high rates of abortion in comparison to neighbouring boroughs, London and England overall. This report will therefore have a specific focus on contraception within the broader topic of sexual health.

## 4. Background

4.1 The APHR this year will continue to have an online microsite format with webpages featuring a combination of written text, user-friendly data presentation, images and short videos. This communication medium was chosen last year in line with the target audience for the report i.e. members of the public, and in recognition of the increasing use of online communication channels to disseminate health information.

## 5. Summary of the APHR 2018

5.1 The APHR this year will aim to communicate with Lewisham residents about sexual health with a specific focus on contraception.

5.2 The following sections have therefore been included in the online microsite:

- **Section 1: Introduction**

  This includes video introductions to the report from Dr Danny Ruta, Director of Public Health; Cllr Muldoon, Chair of the Healthier Communities Select Committee; Cllr Chris Best, Executive Member for

Health, Wellbeing and Older People; and Dr Emily Mabonga, Sexual Health and HIV Consultant at Lewisham and Greenwich Trust (LGT).

- **Section 2: What do we know about sexual health in Lewisham?**

  Key sexual health data for Lewisham is summarised in several infographic sheets in this section. A link to all of the public health dashboards is also included to give viewers/readers a broader overview of public health in Lewisham.

- **Section 3: Contraception - What do you know?**

  A short interactive quiz in this section has been designed to test readers'/viewers' knowledge of different types of contraception.

- **Section 4: Contraception Case-studies**

  Three real-life stories of contraception use from Lewisham residents are shared in this section. A number of short videos featuring Dr Emily Mabonga (sexual health and HIV consultant) explaining different forms of contraception are also included in this section.

- **Section 5: Contraception Services**

  This section will outline the main services available for contraception in the borough.

- **Section 6: What's new for sexual health in Lewisham?**

  This section provides a brief overview of new sexual health initiatives in Lewisham including an overview of the LSL sexual health strategy 2019-2024 and access to sexual health services in Lewisham pharmacies.

5.3 The online microsite will go live at the end of January 2019 and will be available at the following URL: http://lewishampublichealth.uk/sexualhealth.

## 6. Financial Implications

6.1 There are no specific financial implications arising from this report.

6.2 All the work described in the report is funded from the ring-fenced Public Health Grant.

## 7. Legal Implications

7.1 The requirement to produce an APHR is set out above.

## 8. Crime and Disorder Implications

8.1 There are no specific crime and disorder implications arising from this report.

## 9. Equalities Implications

9.1 There are no specific equalities implications arising from this report.

## 10. Environmental Implications

10.1 There are no specific environmental implications arising from this report.

## 11. Conclusion

11.1 The report focuses on the topic of sexual health with a focus on contraception and aims to communicate with members of the Lewisham community. The report will continue to have a new online microsite format to enhance accessibility and engagement with the report.

| Healthier Communities Select Committee | | | |
|---|---|---|---|
| Title | Select Committee work programme | | |
| Contributor | Scrutiny Manager | Item | 10 |
| Class | Part 1 (open) | 16 January 2019 | |

## 1. Purpose

To advise Members of the proposed work programme for the 2018/19 municipal year and to decide on the agenda items for the next meeting.

## 2. Summary

2.1 At the beginning of the municipal year, each select committee drew up a draft work programme for submission to the Business Panel for consideration.

2.2 The Business Panel considered the proposed work programmes of each of the select committees on 24 July 2018 and agreed a co-ordinated overview and scrutiny work programme. However, the work programme can be reviewed at each Select Committee meeting so that Members are able to include urgent, high priority items and remove items that are no longer a priority.

## 3. Recommendations

3.1 The Committee is asked to:

- note the work plan attached at **Appendix B** and discuss any issues arising from the programme;
- specify the information and analysis required in the report for each item on the agenda for the next meeting, based on desired outcomes, so that officers are clear about what they need to provide;
- review all forthcoming key decisions, attached at **Appendix C**, and consider any items for further scrutiny;

## 4. The work programme

4.1 The work programme for 2018/19 was agreed at the Committee's meeting on 27 June 2018.

4.2 The Committee is asked to consider if any urgent issues have arisen that require scrutiny and if any existing items are no longer a priority and can be removed from the work programme. Before adding additional items, each item should be considered against agreed criteria.

4.3 The flow chart attached at **Appendix A** may help Members decide if proposed additional items should be added to the work programme. The Committee's work programme needs to be achievable in terms of the amount of meeting time available. If the Committee agrees to add additional item(s) because they are

urgent and high priority, Members will need to consider which medium/low priority item(s) should be removed in order to create sufficient capacity for the new item(s).

4.4 Items within each Select Committee work programme are linked to the Council's corporate priorities. Work is currently underway to develop a new corporate strategy, which will give corporate expression to the priorities of the new administration. Once developed, scrutiny work programmes can be adjusted to reflect the new corporate strategy and corporate priorities, if required. It is expected that the new strategy will be approved at full Council in November 2018.

## 5. The next meeting

5.1 The following reports are scheduled for the meeting on 11 February 2019:

| Agenda item | Review type | Link to Corporate Priority | Priority |
|---|---|---|---|
| **Lewisham People's Parliament** | Standard item | Active, healthy citizens | Medium |
| **Care at Home - update** | Standard item | Active, healthy citizens | Medium |
| **Social prescribing in-depth review update** | Standard item | Active, healthy citizens | Medium |
| **Adult learning Lewisham annual report** | Standard item | Active, healthy citizens | Medium |
| **Leisure centre contract** | Standard item | Active, healthy citizens | Medium |

5.2 The Committee is asked to specify the information and analysis it would like to see in the reports for these items, based on the outcomes the Committee would like to achieve, so that officers are clear about what they need to provide for the next meeting.

## 6. Financial Implications

There are no financial implications arising from this report.

## 7. Legal Implications

In accordance with the Council's Constitution, all scrutiny select committees must devise and submit a work programme to the Business Panel at the start of each municipal year.

## 8. Equalities Implications

8.1 The Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing

the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

8.2 The Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

8.3 There may be equalities implications arising from items on the work programme and all activities undertaken by the Select Committee will need to give due consideration to this.

## 9. Date of next meeting

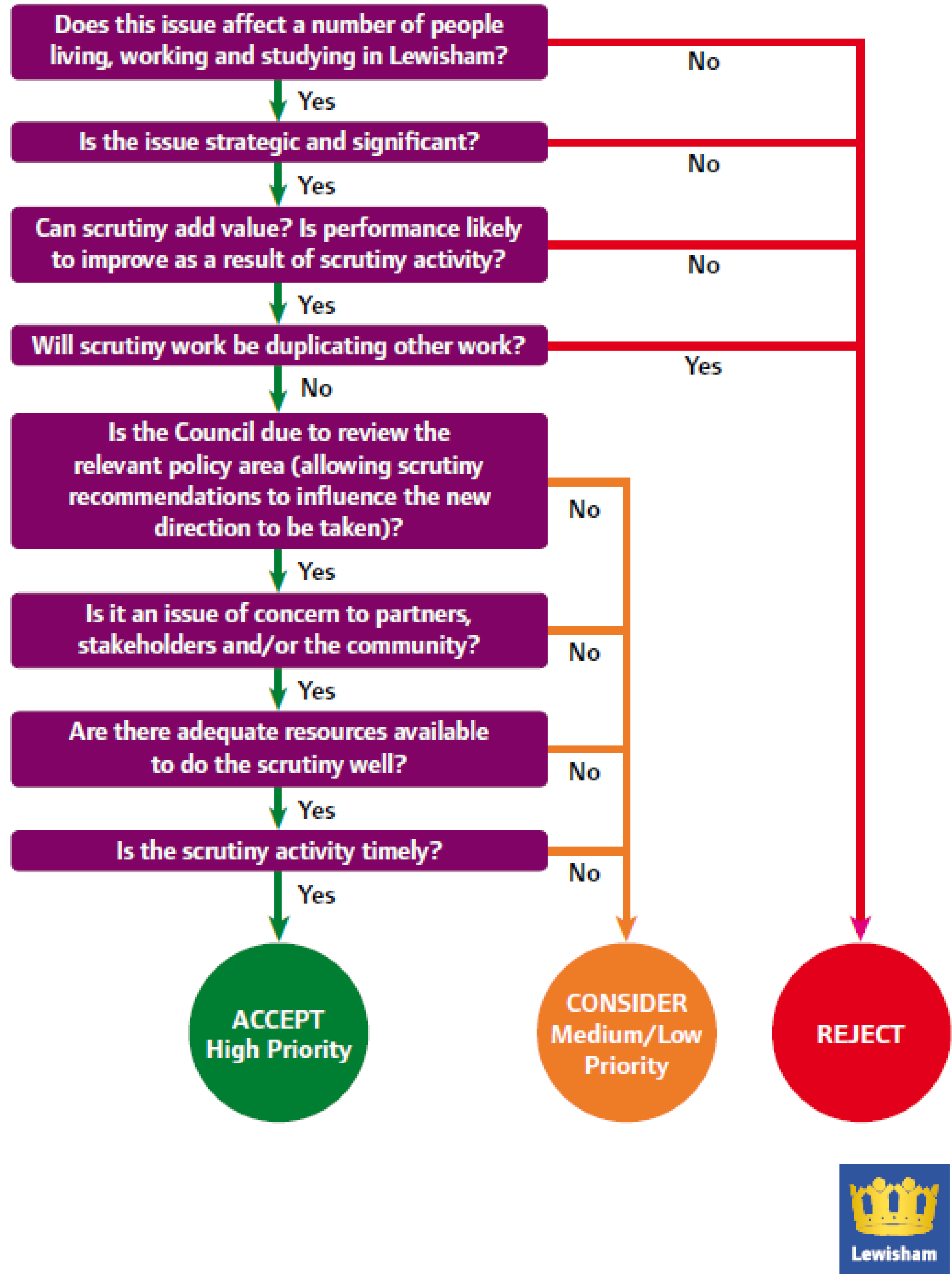
The date of the next meeting is Monday 11 February 2019.

**Background Documents**

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide

# Scrutiny work programme – prioritisation process



**Healthier Communities Select Committee work programme 2018/19**

**Programme of work**

| Work item | Type of item | Priority | Strategic priority | Delivery deadline | 27-Jun | 04-Sep | 09-Oct | 03-Dec | 16-Jan | 11-Feb |
|---|---|---|---|---|---|---|---|---|---|---|
| Lewisham future programme | Standard item | High | CP9 | Ongoing | | | Budget cuts | | | |
| Confirmation of Chair and Vice Chair | Constitutional req | High | CP9 | June | | | | | | |
| Select Committee work programme 2017/18 | Constitutional req | High | CP9 | June | | | | | | |
| Sexual and reproductive health services | Standard item | Medium | CP9 | June | | | | | | |
| Public health grant cuts consultation | Standard item | High | CP9 | September | | | | | | |
| Draft LSL sexual health strategy | Standard item | High | CP9 | September | | | | | | |
| Healthwatch annual report | Standard item | Medium | CP9 | September | | | | | | |
| Overview of adult social care services | Information item | Medium | CP9 | September | | | | | | |
| TB prevention | Information item | Medium | CP9 | September | | | | | | |
| Improving access to and provision of primary care | Performance monitoring | High | CP9 | October | | | | | | |
| Adult safeguarding annual report | Standard item | High | CP9 | October | | | | | | |
| Pathology services | Information item | High | CP9 | October | | | | | | |
| Blue badge applications | Information item | Medium | CP9 | October | | | | | | |
| Public health grant cuts consultation | Standard item | High | CP9 | December | | | | | | |
| Lewisham hospital update (systems resilience) | Performance monitoring | High | CP9 | December | | | | | | |
| Pathology services | Standard item | High | CP9 | December | | | | | | |
| Care at Homes: arrangements for integrating health and care services | Standard item | High | CP9 | December | | | | | | |
| Partnership commissioning intentions | Information item | High | CP9 | December | | | | | | |
| Delivery of the Lewisham Health & Wellbeing priorities | Standard item | High | CP9 | January | | | | | | |
| Bullying and harassment at Lewisham and Greenwich NHS Trust | Standard item | High | CP9 | January | | | | | | |
| Final LSL sexual health strategy | Standard item | High | CP9 | January | | | | | | |
| SLaM CQC report | Standard item | Medium | CP9 | January | | | | | | |
| Public health annual report | Standard item | Medium | CP9 | January | | | | | | |
| EU exit operational readiness within the health and care system | Information item | High | CP9 | January | | | | | | |
| Lewisham People's Parliament | Standard item | Medium | CP9 | February | | | | | | |
| Care at Homes: arrangements for integrating health and care services | Standard item | Medium | CP9 | February | | | | | | |
| Social prescribing in-depth review update | Policy development | Medium | CP9 | February | | | | | | |
| Leisure centre contract | Standard item | Medium | CP9 | February | | | | | | |
| Adult learning Lewisham annual report | Standard item | Medium | CP9 | February | | | | | | |

| | |
|---|---|
| | Item completed |
| | Item on-going |
| | Item outstanding |
| | Proposed timeframe |
| | Item added |

| Meetings | | | | | |
|---|---|---|---|---|---|
| 1) | Tuesday | 27 June | 4) | Thursday | 3 December |
| 2) | Thursday | 4 September | 6) | Tuesday | 16 January |
| 3) | Thursday | 9 October | 7) | Thursday | 11 February |

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## FORWARD PLAN OF KEY DECISIONS

# Forward Plan January 2019 - April 2019

This Forward Plan sets out the key decisions the Council expects to take during the next four months.

Anyone wishing to make representations on a decision should submit them in writing as soon as possible to the relevant contact officer (shown as number (7) in the key overleaf). Any representations made less than 3 days before the meeting should be sent toKevin Flaherty, the Local Democracy Officer, at the Council Offices or kevin.flaherty@lewisham.gov.uk. However the deadline will be 4pm on the working day prior to the meeting.

A “key decision”* means an executive decision which is likely to:

(a) result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council’s budget for the service or function to which the decision relates;

(b) be significant in terms of its effects on communities living or working in an area comprising two or more wards.

| | | | | | |
|---|---|---|---|---|---|
| October 2018 | **Housing Assistance Policy** | 16/01/19<br>Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing | | |
| November 2018 | **Award of a Printing Services Contract for the ICT Shared Service Authorities** | 16/01/19<br>Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, | | |

| FORWARD PLAN – KEY DECISIONS | | | | | |
|---|---|---|---|---|---|
| **Date included in forward plan** | **Description of matter under consideration** | **Date of Decision Decision maker** | **Responsible Officers / Portfolios** | **Consultation Details** | **Background papers / materials** |
| | | | Cabinet Member for Democracy, Refugees & Accountability | | |
| November 2018 | **Gambling Statement** | 16/01/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Joani Reid, Cabinet Member for Safer Communities | | |
| November 2018 | **Adoption of Perry Vale and Christmas Estate Conservation Area Article 4 Direction and Conservation Area Appraisal** | 16/01/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Mayor Damien Egan, Mayor | | |
| November 2018 | **Contract Award Carers Specialist Information Advice and Support Service** | 16/01/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor | | |
| May 2018 | **2 PCSA Contract Awards for Stage 1 of two SEND school expansion projects** | 16/01/19 Mayor and Cabinet | Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance | | |
| December 2018 | **Council Tax Base** | 16/01/19 Mayor and Cabinet | David Austin, Head of Corporate Resources and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs | | |

| FORWARD PLAN – KEY DECISIONS | | | | | |
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| | | | (job share) | | |
| December 2018 | **Decent Homes Update'** | 16/01/19<br>Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing | | |
| December 2018 | **Article 4 Direction to withdraw PD rights for change of use from dwelling house (Use Class C3) to small HMOs (Use Class 4)** | 16/01/19<br>Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Mayor Damien Egan, Mayor | | |
| December 2018 | **Stillness Junior School Instrument of Government** | 16/01/19<br>Mayor and Cabinet | Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance | | |
| December 2018 | **Financial Regulations and the Directorate Schemes of Delegation** | 16/01/19<br>Mayor and Cabinet | David Austin, Head of Corporate Resources and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share) | | |
| December 2018 | **Demolition of Mayow Road Warehouse to build new Council Homes** | 16/01/19<br>Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing | | |

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| December 2018 | **Proposal to discontinue Main Grants funding to Lewisham Disability Coalition** | 16/01/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Jonathan Slater, Cabinet Member for Community Sector | | |
| December 2018 | **New Homes Better Places: Longfield Crescent** | 16/01/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing | | |
| December 2018 | **Tipping, Transportation & Treatment of Organic Waste Contract award** | 16/01/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share) | | |
| August 2018 | **Council Tax Reduction - Consultation 2019-20** | 23/01/19 Council | Kevin Sheehan, Executive Director for Customer Services and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share) | | |
| October 2018 | **Council Tax Base** | 23/01/19 Council | David Austin, Head of Corporate Resources and Councillor Joe Dromey, Cabinet Member for | | |

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| | | | Finance, Skills and Jobs (job share) | | |
| December 2018 | **Financial Regulations and the Directorate Schemes of Delegation** | 23/01/19<br>Council | David Austin, Head of Corporate Resources and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share) | | |
| December 2018 | **Gambling Statement** | 23/01/19<br>Council | Aileen Buckton, Executive Director for Community Services and Councillor Joani Reid, Cabinet Member for Safer Communities | | |
| October 2018 | **Greenvale expansion phase 1: demolition contract award report** | 29/01/19<br>Executive Director for Resources and Regeneration | Kevin Sheehan, Executive Director for Customer Services and Councillor Chris Barnham, Cabinet Member for School Performance | | |
| October 2018 | **Chelwood Nursery Expansion** | 29/01/19<br>Executive Director for Resources and Regeneration | Kevin Sheehan, Executive Director for Customer Services and Councillor Chris Barnham, Cabinet Member for School Performance | | |
| October 2018 | **Rockbourne Community Centre Refurbishment** | 29/01/19<br>Executive Director for Resources and | Kevin Sheehan, Executive Director for Customer Services and | | |

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| | | Regeneration | Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share) | | |
| December 2018 | **Provision of Healthwatch - Extension of Contract** | 29/01/19 Executive Director for Community Services | Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor | | |
| December 2018 | **Annual Budget 2019-20** | 06/02/19 Mayor and Cabinet | David Austin, Head of Corporate Resources and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share) | | |
| October 2018 | **Public Health cuts revised proposals** | 06/02/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor | | |
| November 2018 | **Lewisham Transport Strategy and Local Implementation Plan 2019-2041** | 06/02/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share) | | |
| November 2018 | **Determined Admission Arrangements 2019-20** | 06/02/19 Mayor and Cabinet | Sara Williams, Executive Director, Children and | | |

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| | | | Young People and Councillor Chris Barnham, Cabinet Member for School Performance | | |
| December 2018 | **Parking Policy Update** | 06/02/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share) | | |
| December 2018 | **Beckenham Place Park update** | 06/02/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share) | | |
| December 2018 | **Redevelopment of PLACE/Ladywell site** | 06/02/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing | | |
| November 2018 | **Corporate Strategy** | 13/02/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member for Democracy, Refugees & | | |

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| | | | Accountability | | |
| November 2018 | **Adoption of Charter against Modern Slavery and Approval of 1st Annual Modern Slavery and Human Trafficking Statement** | 13/02/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Joani Reid, Cabinet Member for Safer Communities | | |
| October 2018 | **Neighbourhood CIL Strategy** | 13/02/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Mayor Damien Egan, Mayor | | |
| December 2018 | **Public Health Neighbourhood Grants** | 13/02/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Jonathan Slater, Cabinet Member for Community Sector | | |
| December 2018 | **Council Budget Update** | 13/02/19 Mayor and Cabinet | David Austin, Head of Corporate Resources and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share) | | |
| November 2018 | **Neighbourhood CIL Strategy** | 27/02/19 Council | Kevin Sheehan, Executive Director for Customer Services and Mayor Damien Egan, Mayor | | |
| November 2018 | **Annual Budget 2019-20** | 27/02/19 | David Austin, Head of | | |

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| | | Council | Corporate Resources and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share) | | |
| November 2018 | **Adoption of Charter against Modern Slavery and Approval of 1st Annual Modern Slavery and Human Trafficking Statement** | 27/02/19 Council | Aileen Buckton, Executive Director for Community Services and Councillor Joani Reid, Cabinet Member for Safer Communities | | |
| August 2018 | **Lewisham Strategic Heat Network Business Case** | 13/03/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Mayor Damien Egan, Mayor | | |
| December 2018 | **Commissioning of Older Adults Day Services** | 13/03/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor | | |
| December 2018 | **Learning Disability Framework - shortlisting approval** | 13/03/19 Mayor and Cabinet | Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor | | |
| May 2018 | **Stillness School Kitchen and Dining Hall Contract** | 19/03/19 Executive Director for Children and Young People | Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet | | |

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| | | | Member for School Performance | | |
| December 2018 | **Heathside and Lethbridge Phases 5 & 6 Land Assembly. Part 1 & 2** | 27/03/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing | | |
| December 2018 | **New Woodlands School Remodelling works Contract Award** | 27/03/19 Mayor and Cabinet | Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance | | |
| December 2018 | **Proposals for private rented sector licensing in Lewisham** | 27/03/19 Mayor and Cabinet | Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing | | |

| FORWARD PLAN – KEY DECISIONS | | | | | |
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